

		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.

<p>I. IDPH License ID Number: <u>0042820</u></p> <p>Facility Name: <u>COULTERVILLE CARE INC.</u></p> <p>Address: <u>13138 STATE ROUTE 13</u> <u>COULTERVILLE</u> <u>62237</u> <small>Number City Zip Code</small></p> <p>County: <u>RANDOLPH</u></p> <p>Telephone Number: <u>(618) 758-2256</u> Fax # <u>(618) 758-3407</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/12/1999</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="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 _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>KEN MARX</u> Telephone Number: <u>(314) 231-5544</u> 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 _____	<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>01/01/11</u> to <u>12/31/11</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>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) <u>KEN MARX PARTNER</u> (Firm Name & Address) <u>BKD, LLP 211 N BROADWAY, STE 600, ST. LOUIS MO 63102</u> (Telephone) <u>(314) 231-5544</u> Fax # <u>(314) 231-9731</u></td> </tr> </table> <p style="text-align: right;">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>KEN MARX PARTNER</u> (Firm Name & Address) <u>BKD, LLP 211 N BROADWAY, STE 600, ST. LOUIS MO 63102</u> (Telephone) <u>(314) 231-5544</u> Fax # <u>(314) 231-9731</u>
<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 _____	<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 _____																												
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____																												
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>KEN MARX PARTNER</u> (Firm Name & Address) <u>BKD, LLP 211 N BROADWAY, STE 600, ST. LOUIS MO 63102</u> (Telephone) <u>(314) 231-5544</u> Fax # <u>(314) 231-9731</u>																												

Facility Name & ID Number COULTERVILLE CARE INC.

0042820 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 _____

	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	75	Skilled (SNF)	75	27,375	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	12,613	7,792	4,825	25,230	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,613	7,792	4,825	25,230	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.16%

D. How many bed-hold days during this year were paid by the Department?

0 (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)

N/A

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

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 11/12/1999

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/12/1999 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 75 and days of care provided 4,825

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number **COULTERVILLE CARE INC.** # **0042820** Report Period Beginning: **01/01/11** Ending: **12/31/11**

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	201,996	18,644	6,116	226,756		226,756		226,756		1
2	Food Purchase		194,391		194,391		194,391	(786)	193,605		2
3	Housekeeping	107,134	10,727	2,110	119,971		119,971		119,971		3
4	Laundry	53,460	7,004	5,855	66,319		66,319		66,319		4
5	Heat and Other Utilities			108,429	108,429		108,429		108,429		5
6	Maintenance	40,300	2,274	55,614	98,188		98,188	(7,525)	90,663		6
7	Other (specify):*										7
8	TOTAL General Services	402,890	233,040	178,124	814,054		814,054	(8,311)	805,743		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,159,099	114,942	530,477	1,804,518		1,804,518		1,804,518		10
10a	Therapy										10a
11	Activities	39,653	6,632		46,285		46,285		46,285		11
12	Social Services	28,474			28,474		28,474		28,474		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,227,226	121,574	536,477	1,885,277		1,885,277		1,885,277		16
	C. General Administration										
17	Administrative	167,420	5,698	172,242	345,360		345,360	(1,548)	343,812		17
18	Directors Fees										18
19	Professional Services			107,020	107,020		107,020		107,020		19
20	Dues, Fees, Subscriptions & Promotions			29,090	29,090		29,090	(15,139)	13,951		20
21	Clerical & General Office Expenses		13,301	35,904	49,205		49,205		49,205		21
22	Employee Benefits & Payroll Taxes			398,660	398,660		398,660		398,660		22
23	Inservice Training & Education			4,383	4,383		4,383		4,383		23
24	Travel and Seminar			21,689	21,689		21,689		21,689		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			79,187	79,187		79,187		79,187		26
27	Other (specify):*										27
28	TOTAL General Administration	167,420	18,999	848,175	1,034,594		1,034,594	(16,687)	1,017,907		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,797,536	373,613	1,562,776	3,733,925		3,733,925	(24,998)	3,708,927		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			93,473	93,473		93,473		93,473		30
31	Amortization of Pre-Op. & Org.			3,792	3,792		3,792		3,792		31
32	Interest			116,348	116,348		116,348	(363)	115,985		32
33	Real Estate Taxes			72,499	72,499		72,499		72,499		33
34	Rent-Facility & Grounds			322,062	322,062		322,062		322,062		34
35	Rent-Equipment & Vehicles			7,501	7,501		7,501		7,501		35
36	Other (specify):*										36
37	TOTAL Ownership			615,675	615,675		615,675	(363)	615,312		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			6,654	6,654		6,654		6,654		38
39	Ancillary Service Centers		75,186	65,163	140,349		140,349		140,349		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			41,400	41,400		41,400		41,400		42
43	Other (specify):* BAD DEBT			167,005	167,005		167,005	(167,005)			43
44	TOTAL Special Cost Centers		75,186	280,222	355,408		355,408	(167,005)	188,403		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,797,536	448,799	2,458,673	4,705,008		4,705,008	(192,366)	4,512,642		45

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

Facility Name & ID Number **COULTERVILLE CARE INC.**

0042820

Report Period Beginning:

01/01/11

Ending:

12/31/11

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(786)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,525)	6		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	(363)	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				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	(167,005)	43		24
25	Fund Raising, Advertising and Promotional	(15,139)	20		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	(1,548)	17		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (192,366)		\$	30

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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (192,366)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY

48		49		50		51		52	
----	--	----	--	----	--	----	--	----	--

COULTERVILLE CARE INC.

ID# 0042820

Report Period Beginning: 01/01/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	OTHER INCOME	\$	(1,548)	17
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49	Total		(1,548)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COULTERVILLE CARE INC.# 0042820

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	(786)	0	0	0	0	0	0	0	0	0	0	(786)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(7,525)	0	0	0	0	0	0	0	0	0	0	(7,525)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,311)	0	0	0	0	0	0	0	0	0	0	(8,311)	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,548)	0	0	0	0	0	0	0	0	0	0	(1,548)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(15,139)	0	0	0	0	0	0	0	0	0	0	(15,139)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(16,687)	0	0	0	0	0	0	0	0	0	0	(16,687)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,998)	0	0	0	0	0	0	0	0	0	0	(24,998)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COULTERVILLE CARE INC.# 0042820

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(363)	0	0	0	0	0	0	0	0	0	0	(363)	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	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(363)	0	0	0	0	0	0	0	0	0	0	(363)	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):*	(167,005)	0	0	0	0	0	0	0	0	0	0	(167,005)	43
44	TOTAL Special Cost Centers	(167,005)	0	0	0	0	0	0	0	0	0	0	(167,005)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(192,366)	0	0	0	0	0	0	0	0	0	0	(192,366)	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

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number COULTERVILLE CARE INC. # 0042820 Report Period Beginning: 01/01/11 Ending: 12/31/11

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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

Facility Name & ID Number COULTERVILLE CARE INC.

0042820

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

COULTERVILLE CARE INC.

0042820

Report Period Beginning:

01/01/11

Ending:

12/31/11

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										
										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	BANK OF NEW YORK		X	CONSTRUCTION FINANCING		\$ 4,000,000	\$		\$ 115,778	1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	RICKEL		X	START UP EXPENSE		25,000			285	6									
7	FRIAR		X	START UP EXPENSE		25,000			285	7									
8										8									
9	TOTAL Facility Related					\$ 4,050,000	\$		\$ 116,348	9									
B. Non-Facility Related*																			
10										10									
11										11									
12										12									
13										13									
14	TOTAL Non-Facility Related					\$	\$		\$	14									
15	TOTALS (line 9+line14)					\$ 4,050,000	\$		\$ 116,348	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2010 report.		\$	70,745	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.)		\$	72,499	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,754	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	70,745	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.		\$	72,499	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006		8
	2007	61,408	9
	2008	66,109	10
	2009	70,745	11
	2010	72,499	12

	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME =Facility COUNTY RANDOLPH

FACILITY IDPH LICENSE NUMBER 0042820

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>16-043-056-50</u>	<u>NURSING FACILITY</u>	\$ <u>72,499.00</u>	\$ <u>72,499.00</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>72,499.00</u></u>	\$ <u><u>72,499.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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.)

C. Tax Bills

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.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number COULTERVILLE CARE INC.

0042820

Report Period Beginning:

01/01/11

Ending:

12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number COULTERVILLE CARE INC.

0042820

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	75		1999	1999	\$ 3,409,916	\$ 39,584	40	\$ 39,584	\$	\$ 980,815	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		ALARM SYSTEM	1999		32,465		10			32,465	9
10		CONCRETE FLOOR- STORAGE BUILDING	2005		2,450	68	15	68		953	10
11		REMOVAL OF DINING ROOM WALL & MINOR REPAINTING	2007		7,960	221	5	221		2,078	11
12		PARKING LOT	2007		9,587	799	15	799		7,350	12
13		FRONT DOOR OF BUILDING	2008		5,556	231	10	231		1,898	13
14		OUTDOOR KEYPAD	2008		1,083	90	5	90		704	14
15		SMOKER'S PAVILLION	2008		2,011	168	5	168		1,072	15
16		CABLING FOR VOICE & INTERNET	2009		9,072	756	5	756		4,233	16
17		EXTERIOR LIGHTING	2009		1,060	88	5	88		513	17
18		NEW SLIDE DOOR PACKAGE	2009		7,044	294	10	294		1,233	18
19		HALL SHOWER ROOM FLOORING	2010		9,367	390	10	390		937	19
20		HALL RECEIVING DOOR	2010		4,345	181	10	181		398	20
21		HALL SHOWER ROOM FLOORING	2010		3,122	130	10	130		286	21
22		HALL SHOWER ROOM PLUMBING	2010		5,050	210	10	210		463	22
23		PATIO FENCE	2010		6,090	254	10	254		457	23
24		PATIO FFENCE IMPROVEMENTS	2011		1,200	30	10	30		30	24
25		PARKING LOT REPAIR AND SEAL	2011		4,643	464	5	464		464	25
26		Door hinges (qty 3)	2011		3,840	256	5	256		256	26
27		Kitchen Make-Up Air Unit	2011		24,618	547	15	547		547	27
28		Kitchen Make-Up Air Unit add'l	2011		247	4	15	4		4	28
29		Door hinges (qty 12)	2011		868	43	5	43		43	29
30		Door hinges (qty 3)	2011		3,840	192	5	192		192	30
31		Mixer Valves (North Hall)	2011		1,823	30	15	30		30	31
32		Fence Posts	2011		540	6	15	6		6	32
33		Kitchen Make-Up Air Unit add'l	2011		344	4	15	4		4	33
34		Door hinges (qty 3)	2011		3,840	128	5	128		128	34
35		Seal Kits (qty 15)	2011		3,840	128	5	128		128	35
36		Combination Locks	2011		277	9	5	9		9	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

Facility Name & ID Number COULTERVILLE CARE INC.

0042820

Report Period Beginning:

01/01/11

Ending:

12/31/11

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)	\$ 3,566,098	\$ 45,307		\$ 45,307	\$	\$ 1,037,697	70

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

Facility Name & ID Number COULTERVILLE CARE INC.

0042820

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	\$ 487,235	\$ 44,173	\$ 44,173	\$		\$ 297,357	71
72	Current Year Purchases	47,566	3,993	3,993			2,625	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 534,801	\$ 48,166	\$ 48,166	\$		\$ 299,982	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	FACILITY	94 WHEELCHAIR VAN	2002	\$ 1,000	\$	\$	\$		\$ 1,000	76
77										77
78										78
79										79
80	TOTALS			\$ 1,000	\$	\$	\$		\$ 1,000	80

E. Summary of Care-Related Assets

	1 Reference	2 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)	\$ 4,101,899	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 93,473	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 93,473	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,338,679	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					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			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: Southern Healthcare, LLC

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:	<u>1999</u>	<u>75</u>	<u>06/15/2011</u>	\$ <u>209,015</u>	<u>10</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>75</u>		\$ <u>209,015</u>			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 _____.

113,047

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: \$ 7,501 Description: 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			\$ _____	\$ _____	18
19			\$ _____	\$ _____	19
20			\$ _____	\$ _____	20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 06/15/2011

Ending 06/14/2021

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2012 \$ 420,000

13. /2013 \$ 420,000

14. /2014 \$ 420,000

* 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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	\$	4,075	\$ 206,859	\$	4,075	\$ 206,859	1
2	Licensed Speech and Language Development Therapist		hrs		1,459	92,510		1,459	92,510	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,614	231,109		4,614	231,109	4
5	Physician Care		visits							5
6	Dental Care		visits							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			\$	10,148	\$ 530,477	\$	10,148	\$ 530,477	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.

Facility Name & ID Number **COULTERVILLE CARE INC.**# **0042820**Report Period Beginning: **01/01/11**

Ending:

12/31/11**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/11**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 210,540	\$	1
2	Cash-Patient Deposits	14,636		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>350,239</u>)	933,826		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,367		6
7	Other Prepaid Expenses	48,255		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>LEASE DEPOSIT</u>	100,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,397,624	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,057,311		14
15	Leasehold Improvements, at Historical Cost	44,077		15
16	Equipment, at Historical Cost	12,394		16
17	Accumulated Depreciation (book methods)	(115,794)		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)	\$ 2,997,988	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,395,612	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 506,841	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,466		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,987		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,800		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	3,024		34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>MANAGEMENT FEE PAYABLE</u>	12,097		36
37	<u>DEFERRED GAIN/LOSS ON SALE</u>	23,872		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 636,087	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	3,034,183		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)	\$ 3,034,183	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,670,270	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 725,342	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,395,612	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 701,614	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 701,614	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	23,728	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)	\$ 23,728	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)	\$ 725,342	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number COULTERVILLE CARE INC.

0042820

Report Period Beginning: 01/01/11

Ending: 12/31/11

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	\$ 3,140,507	1
2	Discounts and Allowances for all Levels	(75,649)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,064,858	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,327,695	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,327,695	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	786	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	199,636	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,382	19
20	Radiology and X-Ray	1,506	20
21	Other Medical Services	109,315	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 322,625	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	441	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 441	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER INCOME	13,117	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,117	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,728,736	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	814,054	31
32	Health Care	1,885,277	32
33	General Administration	1,034,594	33
B. Capital Expense			
34	Ownership	615,675	34
C. Ancillary Expense			
35	Special Cost Centers	314,008	35
36	Provider Participation Fee	41,400	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,705,008	40
41	Income before Income Taxes (line 30 minus line 40)**	23,728	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 23,728	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 & ID Number **COULTERVILLE CARE INC.**

0042820

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	4,680	4,680	\$ 130,000	\$ 27.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,328	6,328	142,739	22.56	3
4	Licensed Practical Nurses	17,093	17,093	290,851	17.02	4
5	CNAs & Orderlies	53,762	53,762	570,119	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,580	3,580	39,653	11.08	10
11	Social Service Workers	2,093	2,093	28,474	13.60	11
12	Dietician	20,214	20,214	201,996	9.99	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,018	3,018	40,300	13.35	17
18	Housekeepers	11,581	11,581	107,134	9.25	18
19	Laundry	6,012	6,012	53,460	8.89	19
20	Administrator	2,080	2,080	71,093	34.18	20
21	Assistant Administrator					21
22	Other Administrative	6,859	6,859	96,327	14.04	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					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,289	2,289	25,390	11.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,589	139,589	\$ 1,797,536 *	\$ 12.88	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

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

Facility Name & ID Number COULTERVILLE CARE INC.

0042820

Report Period Beginning: 01/01/11

Ending: 12/31/11

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. LSN 3150
- (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? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,259 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? Yes
If YES, give effective date of lease. 06/15/11
- (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. \$ 41,400
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 benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? n/a
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? n/a
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? Review
Firm Name: BKD, LLP
- (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.