FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0042820

Facility Name: Coulterville Care Center

Address: 13138 State Route 13 (Number) Coulterville (City) 62237 (Zip Code)

County: Randolph

Telephone Number: (618) 758-2256 **Fax #** (618) 758-3407

HFS ID Number: 364137587001

Date of Initial License for Current Owners: 11/12/1999

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** 630-361-2868
Email Address: info@templinhealthcare.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2013 to 12/31/13 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) Andrea McFadden
(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, PO Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 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 Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,940	8,581	5,570	25,091	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,940	8,581	5,570	25,091	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.66%

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 [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 11/12/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/12/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 75 and days of care provided 5,570

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number Coulterville Care Center # 0042820 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	186,015	11,875	5,435	203,325		203,325		203,325			1
2	Food Purchase		205,784		205,784		205,784	(1,247)	204,537			2
3	Housekeeping	73,053	13,940		86,993		86,993		86,993			3
4	Laundry	61,046	8,984		70,030		70,030		70,030			4
5	Heat and Other Utilities			102,887	102,887		102,887		102,887			5
6	Maintenance	22,386	2,074	62,854	87,314		87,314	3,740	91,054			6
7	Other (specify):* **Waste Removal**			9,439	9,439		9,439		9,439			7
8	**TOTAL General Services**	342,500	242,657	180,615	765,772		765,772	2,493	768,265			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,303,732	113,172	58,490	1,475,394		1,475,394		1,475,394			10
10a	Therapy			654,251	654,251		654,251		654,251			10a
11	Activities	56,866	7,310	6,487	70,663		70,663		70,663			11
12	Social Services	31,239		2,419	33,658		33,658		33,658			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,391,837	120,482	727,647	2,239,966		2,239,966		2,239,966			16
	C. General Administration											
17	Administrative	83,403		85,000	168,403		168,403		168,403			17
18	Directors Fees											18
19	Professional Services			89,076	89,076		89,076	(5,747)	83,329			19
20	Dues, Fees, Subscriptions & Promotions			9,462	9,462		9,462	(50)	9,412			20
21	Clerical & General Office Expenses	127,175	15,802	8,202	151,179		151,179		151,179			21
22	Employee Benefits & Payroll Taxes			417,709	417,709		417,709		417,709			22
23	Inservice Training & Education			1,971	1,971		1,971		1,971			23
24	Travel and Seminar			6,848	6,848		6,848	(917)	5,931			24
25	Other Admin. Staff Transportation			3,999	3,999		3,999		3,999			25
26	Insurance-Prop.Liab.Malpractice			74,759	74,759		74,759	(5,453)	69,306			26
27	Other (specify):*											27
28	**TOTAL General Administration**	210,578	15,802	697,026	923,406		923,406	(12,167)	911,239			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,944,915	378,941	1,605,288	3,929,144		3,929,144	(9,674)	3,919,470			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.

Facility Name & ID Number Coulterville Care Center #0042820 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/13

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			58,863	58,863		58,863	132,693	191,556			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,046	19,046		19,046	(1,515)	17,531			32
33	Real Estate Taxes			87,301	87,301		87,301		87,301			33
34	Rent-Facility & Grounds			571,011	571,011		571,011		571,011			34
35	Rent-Equipment & Vehicles			14,255	14,255		14,255		14,255			35
36	Other (specify):*											36
37	**TOTAL Ownership**			750,476	750,476		750,476	131,178	881,654			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,025	8,025		8,025		8,025			38
39	Ancillary Service Centers		165,065		165,065		165,065		165,065			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			155,445	155,445		155,445		155,445			42
43	Other (specify):* See Schedule 4a			50,925	50,925		50,925	(28,121)	22,804			43
44	**TOTAL Special Cost Centers**		165,065	214,395	379,460		379,460	(28,121)	351,339			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,944,915	544,006	2,570,159	5,059,080		5,059,080	93,383	5,152,463			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 Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,247)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,861)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	132,693	30		9
10	Interest and Other Investment Income	(1,515)	32		10
11	Discounts, Allowances, Rebates & Refunds	(5,453)	26		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	(50)	20		17
18	Fines and Penalties	(844)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,747)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,530)	43		24
25	Fund Raising, Advertising and Promotional	(12,886)	43		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 See Page 5A	2,823			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 93,383		$	30

BHF USE ONLY								
48		49		50		51		52

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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 93,383		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

STATE OF ILLINOIS **Page 5A**

Coulterville Care Center

ID# 0042820

Report Period Beginning: 1/1/2013

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Expense minor repairs originally capitalized	$ 3,740	6	1
2	Out of State Travel	(917)	24	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
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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**	2,823		49

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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
Board of Directors:		None		None		
Harold Joines-President	0					
Kenneth Curry-Secretary/Treasurer	0					
William Jarrett-Board Member	0					
William Mueller-Board Member	0					

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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								1
2	N/A							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
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16								16
17								17
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		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 Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Southern Healthcare, LLC		X	Working Capital	Interest Only	01/01/12	300,000	300,000	Demand	0.0500	15,794	6
7	Southern Healthcare, LLC		X	Working Capital	Interest Only	12/31/13	830,051	830,051	Demand	0.0500	114	7
8	Southern Healthcare, LLC		X	Working Capital	Interest Only	03/08/13	50,000		Demand	0.0500	3,138	8
9	TOTAL Facility Related						$ 1,180,051	$ 1,130,051			$ 19,046	9
	B. Non-Facility Related*											
10												10
11								Interest income offset			(1,515)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,515)	14
15	TOTALS (line 9+line14)						$ 1,180,051	$ 1,130,051			$ 17,531	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** 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.)**

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 68,844	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.)	2012	$ 78,072	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,228	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 78,073	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.		$ 87,301	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	66,109	8
	2009	70,745	9
	2010	72,499	10
	2011	72,646	11
	2012	78,072	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Coulterville Care Center COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0042820

CONTACT PERSON REGARDING THIS REPORT Andrea McFadden

TELEPHONE (618) 758-2256 FAX #: (618) 758-3407

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-043-056-50	NURSING FACILITY	$ 78,072.34	$ 78,072.34
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 78,072.34	$ 78,072.34

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 X _____ 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,606 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	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	
4	75		1999	1999	$ 3,409,916	$	40	$ 85,248	$ 85,248	$ 1,151,311	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		15	163	163	1,279	10
11	Removal of Dining Room Wall and Minor Repainting			2007	7,960		5	1,592	1,592	5,262	11
12	Parking Lot			2007	9,587		15	639	639	8,628	12
13	Front Door of Building			2008	5,556		10	556	556	3,010	13
14	Outdoor Keypad			2008	1,083		5	162	162	1,083	14
15	Smoker's Pavillion			2008	2,011		5	402	402	1,876	15
16	Cabling for Voice & Internet			2009	9,072		5	1,814	1,814	7,861	16
17	Exterior Lighting			2009	1,060		5	212	212	937	17
18	New Slide Door Package			2009	7,044		10	704	704	2,641	18
19	Hall Shower Room Flooring			2010	9,367		10	937	937	2,811	19
20	Hall Receiving Door			2010	4,345		10	435	435	1,268	20
21	Hall Shower Room Flooring			2010	3,122		10	312	312	910	21
22	Hall Shower Room Flooring			2010	5,050		10	505	505	1,473	22
23	Patio Fence			2010	6,090		10	609	609	1,675	23
24	Patio Fence Improvements			2011	1,200		10	120	120	270	24
25	Parking Lot Repair and Seal			2011	4,643	929	5	929		2,322	25
26	Door hinges (qty 3)			2011	3,840	768	5	768		1,792	26
27	Kitchen Make-Up Air Unit			2011	24,618	1,641	15	1,641		3,829	27
28	Kitchen Make-Up Air Unit add'l			2011	247	16	15	16		37	28
29	Door hinges (qty 12)			2011	868	174	5	174		391	29
30	Door hinges (qty 3)			2011	3,840	768	5	768		1,728	30
31	Mixer Valves (North Hall)			2011	1,823	122	15	122		274	31
32	Fence Posts			2011	540	36	15	36		78	32
33	Kitchen Make-Up Air Unit add'l			2011	344	23	15	23		50	33
34	Door hinges (qty 3)			2011	3,840	768	5	768		1,664	34
35	Seal Kits (qty 15)			2011	3,840	768	5	768		1,664	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

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Combination Locks	2011	$ 277	$ 55	5	$ 55	$	$ 119	37
38									38
39	Kitchen Remodel:								39
40	Duct Heater	2012	2,057	411	15	137	(274)	206	40
41	Re-route refrigeration piping	2012	10,293	2,059	15	686	(1,373)	1,029	41
42	Motor, wheel, and bracket	2012	1,575	315	15	105	(210)	158	42
43	Kitchen unit switch and valves	2012	1,627	325	15	108	(217)	162	43
44	Kitchen compressor and line filter dryer	2012	4,217	843	15	281	(562)	422	44
45	Kitchen Walk-in cooling unit switch	2012	1,532	306	15	102	(204)	153	45
46	New Fire Sprinkler line	2012	1,361	272	15	91	(181)	136	46
47	Commercial Disposer	2012	1,412	471	15	94	(377)	141	47
48									48
49	Resident Room Remodel:								49
50	Vanities	2012	4,377	1,321	15	292	(1,029)	438	50
51	Overhead Bed lighting	2012	3,203	461	15	214	(247)	321	51
52	Mini blinds for Room 208	2012	322	64	15	21	(43)	32	52
53	PTAC Units	2012	6,805	2,268	15	454	(1,814)	681	53
54									54
55	Secure Wireless Solution Hardware & Labor	2012	6,088	1,218	15	406	(812)	609	55
56	Door hinges (qty 3)	2012	3,728	746	15	249	(497)	373	56
57	Parking curbs	2012	622	124	15	41	(83)	62	57
58	Window A/C (Employee lounge)	2012	472	94	15	31	(63)	47	58
59	5-ton compressor (common area)	2012	2,947	589	15	196	(393)	294	59
60	Water Heater	2012	6,945	2,315	15	463	(1,852)	695	60
61	Storage Building	2012	4,956	1,652	15	330	(1,322)	495	61
62									62
63	Water Heater (2)	2013	14,682	2,894	15	489	(2,405)	489	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,645,319	$ 24,816		$ 105,268	$ 80,452	$ 1,245,651	70

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

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	$ 574,526	$ 17,762	$ 70,003	$ 52,241	3	$ 432,531	71
72	Current Year Purchases	98,850	16,285	16,285		3	16,285	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 673,376	$ 34,047	$ 86,288	$ 52,241		$ 448,816	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 4,318,695	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,863	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 191,556	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 132,693	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,694,467	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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.

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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. [X] 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:	1999	75	6/15/11	$ 377,215	10		3
4	Additions							4
5								5
6								6
7	TOTAL		75		$ 377,215 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 193,796
   This amount was calculated by dividing the total amount to be amortized 2,954,218
   by the length of the lease 20 Years .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning 06/15/2011
    Ending 06/14/2031

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

	Fiscal Year Ending	Annual Rent
12.	6/2014	$ 420,000
13.	6/2015	$ 420,000
14.	6/2016	$ 420,000

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 14,255 Description: Copier - $11,062, Medical Equipment - $2,556, Dishwasher - $637
    (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

* 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.

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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?
   - [ ] YES
   - [X] NO

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.

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.

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	5,390	$ 274,893	$	5,390	$ 274,893	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,596	101,343		1,596	101,343	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,560	278,015		5,560	278,015	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				165,065		165,065	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			$	12,546	$ 654,251	$ 165,065	12,546	$ 819,316	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.

STATE OF ILLINOIS

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 160,599	$ 160,599	1
2	Cash-Patient Deposits	8,506	8,506	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 345,700)	1,383,936	1,383,936	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	143,236	143,236	6
7	Other Prepaid Expenses	44,691	44,691	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Lease Deposit	300,000	300,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,040,968	$ 2,040,968	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	3,545,478	14
15	Leasehold Improvements, at Historical Cost	87,416	99,841	15
16	Equipment, at Historical Cost	190,592	673,376	16
17	Accumulated Depreciation (book methods)	(586,537)	(1,694,467)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	500,000	500,000	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,248,782	$ 3,124,228	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,289,750	$ 5,165,196	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 616,353	$ 616,353	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,937	5,937	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,223	50,223	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,842	3,842	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	Due to IDPH	30,783	30,783	36
37	Deferred Gain/Loss on Sale	21,030	21,030	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 728,168	$ 728,168	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,130,051	1,130,051	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Capital Lease Obligation	2,953,736	2,953,736	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,083,787	$ 4,083,787	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,811,955	$ 4,811,955	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 477,795	$ 353,241	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,289,750	$ 5,165,196	48

*(See instructions.)

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 401,682	1
2	Restatements (describe):		2
3	**Rounding**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 401,684	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	76,111	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)**	$ 76,111	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)**	$ 477,795	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,897,866	1
2	Discounts and Allowances for all Levels	(208,834)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,689,032	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	361,680	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 361,680	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	135	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,595	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	71,464	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 75,194	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,515	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,515	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income (Offset), Deferred Gain/Loss	7,770	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,770	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,135,191	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	765,772	31
32	Health Care	2,239,966	32
33	General Administration	923,406	33
	B. Capital Expense		
34	Ownership	750,476	34
	C. Ancillary Expense		
35	Special Cost Centers	224,015	35
36	Provider Participation Fee	155,445	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,059,080	40
41	**Income before Income Taxes (line 30 minus line 40)****	76,111	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 76,111	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 905,475	44
45	Private Pay - Net Inpatient Revenue	1,417,501	45
46	Medicare - Net Inpatient Revenue	2,366,056	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,689,032	49

* **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 Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 77,226	$ 37.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,803	4,942	114,822	23.23	3
4	Licensed Practical Nurses	17,909	18,753	313,007	16.69	4
5	CNAs & Orderlies	51,807	54,734	637,243	11.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,936	5,158	56,866	11.02	10
11	Social Service Workers	1,976	2,136	31,239	14.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,781	17,819	186,015	10.44	15
16	Dishwashers					16
17	Maintenance Workers	1,542	1,738	22,386	12.88	17
18	Housekeepers	8,273	8,682	73,053	8.41	18
19	Laundry	6,608	7,042	61,046	8.67	19
20	Administrator	2,000	2,080	83,403	40.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,427	9,455	127,175	13.45	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	1,715	2,065	24,782	12.00	31
32	Other Health Care(specify)					32
33	Other(specify) Nurse Admin	3,683	4,289	136,652	31.86	33
34	TOTAL (lines 1 - 33)	132,460	140,973	$ 1,944,915 *	$ 13.80	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,435	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	12	976	L10, C3	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	Monthly	2,499	L11, C3	44
45	Social Service Consultant	Monthly	2,419	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	12	$ 17,329		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	37	1,250	L10, C3	51
52	Certified Nurse Assistants/Aides	64	1,340	L10, C3	52
53	TOTAL (lines 50 - 52)	101	$ 2,590		53

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Andrea McFadden	Exec Director	0	$ 83,403
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,403

B. Administrative - Other

Description	Amount
Management Fees - Howell Business Solutions	$ 85,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 85,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Processing	$ 15,099
Bonnett, Fairbourn,Friedman & Bal	Collections-Disallowed (col 7)	369
Armstrong Teasdale LLP	Legal	2,226
The Lowenbaum Partnership, LLC	Legal	405
Farris Law Office	Collections-Disallowed (col 7)	5,378
John F. Clendenin	Legal	660
Templin Healthcare Accounting Serv	Accounting	10,514
Dale Guebert, CPA	Accounting	4,486
Answers on Demand	Computer Services	14,477
CTS Technology Solutions	Computer Services	27,352
Ivans	Computer Services	1,429
See Attached Schedule 21a	Computer Services	6,681
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 89,076

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,851
Unemployment Compensation Insurance	5,701
FICA Taxes	136,970
Employee Health Insurance	144,924
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals / Screenings	3,668
Disability Insurance	1,804
Uniforms	584
Other Benefits	15,207
TOTAL (agree to Schedule V, line 22, col.8)	$ 417,709

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	3,367
Health Care Worker Background Check	552
(Indicate # of checks performed 55)	
Patient Background Checks 60	600
Miscellaneous License/Fees	300
Misc. Dues & Subscriptions	663
Less: Public Relations Expense	(50)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,412

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	#REF!
Seminar Expense	#REF!
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ #REF!

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Coulterville Care Center **#** 0042820 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/13

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? **No**
If YES, give association name and amount. **N/A**

(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? **No** 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? **3 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,883** 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. **6/15/11**

(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. $ **155,445**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,247**

(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? **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? **No**
Firm Name: **N/A**

(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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.