

		FOR BHF USE			

LL2

Supportive Living Facility

**2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p>I. Facility ID Number: <u>1000100</u></p> <p>Facility Name: <u>PINNACLE PLACE</u></p> <hr/> <p>Address: <u>1125 NORTH 5TH STREET</u> <u>SAVANNA</u> <u>61074</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>CARROLL</u></p> <p>Telephone Number: (<u>815</u>) <u>273-2105</u> Fax # <u>815 778-4503</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>JUNE 30, 2008</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501(C)3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>MILT RUE</u> Telephone Number: (<u>815</u>) <u>778-3610</u></p> <p>Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(C)3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2010</u> to <u>12/31/2010</u> 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.</p> <p align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;">(Signed) _____</td> <td style="width:50%; border: none;">4/21/2011</td> </tr> <tr> <td style="border: none;">(Type or Print Name) <u>MILT RUE</u></td> <td style="border: none;">(Date)</td> </tr> <tr> <td style="border: none;">(Title) <u>CFO</u></td> <td style="border: none;"></td> </tr> </table> <hr/> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;">(Signed) _____</td> <td style="width:50%; border: none;">(Date)</td> </tr> <tr> <td style="border: none;">(Print Name and Title) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">(Firm Name & Address) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">(Telephone) (<u> </u>) _____</td> <td style="border: none;">Fax # (<u> </u>) _____</td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	(Signed) _____	4/21/2011	(Type or Print Name) <u>MILT RUE</u>	(Date)	(Title) <u>CFO</u>		(Signed) _____	(Date)	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (<u> </u>) _____	Fax # (<u> </u>) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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(Telephone) (<u> </u>) _____	Fax # (<u> </u>) _____																																						

Facility Name PINNACLE PLACE

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	19	Single Unit Apartment	19	6,935	1
2	2	Double Unit Apartment	2	730	2
3		Other			3
4	21	TOTALS	21	7,665	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	455	3,003		3,458	5
6	Double Unit		92		92	6
7	Other					7
8	TOTALS	455	3,095		3,550	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 46.31%

D. Indicate the number of paid bed-hold days the SLF had during this year
 Also, indicate the number of unpaid bed-hold days the SLF had during this year. **(Do not include bed-hold days in Section B.)**

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents.
 (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? NO If yes, did the facility make all of the required payments of interest and principle? _____

If no, explain. _____

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? NO If yes, did the facility make all of the required payments of interest and principle? _____

If no, explain. _____

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? NO If yes, did the facility make all of the required payments of interest and principle? _____

If no, explain. _____

Facility Name: PINNACLE PLACE

Report Period Beginning:

01/01/2010

Ending: 12/31/2010

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	35,421	31,908	1,225	68,554		68,554	1
2	Housekeeping, Laundry and Maintenance	42,409	7,795	14,006	64,210		64,210	2
3	Heat and Other Utilities			48,401	48,401	(4,116)	44,285	3
4	Other (specify):							4
5	TOTAL General Services	77,830	39,703	63,632	181,165	(4,116)	177,049	5
B. Health Care and Programs								
6	Health Care/ Personal Care	127,509	1,444		128,953		128,953	6
7	Activities and Social Services		553		553		553	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	127,509	1,997		129,506		129,506	9
C. General Administration								
10	Administrative and Clerical	23,464	6,595	24,000	54,059		54,059	10
11	Marketing Materials, Promotions and Advertising			14,004	14,004		14,004	11
12	Employee Benefits and Payroll Taxes			39,686	39,686		39,686	12
13	Insurance-Property, Liability and Malpractice			10,904	10,904		10,904	13
14	Other (specify): Dues & Subscriptions/Seminars			5,078	5,078		5,078	14
15	TOTAL General Administration	23,464	6,595	93,672	123,731		123,731	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	228,803	48,295	157,304	434,402	(4,116)	430,286	16
Capital Expenses								
D. Ownership								
17	Depreciation					67,745	67,745	17
18	Interest					38,612	38,612	18
19	Real Estate Taxes					9,408	9,408	19
20	Rent -- Facility and Grounds			76,106	76,106	(76,106)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			76,106	76,106	39,659	115,765	23
24	GRAND TOTAL (Sum of lines 16 and 23)	228,803	48,295	233,410	510,508	35,543	546,051	24

Facility Name: PINNACLE PLACE

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.35	\$ 19.96	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	4.77	11.38	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	1.82	9.36	7
8	Dishwashers			8
9	Maintenance Workers	1.01	11.81	9
10	Housekeepers	0.93	9.15	10
11	Laundry			11
12	Managers	**		12
13	Other Administrative	0.90	12.88	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	9.78	\$ 11.24	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1	AMCORE BANK	99%		\$ -34,560	1
2	WINNING WHEELS, INC.	1%		-266,504	2
3	AL'S PLACE LIMITED PARTNERSHIP	0%		76,106	3
4					4
5					5
Total				\$ -224,958	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	AMERICAN HEALTH ENTERPRISES	\$ 24,000	1
2	** This fee is for the Manager position		2
Total		\$ 24,000	3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2
WINNING WHEELS, INC.		PROPHETSTOWN	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
AL'S PLACE LIMITED PARTNERSHIP		LYNDON		REAL ESTATE	

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: _____ If yes, what is the value of those services? \$ _____
 (Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: PINNACLE PLACE

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

VIII. OWNERSHIP COSTS

A. Purchase price of land 40,000 # Year land was acquired 1997

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

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

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	21		1997		\$ 1,155,267	\$ 42,010	27.5	\$ 42,010	\$	\$ 554,878	1
2											2
3											3
4											4
5											5
Improvement Type											
6		BUILDING ADDITION		1998	16,500	600	27.5	600		7,775	6
7		WATER HEATER		2002	3,357	96	39.0	86	(10)	951	7
8		SEAL PARKING LOT		2002	6,240	368	15.0	416	48	3,845	8
9		CHIMNEY CAPS		2003	984	36	27.5	36		276	9
10		TUCK POINT		2003	128,000	4,655	27.5	4,655		35,103	10
11		REMODEL BATH		2003	24,893	905	27.5	905		6,751	11
12		ROOF		2003	92,377	3,359	27.5	3,359		24,494	12
13		CARPET		2006	8,269	738	7.0	1,181	443	6,424	13
14		ENTRANCE SIGN		2006	1,621	112	15.0	108	(4)	611	14
15		ASBESTOS REMOVAL		2007	960	74	15.0	64	(10)	295	15
16		SEE SCHEDULE I			143,114	14,493		13,549	(944)	70,320	16
17		TOTAL (lines 1 thru 16)			\$ 1,581,582	\$ 67,446		\$ 66,969	\$ (477)	\$ 711,723	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 73,429	\$ 776	\$ 782	6	6	\$ 71,766	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 73,429	\$ 776	\$ 782	6		\$ 71,766	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: PINNACLE PLACE

Report Period Beginning: 01/01/2010

Ending: 2/31/2010

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: AL'S PLACE LIMITED PARTNERSHIP

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building	1998	21	1/27/1998	\$ 76,106	30		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		21		\$ 76,106			7

8. Is movable equipment rental included in building rental? YES NO

9. Rental amount for movable equipment \$ _____

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	Name of Lender	2		3	4	6		7	8	9						
			Related**				Purpose of Loan	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
			YES	NO									Original	Balance			
		A. Directly Facility Related															
		Long-Term															
1		MIDLAND STATES BANK		X	MORTGAGE	7/27/07	\$ 744,498	\$ 669,627	11/27/27	0.0592	\$ 38,613	1					
2						/ /			/ /			2					
3						/ /			/ /			3					
		Working Capital															
4						/ /			/ /			4					
5						/ /			/ /			5					
6						/ /			/ /			6					
7		TOTAL Facility Related						\$ 744,498	\$ 669,627			\$ 38,613	7				
		B. Non-Facility Related															
8						/ /			/ /			8					
9						/ /			/ /			9					
10		TOTALS (lines 7, 8 and 9)						\$ 744,498	\$ 669,627			\$ 38,613	10				

* If there is an option to buy the building, please provide complete details on an attached schedule.
 ** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: PINNACLE PLACE

Report Period Beginning: 01/01/2010

Ending:

12/31/2010

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 50,600	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,945		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,127		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 58,672	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	1,476,208		14
15	Leasehold Improvements, at Historical Cost	105,374		15
16	Equipment, at Historical Cost	73,429		16
17	Accumulated Depreciation (book methods)	(783,488)		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): NON-DEPRECI	9,061		22
23	Other(specify): LOAN FEES	1,306		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 921,890	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 980,562	\$	25

*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 10,374	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	510,059		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	9,257		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 529,690	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	669,627		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 669,627	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,199,317	\$	45
46	TOTAL EQUITY	\$ (218,755)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 980,562	\$	47

Facility Name: PINNACLE PLACE

Report Period Beginning: 01/01/2010

Ending:

12/31/2010

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 244,739	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 244,739	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	128	9
10	Laundry	4,712	10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 4,840	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15			15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 249,579	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	177,049	19
20	Health Care/ Personal Care	129,506	20
21	General Administration	123,731	21
B. Capital Expense			
22	Ownership	115,765	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 546,051	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (296,472)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (296,472)	31

Facility Name: PINNACLE PLACE

Report Period Beginning: 01/01/2010

Ending:

12/31/2010

Page 5 VIII. OWNERSHIP COSTS

B.

SCHEDULE I	1 Improvement Type	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation
# 16	LOCKS		2008	4,386	375	15	292	(83)	1011
	SMOKE DETECTORS		2008	19,522	1669	15	1,301	(368)	4500
	FIRE DOORS		2008	7,843	671	15	523	(148)	1808
	FLOORING FOR APT		2009	700	171	7	100	(71)	271
	FLOORING		2010	940	188	5	188	0	188
	FLOORING		2010	853	171	5	171	0	171
	AWNING		2010	2,030	102	15	135	33	101
	FLOORING		2010	1,467	293	5	293	0	293
	WASHERS AND DRYERS		2007	3,685	460	7	526	66	2534
	PLASMA TV		2009	1,050	467	3	350	(117)	817
	A/C CONDENSOR		2009	1,020	250	7	146	(104)	396
	ICE MACHINE		2009	2,295	562	7	328	(234)	890
	WATER HEATER		2009	4,628	1133	7	661	(472)	1794
	WHIRLPOOL		2010	8,841	1263	7	1,263	0	1263
	SITework		1997	31,223	1844	15	2,082	238	28458
	EROSION CONTROL		2010	7,195	360	15	480	120	360
	REFRIGERATOR		2004	2,799	250	7	400	150	2674
	WATER HEATER		2004	4,214	376	7	602	226	4026
	NURSE CALL SYSTEM		2005	24,971	2497	10	2,497	0	13734
	ZENITH TV		2005	2,845	406	7	406	0	2236
	SLF ASSESSMENT		2008	9,879	845	15	659	(186)	2277
	DELL COMPUTER		2008	728	140	5	146	6	518
	Schedule I Total			143,114	14,493		13,549	(944)	70,320

STATE OF ILLINOIS

Page 3 Supplemental

Facility Name: PINNACLE PLACE

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

Page 3 IV. Cost Center Expenses

#14 Column 3	2,246	Dues and subscriptions
	<u>2,832</u>	Seminar
	5,078	Total

Page 3 IV. Cost Center Expenses

Adjustments for unallowed expenses

Line 3, Column 5	-4,116	Cable TV for resident rooms
Line 17, Column 5	<u>-477</u>	Adjust to straight line depreciation
	-4,593	Total