

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047803

Facility Name: Ellner Terrace

Address: Market & Columbia Street Evansville 62242
Number City Zip Code

County: Randolph

Telephone Number: (618) 853-4451 Fax # (618) 853-2555

HFS ID Number:

Date of Initial License for Current Owners: 06/01/1990

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 C (3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Jerry Johnson Telephone Number: (309) 685-0595 ext 304
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2010 to 6/30/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	Jerry Johnson	
	(Title)	Controller	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)	Lisa Templin Partner	
	(Firm Name & Address)	Templin Healthcare Accounting Services, LLP PO Box 9, Dunlap, IL 61525	
	(Telephone)	309-265-3630	Fax # ()
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

Facility Name & ID Number Ellner Terrace

0047803 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.					
	1	2	3	4	5
	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,428			5,428
14	TOTALS	5,428			5,428

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.95%

D. How many bed-hold days during this year were paid by the Department?
101 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 06/01/1990

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 2/24/11 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/2011 Fiscal Year: 6/30/2011
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2010 Ending: 6/30/2011
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	18,971	1,586	1,720	22,277		22,277		22,277			1
2	Food Purchase		29,117		29,117		29,117		29,117			2
3	Housekeeping		2,330		2,330		2,330	337	2,667			3
4	Laundry		1,386		1,386		1,386		1,386			4
5	Heat and Other Utilities			13,562	13,562		13,562	505	14,067			5
6	Maintenance	8,717		5,336	14,053		14,053	398	14,451			6
7	Other (specify):*											7
8	TOTAL General Services	27,688	34,419	20,618	82,725		82,725	1,240	83,965			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	161,270	4,972	2,609	168,851		168,851		168,851			10
10a	Therapy			349	349		349		349			10a
11	Activities		1,353		1,353		1,353	439	1,792			11
12	Social Services			1,697	1,697		1,697		1,697			12
13	CNA Training											13
14	Program Transportation			3,909	3,909		3,909		3,909			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	161,270	6,325	9,764	177,359		177,359	439	177,798			16
	C. General Administration											
17	Administrative											17
18	Directors Fees			2,208	2,208		2,208		2,208			18
19	Professional Services			12,909	12,909		12,909	3,769	16,678			19
20	Dues, Fees, Subscriptions & Promotions			2,007	2,007		2,007	411	2,418			20
21	Clerical & General Office Expenses		2,313	6,304	8,617		8,617	45,130	53,747			21
22	Employee Benefits & Payroll Taxes			49,984	49,984		49,984	9,580	59,564			22
23	Inservice Training & Education			68	68		68		68			23
24	Travel and Seminar			2,425	2,425		2,425	511	2,936			24
25	Other Admin. Staff Transportation			939	939		939	238	1,177			25
26	Insurance-Prop.Liab.Malpractice			3,489	3,489		3,489	576	4,065			26
27	Other (specify):*											27
28	TOTAL General Administration		2,313	80,333	82,646		82,646	60,215	142,861			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	188,958	43,057	110,715	342,730		342,730	61,894	404,624			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			9,710	9,710		9,710	2,026	11,736			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			218	218		218	(218)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			49,713	49,713		49,713		49,713			34
35	Rent-Equipment & Vehicles							129	129			35
36	Other (specify):*											36
37	TOTAL Ownership			59,641	59,641		59,641	1,937	61,578			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,348	33,348		33,348		33,348			42
43	Other (specify):* Non-allowable Costs			158,878	158,878		158,878	(158,878)				43
44	TOTAL Special Cost Centers			192,226	192,226		192,226	(158,878)	33,348			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	188,958	43,057	362,582	594,597		594,597	(95,047)	499,550			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$ (157,835)	43	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(549)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,043)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (159,427)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	64,380		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 64,380		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (95,047)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	337	0	0	0	0	0	0	0	0	337	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	505	0	0	0	0	0	0	0	0	505	5
6	Maintenance	0	0	398	0	0	0	0	0	0	0	0	398	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	1,240	0	0	0	0	0	0	0	0	1,240	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	439	0	0	0	0	0	0	0	0	439	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	439	0	0	0	0	0	0	0	0	439	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,769	0	0	0	0	0	0	0	0	3,769	19
20	Fees, Subscriptions & Promotions	0	0	411	0	0	0	0	0	0	0	0	411	20
21	Clerical & General Office Expenses	0	0	45,130	0	0	0	0	0	0	0	0	45,130	21
22	Employee Benefits & Payroll Taxes	0	0	9,580	0	0	0	0	0	0	0	0	9,580	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	511	0	0	0	0	0	0	0	0	511	24
25	Other Admin. Staff Transportation	0	0	238	0	0	0	0	0	0	0	0	238	25
26	Insurance-Prop.Liab.Malpractice	0	0	576	0	0	0	0	0	0	0	0	576	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	60,215	0	0	0	0	0	0	0	0	60,215	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	61,894	0	0	0	0	0	0	0	0	61,894	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	2,026	0	0	0	0	0	0	0	0	2,026	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(549)	0	331	0	0	0	0	0	0	0	0	(218)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	129	0	0	0	0	0	0	0	0	129	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(549)	0	2,486	0	0	0	0	0	0	0	0	1,937	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(158,878)	0	0	0	0	0	0	0	0	0	0	(158,878)	43
44	TOTAL Special Cost Centers	(158,878)	0	0	0	0	0	0	0	0	0	0	(158,878)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(159,427)	0	64,380	0	0	0	0	0	0	0	0	(95,047)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc	100	See Pg 6-Supp		See Pg 6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	\$ 955	Progressive Housing, Inc.	100.00%	\$ 955		1
2	V	11	Activities	274	Progressive Housing, Inc.	100.00%	274		2
3	V	18	Director Fees	2,208	Progressive Housing, Inc.	100.00%	2,208		3
4	V	19	Professional Services	9,916	Progressive Housing, Inc.	100.00%	9,916		4
5	V	20	Dues, Fees, Subs and Promo.	668	Progressive Housing, Inc.	100.00%	668		5
6	V	21	Clerical and General Office	2,812	Progressive Housing, Inc.	100.00%	2,812		6
7	V	24	Travel and Seminar	484	Progressive Housing, Inc.	100.00%	484		7
8	V	32	Interest	145	Progressive Housing, Inc.	100.00%	145		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 17,462			\$ 17,462	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping	\$	Center For Residential Management	Parent Co.	\$ 337	\$ 337	15
16	V	5	Utilities		Center For Residential Management	Parent Co.	505	505	16
17	V	6	Maintenance		Center For Residential Management	Parent Co.	398	398	17
18	V	11	Activities		Center For Residential Management	Parent Co.	439	439	18
19	V	19	Professional Services		Center For Residential Management	Parent Co.	3,769	3,769	19
20	V	20	Dues, Fees, Subs & Promotions		Center For Residential Management	Parent Co.	411	411	20
21	V	21	Clerical and General Office		Center For Residential Management	Parent Co.	45,130	45,130	21
22	V	22	Employee Benefits & Payroll		Center For Residential Management	Parent Co.	9,580	9,580	22
23	V	23	Inservice Training & Education		Center For Residential Management	Parent Co.	0		23
24	V	24	Travel and Seminar		Center For Residential Management	Parent Co.	511	511	24
25	V	25	Other Admin. Staff Transport.		Center For Residential Management	Parent Co.	238	238	25
26	V	26	Insurance-Prop./Liab./Malprac.		Center For Residential Management	Parent Co.	576	576	26
27	V	30	Depreciation		Center For Residential Management	Parent Co.	2,026	2,026	27
28	V	32	Interest		Center For Residential Management	Parent Co.	331	331	28
29	V	35	Rent-Equipment & Vehicles		Center For Residential Management	Parent Co.	129	129	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 64,380	\$ * 64,380	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

Ellner Terrace

0047803

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Sparta Terrace	Sparta	Center for Residential			1
2			Taylorville Terrace	Taylorville	Management	Peoria	Management Co.	2
3			Aviston Terrace	Aviston	Progressive			3
4			Briarbrook Place	East Peoria	Housing, Inc.	Peoria	ICF/DD Provider	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Steger	Workshop	6
7			Terra Estates	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Waltonville	Workshop	8
9			Cardinal	Woodlawn	Perfection			9
10			Western Gardens	MT. Vernon	Cleaning	Olympia Fields	Housekeeping	10
11			Galaxy	Woodlawn				11
12			Bill Goat Hill	MT. Vernon				12
13			Country Club Hill	Country Club Hills				13
14			Lee street	Country Club Hills				14
15			Baker Street	Country Club Hills				15
16			182nd Street	Country Club Hills				16
17			Osage	Park Forest				17
18			Oakwood	Park Forest				18
19			Blair	Park Forest				19
20			Lowell	Hazelcrest				20
21			Marquette	Park Forest				21
22			Cherry	Park Forest				22
23			Luella	Sauk Village				23
24			Olivia	Sauk Village				24
25			Huron	Park Forest				25
26			Wilshire	Park Forest				26
27			Constance	Sauk Village				27
28			175th Place	Country Club Hills				28
29			Sauganash	Park Forest				29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,036	3Hrs/MTG	1.00	Dir. Fees	\$ 564	L18,C3	1
2	Orland Bauer	Treasurer	Board Member	None	9,036	3Hrs/MTG	1.00	Dir. Fees	564	L18,C3	2
3	Robert Bauer	Secretary	Board Member	None	9,037	3Hrs/MTG	1.00	Dir. Fees	563	L18,C3	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,283	3Hrs/MTG	1.00	Dir. Fees	517	L18,C3	4
5	Lawrence Manson	President	Board Memb/CEO	None	152,138	1.18	2.95	Salary	7,950	L21,C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,158		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Ellner Terrace
0047803
6/30/2011

SCHEDULE 7A

	BOARD OF DIRECTOR FEES					Center for Residential Management
	Progressive Housing, Inc.					Larry Manson
	Edward Childers	Orland Bauer	Robert Bauer	Shawn Jeffers	Total	
Lakeview Living Center						4,603
Sparta Terrace	555	555	555	509	2,174	8,156
Ellner Terrace	564	564	563	517	2,208	7,950
Taylorville Terrace	525	525	526	482	2,058	8,624
Aviston Terrace	611	611	611	560	2,393	8,734
Briarbrook Place	579	579	578	531	2,267	9,284
Harris Place	554	554	555	509	2,172	7,972
Joshua Manor	606	606	606	557	2,375	8,283
Terra Estates	646	646	645	592	2,529	8,910
Park Place	471	471	472	433	1,847	7,269
Western Gardens	229	229	229	211	898	3,263
Galaxy	232	232	232	212	908	4,557
Cardinal	204	204	204	187	799	3,545
Bill Goat Hill	234	234	234	215	917	4,328
Country Club Hill	181	181	182	167	711	3,482
Lee Street	199	199	198	182	778	3,576
Baker Street	193	193	192	177	755	3,644
182nd Street	202	202	202	186	792	3,684
Osage	212	212	213	195	832	3,683
Oakwood	206	206	205	189	806	3,779
Blair	210	210	211	193	824	3,847
Lowell	251	251	252	231	985	3,904
Marquette	208	208	207	191	814	4,037
Cherry	223	223	222	204	872	4,170
Luella	238	238	238	219	933	4,125
Olivia	240	240	241	222	943	4,464
Huron	217	217	217	199	850	4,039
Wilshire	213	213	213	195	834	4,239
Constance	166	166	166	145	643	1,417
175th Place	211	211	212	189	823	3,094
Sauganash						177
Steger						1,913
Waltonville	220	220	219	201	860	3,174
Perfection Cleaning						162
Total PHI	9,600	9,600	9,600	8,800	37,600	160,088

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Progressive Housing, Inc.
Street Address PO Box 10528
City / State / Zip Code Peoria, IL. 61612
Phone Number (309) 685-0595
Fax Number (309) 685-8463

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Budgeted Revenue	14,012,681	30	\$ 16,403	\$	809,438	\$ 955	1
2	11	Activities	Budgeted Revenue	14,012,681	30	4,740		809,438	274	2
3	18	Director Fees	Budgeted Revenue	14,012,681	30	37,600		809,438	2,208	3
4	19	Professional Services	Budgeted Revenue	14,012,681	30	170,531		809,438	9,916	4
5	20	Dues, Fees, Subs and Promotions	Budgeted Revenue	14,012,681	30	11,434		809,438	668	5
6	21	Clerical and General Office	Budgeted Revenue	14,012,681	30	48,267		809,438	2,812	6
7	24	Travel and Seminar	Budgeted Revenue	14,012,681	30	8,382		809,438	484	7
8	32	Interest	Budgeted Revenue	14,012,681	30	2,492		809,438	145	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 299,849	\$		\$ 17,462	25

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2010 Ending: 3/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Center For Residential Management
Street Address PO Box 10528
City / State / Zip Code Peoria, IL. 61612
Phone Number (309) 685-0595
Fax Number (309) 685-8463

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Revenue	12,359,018	34	\$ 6,784	\$	613,748	\$ 337	1
2	5	Utilities	Revenue	12,359,018	34	10,175		613,748	505	2
3	6	Maintenance	Revenue	12,359,018	34	8,009		613,748	398	3
4	11	Activities	Revenue	12,359,018	34	8,842		613,748	439	4
5	19	Professional Services	Revenue	12,359,018	34	75,898		613,748	3,769	5
6	20	Dues, Fees, Subs & Promotions	Revenue	12,359,018	34	8,284		613,748	411	6
7	21	Clerical and General Office	Revenue	12,359,018	34	908,778	829,663	613,748	45,130	7
8	22	Employee Benefits & Payroll	Revenue	12,359,018	34	192,921		613,748	9,580	8
9	23	Inservice Training & Education	Revenue	12,359,018	34	8		613,748		9
10	24	Travel and Seminar	Revenue	12,359,018	34	10,280		613,748	511	10
11	25	Other Admin. Staff Transport.	Revenue	12,359,018	34	4,786		613,748	238	11
12	26	Insurance-Prop./Liab./Malprac.	Revenue	12,359,018	34	11,606		613,748	576	12
13	30	Depreciation	Revenue	12,359,018	34	40,795		613,748	2,026	13
14	32	Interest	Revenue	12,359,018	34	6,672		613,748	331	14
15	35	Rent-Equipment & Vehicles	Revenue	12,359,018	34	2,604		613,748	129	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,296,442	\$ 829,663		\$ 64,380	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE											
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)											
	1	2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
	A. Directly Facility Related										
	Long-Term										
1							\$				\$
2											
3											
4											
5											
	Working Capital										
6	Vendor Finance Charge		X	Working Capital							73
7	Allocation from Parent Co.	X		Working Capital							446
8	Amort of Loan Cost		X	Line of Credit Fee							30
9	TOTAL Facility Related						\$				\$ 549
	B. Non-Facility Related*										
10											
11	Offset Interest Income										(549)
12											
13											
14	TOTAL Non-Facility Related						\$				\$ (549)
15	TOTALS (line 9+line14)						\$				\$

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

HFS 3745 (N-4-99)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2010		\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010		12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION\$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	Ellner Terrace	COUNTY	Randolph
---------------	----------------	--------	----------

CONTACT PERSON REGARDING THIS REPORT N/A

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Ex Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100

B. General Construction Type: Exterior Wood/Siding Frame Wood Number of Stories One

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2011	\$ 25,000	1
2					2
3	TOTALS			\$ 25,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			2011		\$ 475,000	\$ 4,948		\$ 4,948		\$ 4,948	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1996	1,100	73	15	73		1,087	9
10	Building Improvement			1998	659	44	15	44		582	10
11	Flooring and Trim			2001	1,205	80	15	80		789	11
12	Jany Plumbing Backflow Preventor			2006	549	37	15	37		193	12
13	Bathroom Remodel			2006	2,038	136	15	136		643	13
14	Bathroom Remodel			2007	251	17	15	17		70	14
15	Furnace			2008	1,562	104	15	104		356	15
16	Dinning Room Remodel			2008	720	48	15	48		160	16
17	Bathroom Remodel			2008	514	34	15	34		114	17
18	Plumbing Improvement			2008	1,075	72	15	72		203	18
19	Plumbing Improvement			2008	1,895	126	15	126		358	19
20	Flooring and Trim			2008	1,885	126	15	126		346	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29	Allocation from Parent Co.							648	648		29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 488,453	\$ 5,845		\$ 6,493	\$ 648	\$ 9,849	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 38,221	\$ 3,612	\$ 3,612		5-10Yrs	\$ 20,210	71
72	Current Year Purchases	2,431	121	121		5-10Yrs	121	72
73	Fully Depreciated Assets	10,476				5-10Yrs	10,476	73
74	Allocated From Parent Co.			1,378	1,378			74
75	TOTALS	\$ 51,128	\$ 3,733	\$ 5,111	\$ 1,378		\$ 30,807	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Trans	2004 Ford Freestar	2004	\$ 19,386	\$	\$	\$	5	\$ 19,386	76
77	Resident Trans	2004 Ford Lift Van	2004	30,995				5	30,995	77
78	Resident Trans	2004 Ford Free- Alternator	2004	659	132	132		5	143	78
79										79
80	TOTALS			\$ 51,040	\$ 132	\$ 132	\$		\$ 50,524	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 615,621 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,710 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,736 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,026 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 91,180 85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: RFMS - Lease expired on 2/24/11. Facility purchased.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		16	06/01/00	\$ 49,713			3
4	Additions							4
5								5
6								6
7	TOTAL		16		\$ 49,713			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
- N/A
- N/A

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 129
- Description: Allocated from Parent Co - postage machine, copier
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18		N/A			18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning 6/1/10
Ending 2/24/11
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending
- Annual Rent
12. /2012 \$ N/A
13. /2013 \$ N/A
14. /2014 \$ N/A

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	☐ YES ☒ NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY COMMUNITY COLLEGE HOURS PER CNA	3. CLINICAL PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY HOURS PER CNA
--	---	---	---

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	10(3)	visits		21	1,587		21	1,587	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	21	\$ 1,587	\$	21	\$ 1,587	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 300	\$ 300	1
2	Cash-Patient Deposits	9,838	9,838	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,876)	204,715	204,715	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	115	115	6
7	Other Prepaid Expenses	1,344	1,344	7
8	Accounts Receivable (owners or related parties)	730,465	730,465	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 946,777	\$ 946,777	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,000	13
14	Buildings, at Historical Cost	488,453	488,453	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	102,168	102,168	16
17	Accumulated Depreciation (book methods)	(91,180)	(91,180)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 524,441	\$ 524,441	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,471,218	\$ 1,471,218	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,222	\$ 3,222	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,838	9,838	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,605	14,605	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	66,872	66,872	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 94,537	\$ 94,537	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 94,537	\$ 94,537	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,376,681	\$ 1,376,681	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,471,218	\$ 1,471,218	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,172,982	1
2	Restatements (describe):		2
3			3
4	Rounding	(4)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,172,978	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	203,703	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 203,703	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,376,681	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Ellner Terrace

0047803

Report Period Beginning: 7/1/2010

Ending: 6/30/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 613,748	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 613,748	3
	B. Ancillary Revenue		
4	Day Care	157,835	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 157,835	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services Transport., DSP Training	13,756	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,756	23
	D. Non-Operating Revenue		
24	Contributions	1,408	24
25	Interest and Other Investment Income***	11,553	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,961	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 798,300	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	82,725	31
32	Health Care	177,359	32
33	General Administration	82,646	33
	B. Capital Expense		
34	Ownership	59,641	34
	C. Ancillary Expense		
35	Special Cost Centers	158,878	35
36	Provider Participation Fee	33,348	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 594,597	40
41	Income before Income Taxes (line 30 minus line 40)**	203,703	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 203,703	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name	Ellner Terrace
ID#	0047803
FYE	6/30/2011

SCH 19A

Schedule XVII
Page 19

This facility is a Not-For-Profit Under IRC 501C(3)
and is part of a Consolidated Entity Tax Return.
Therefore, the Income or Loss cannot be
traced to the Federal Income Tax Return.

Facility Name & ID Number **Ellner Terrace**# **0047803**

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	304	311	4,354	14.00	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,200	2,248	18,971	8.44	15
16	Dishwashers					16
17	Maintenance Workers	873	873	8,717	9.99	17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,890	2,068	27,808	13.45	29
30	Habilitation Aides (DD Homes)	13,634	14,719	129,108	8.77	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,901	20,219	\$ 188,958 *	\$ 9.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	20	\$ 1,700	L1, C3	35
36	Medical Director	Monthly	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	16	400	L10, C3	38
39	Pharmacist Consultant	10	622	L10, C3	39
40	Physical Therapy Consultant	3	198	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	151	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	25	1,697	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	76	\$ 5,968		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
			\$	Workers' Compensation Insurance		\$ 4,648	IDPH License Fee		\$		
				Unemployment Compensation Insurance		7,167	Advertising: Employee Recruitment		114		
N/A Allocated frm CRM				FICA Taxes		13,439	Health Care Worker Background Check				
				Employee Health Insurance		23,815	(Indicate # of checks performed 6)		229		
				Employee Meals			Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*			Software Fees		506		
				Employee Moral		354	IHCA Dues		368		
				403B Retirement Contribution		462	Miscellaneous Dues & Fees		688		
				Drug Testing		69	Subscriptons		102		
				Employee Physicals		30	Allocation from Parent Co.		411		
							Less: Public Relations Expense		()		
				Allocation from Parent Co.		9,580	Non-allowable advertising		()		
							Yellow page advertising		()		
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,		\$ 59,564	TOTAL (agree to Sch. V,		\$ 2,418		
(List each licensed administrator separately.)			\$	line 22, col.8)			line 20, col. 8)				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount	
Allocated from Center For Residential Management			\$	N/A				Out-of-State Travel		\$	
								In-State Travel		1,452	
								Allocation from Parent Co.		456	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					Seminar Expense		973	
(Attach a copy of any management service agreement)								Allocation from Parent Co.		55	
C. Professional Services								Entertainment Expense		()	
Vendor/Payee	Type	Amount						(agree to Sch. V,			
Schuyler Roche	Legal	\$	3,326					line 24, col. 8)			
Wells Fargo	Bond Trustee		269					TOTAL		\$ 2,936	
Mike Kaplan	Financial Consulting		173								
Personnel Planners	UC Consultant		400								
Heinold-Banwart, LTD	Accounting		5,114								
Barbara Weiner	Legal		58								
Wildman, Harrold, Allen	Legal		2,759								
Dean Group Consulting	HR Consultant		208								
Ice Miller	Legal		144								
Title Professionals	Loan Settlement fee		458								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$					
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 12,909								

* Attach copy of IMRF notifications

**See instructions.

Ellner Terrace
0047803
Period Beginning 7/1/2010
Period End 6/30/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		12,909
Management Allocation		
National Hotline Services	Employee Hotline	89
Mike Kaplan	Finanacial Consultant	2,994
Klancic Architect PC	Architect	68
Title Professionals	Loan Settlement fees	618
Total (agree to Schedule V, line 19, column 8)		16,678

Ellner Terrace
0047803
Period Beginning7/1/2010
Period End6/30/2011

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility	Invoice Total	Allocated Total
Vendor/Payee	Total	Total
Schuyler, Roche, Crisham	2,512.33	2,512.33
Parent Company Allocation:		
BARBARA WEINER	1,000.00	57.76
ICE MILLER	2,500.00	144.41
SCHUYLER, ROCHE & CRISHAM	350.00	20.82
SCHUYLER, ROCHE & CRISHAM	500.00	29.75
SCHUYLER, ROCHE & CRISHAM	516.00	29.81
SCHUYLER, ROCHE & CRISHAM	400.00	23.11
SCHUYLER, ROCHE & CRISHAM	600.00	34.66
SCHUYLER, ROCHE & CRISHAM	180.00	10.40
SCHUYLER, ROCHE & CRISHAM	16.00	0.95
SCHUYLER, ROCHE & CRISHAM-refund	(182.75)	(10.00)
SCHUYLER, ROCHE & CRISHAM	504.00	29.88
SCHUYLER, ROCHE & CRISHAM	375.35	21.68
SCHUYLER, ROCHE & CRISHAM	3,547.00	204.89
SCHUYLER, ROCHE & CRISHAM	369.39	21.34
SCHUYLER, ROCHE & CRISHAM	350.00	20.22
SCHUYLER, ROCHE & CRISHAM	6,522.64	376.78
WILDMAN, HERROLD, ALLEN & DIXON LLP	860.00	51.16
WILDMAN, HERROLD, ALLEN & DIXON LLP	2,752.00	163.73
WILDMAN, HERROLD, ALLEN & DIXON LLP	24,064.41	1,390.07
WILDMAN, HERROLD, ALLEN & DIXON LLP	3,010.00	178.44
WILDMAN, HERROLD, ALLEN & DIXON LLP	1,099.25	65.17
WILDMAN, HERROLD, ALLEN & DIXON LLP	220.00	13.04
WILDMAN, HERROLD, ALLEN & DIXON LLP	8,260.00	477.14
WILDMAN, HERROLD, ALLEN & DIXON LLP	1,897.50	109.61
WILDMAN, HERROLD, ALLEN & DIXON LLP	5,378.29	310.68
Total Legal Fees		6,287.83

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$368
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? N/A If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 33,348
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 85
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold- Banwart, LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	18,971	1,586	1,720	22,277	0	22,277	0	22,277
2. Food Purchase	0	29,117	0	29,117	0	29,117	0	29,117
3. Housekeeping	0	2,330	0	2,330	0	2,330	337	2,667
4. Laundry	0	1,386	0	1,386	0	1,386	0	1,386
5. Heat and Other Utilities	0	0	13,562	13,562	0	13,562	505	14,067
6. Maintenance	8,717	0	5,336	14,053	0	14,053	398	14,451
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	27,688	34,419	20,618	82,725	0	82,725	1,240	83,965
9. Medical Director	0	0	1,200	1,200	0	1,200	0	1,200
10. Nursing & Medical Records	161,270	4,972	2,609	168,851	0	168,851	0	168,851
10a. Therapy	0	0	349	349	0	349	0	349
11. Activities	0	1,353	0	1,353	0	1,353	439	1,792
12. Social Services	0	0	1,697	1,697	0	1,697	0	1,697
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	3,909	3,909	0	3,909	0	3,909
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	161,270	6,325	9,764	177,359	0	177,359	439	177,798
17. Administrative	0	0	0	0	0	0	0	0
18. Directors Fees	0	0	2,208	2,208	0	2,208	0	2,208
19. Professional Services	0	0	12,909	12,909	0	12,909	3,769	16,678
20. Fees, Subscriptions & Promotion	0	0	2,007	2,007	0	2,007	411	2,418
21. Clerical & General Office	0	2,313	6,304	8,617	0	8,617	45,130	53,747
22. Employee Benefits & Payroll	0	0	49,984	49,984	0	49,984	9,580	59,564
23. Inservice Training & Education	0	0	68	68	0	68	0	68
24. Travel and Seminar	0	0	2,425	2,425	0	2,425	511	2,936
25. Other Admin. Staff Trans	0	0	939	939	0	939	238	1,177
26. Insurance-Prop.Liab.Malpractice	0	0	3,489	3,489	0	3,489	576	4,065
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	0	2,313	80,333	82,646	0	82,646	60,215	142,861
29. Total General Administrative	188,958	43,057	110,715	342,730	0	342,730	61,894	404,624
30. Depreciation	0	0	9,710	9,710	0	9,710	2,026	11,736
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	218	218	0	218	-218	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	49,713	49,713	0	49,713	0	49,713
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	129	129
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	59,641	59,641	0	59,641	1,937	61,578
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Other (specify):*	0	0	33,348	33,348	0	33,348	0	33,348
43. Other (specify):*	0	0	158,878	158,878	0	158,878	-158,878	0
44. Total Special Cost Ce	0	0	192,226	192,226	0	192,226	-158,878	33,348
45. Grand Total	188,958	43,057	362,582	594,597	0	594,597	-95,047	499,550

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	300	300
2. Cash - Patient Deposits	9,838	9,838
3. Accounts & Notes Recievable	204,715	204,715
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	115	115
7. Other Prepaid Expenses	1,344	1,344
8. Accounts Receivable-Owner/Related Party	730,465	730,465
9. Other (specify):	0	0
10. Total current assets	946,777	946,777
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	25,000	25,000
14. Buildings, at Historical Cost	488,453	488,453
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	102,168	102,168
17. Accumulated Depreciation (book methods)	-91,180	-91,180
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	524,441	524,441
25. Total Assets	1,471,218	1,471,218
CURRENT LIABILITIES		
26. Accounts Payable	3,222	3,222
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	9,838	9,838
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	14,605	14,605
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	66,872	66,872
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	94,537	94,537
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	94,537	94,537
47.Total Equity	1,376,681	1,376,681
48.Total Liabilities and Equity	1,471,218	1,471,218

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	613,748
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	613,748
4. Day Care	157,835
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	157,835
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	13,756
22. Laundry	0
Subtotal - Other Operating Revenue	13,756
24. Contributions	1,408
25. Interest and Other Investments Income	11,553
Subtotal - Non-Operating Revenue	12,961
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	798,300
31. General Services	87,203
32. Health Care	186,867
33. General Administration	69,908
34. Ownership	80,884
35. Special Cost Centers	164,224
35. Provider Participation Fee	34,732
37. Other	0
40. Total Expenses	623,818
41. Income Before Income Taxes	174,482
42. Income Taxes	0
43. Net Income or Loss for the Year	174,482