

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.

0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	310	Skilled (SNF)	310	113,460	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	310	TOTALS	310	113,460	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF	46,771		3,078	49,849	8
9	SNF/PED					9
10	ICF	45,245	795		46,040	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	92,016	795	3,078	95,889	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.51%

D. How many bed-hold days during this year were paid by Public Aid? 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 1975

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 31 and days of care provided 3,017

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/00 Fiscal Year: 12/31/00
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTE # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	268,619	50,620	22,475	341,714		341,714		341,714		1
2	Food Purchase		454,981		454,981	(41,109)	413,872	(38)	413,834		2
3	Housekeeping	252,181	82,049		334,230		334,230	1,468	335,698		3
4	Laundry	109,569	36,424		145,993		145,993		145,993		4
5	Heat and Other Utilities			199,904	199,904		199,904	4,995	204,899		5
6	Maintenance	161,634	38,075	89,433	289,142		289,142	(15,148)	273,994		6
7	Other (specify):*							60	60		7
8	TOTAL General Services	792,003	662,149	311,812	1,765,964	(41,109)	1,724,855	(8,663)	1,716,192		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	2,464,652	144,681	19,480	2,628,813		2,628,813	(2,410)	2,626,403		10
10a	Therapy	176,388	37	27,147	203,572		203,572		203,572		10a
11	Activities	182,392	22,358	574	205,324		205,324		205,324		11
12	Social Services	115,093		6,944	122,037		122,037		122,037		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,938,525	167,076	57,145	3,162,746		3,162,746	(2,410)	3,160,336		16
	C. General Administration										
17	Administrative	302,951		80,630	383,581		383,581	82,101	465,682		17
18	Directors Fees										18
19	Professional Services			572,214	572,214	(27,547)	544,667	(431,722)	112,945		19
20	Dues, Fees, Subscriptions & Promotions			91,192	91,192		91,192	(51,716)	39,476		20
21	Clerical & General Office Expenses	193,181	64,292	202,432	459,905		459,905	(13,584)	446,321		21
22	Employee Benefits & Payroll Taxes			631,389	631,389	41,109	672,498		672,498		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,415	3,415		3,415	3,048	6,463		24
25	Other Admin. Staff Transportation							304	304		25
26	Insurance-Prop.Liab.Malpractice			204,030	204,030		204,030	1,718	205,748		26
27	Other (specify):*							56,779	56,779		27
28	TOTAL General Administration	496,132	64,292	1,785,302	2,345,726	13,562	2,359,288	(353,072)	2,006,216		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,226,660	893,517	2,154,259	7,274,436	(27,547)	7,246,889	(364,145)	6,882,744		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.

MID-AMERICA CONVALESCENT CENTER, INC.

0016618

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	<u>41,109</u>	
2	FOOD		<u>41,109</u>

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	<u>27,547</u>	
19	PROFESSIONAL FEES		<u>27,547</u>

To reclass cost of appealing real estate taxes

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
	Depreciation			266,516	266,516		266,516	(9,324)	257,192			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,779	35,779		35,779	(35,779)				32
33	Real Estate Taxes			370,116	370,116	27,547	397,663	4,548	402,211			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,770	19,770		19,770	(9,610)	10,160			35
36	Other (specify):*											36
37	TOTAL Ownership			692,181	692,181	27,547	719,728	(50,165)	669,563			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		139,911	157,309	297,220		297,220		297,220			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			170,190	170,190		170,190		170,190			42
43	Other (specify):*	128,671		15,112	143,783		143,783	(143,783)				43
44	TOTAL Special Cost Centers	128,671	139,911	342,611	611,193		611,193	(143,783)	467,410			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,355,331	1,033,428	3,189,051	8,577,810		8,577,810	(558,093)	8,019,717			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,701)	30		9
10	Interest and Other Investment Income	(41,202)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(38)	2		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	(99)	21		18
19	Entertainment				19
20	Contributions	(5,530)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(145,665)	21		24
25	Fund Raising, Advertising and Promotional	(46,730)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(24,970)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(193,501)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (476,436)		\$	30

OHF 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	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)	(81,657)	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (81,657)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (558,093)		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0016618

Report Period Beginning: 01/01/00

Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance	\$	6 1
2	MARKETING SALARIES	(128,671)	43 2
3	MARKETING CONSULTANT	(15,112)	43 3
4			4
5	THEFT & LOSS	(518)	21 5
6	NON CARE ASSET DEPRECIATION	(7,565)	30 6
7	PRIOR PERIOD OFFICE	(46)	21 7
8			8
9	UNIFORM EXPENSE (INC.)	(1,437)	10 9
10	RENTAL INCOME	(9,000)	6 10
11	PROFESSIONAL FEES	(6,250)	19 11
12	CAPITALIZED R&M	(13,350)	6 12
13	NON-ALLOWABLE CAR LEASES	(11,327)	35 13
14	NON-ALLOWABLE SEMINAR EXPENSE	(225)	24 14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
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78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(193,501)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.# 0016618 Report Period Beginning:01/01/00

Ending:

12/31/00

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(38)											(38)	2
3	Housekeeping			1,468									1,468	3
4	Laundry													4
5	Heat and Other Utilities			2,367		2,628							4,995	5
6	Maintenance	(22,350)		5,304		1,898							(15,148)	6
7	Other (specify):*					60							60	7
8	TOTAL General Services	(22,388)		9,139		4,586							(8,663)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,437)		(973)									(2,410)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(1,437)		(973)									(2,410)	16
	C. General Administration													
17	Administrative			101,492	(21,350)	1,959							82,101	17
18	Directors Fees													18
19	Professional Services	(6,250)		(427,019)	1,281	266							(431,722)	19
20	Fees, Subscriptions & Promotions	(52,260)		511	14	19							(51,716)	20
21	Clerical & General Office Expenses	(171,298)		157,488	24	202							(13,584)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(225)		3,273									3,048	24
25	Other Admin. Staff Transportation			304									304	25
26	Insurance-Prop.Liab.Malpractice			1,482		236							1,718	26
27	Other (specify):*			53,299	3,480								56,779	27
28	TOTAL General Administration	(230,033)		(109,170)	(16,551)	2,682							(353,072)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(253,858)		(101,004)	(16,551)	7,268							(364,145)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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)	
30	D. Ownership													
	Depreciation	(26,266)		14,145	52	2,745							(9,324)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(41,202)		199		5,224							(35,779)	32
33	Real Estate Taxes					4,548							4,548	33
34	Rent-Facility & Grounds			19,579		(19,579)								34
35	Rent-Equipment & Vehicles	(11,327)		1,717									(9,610)	35
36	Other (specify):*													36
37	TOTAL Ownership	(78,795)		35,640	52	(7,062)							(50,165)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(143,783)											(143,783)	43
44	TOTAL Special Cost Centers	(143,783)											(143,783)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(476,436)		(65,364)	(16,499)	206							(558,093)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See attached.		See attached.		

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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item			Name of Related Organization							
15	V	3	HOUSEKEEPING	\$		MANAGCARE, INC.	100.00%	\$ 1,468	\$	1,468	15	
16	V	5	UTILITIES			MANAGCARE, INC.	100.00%	2,367		2,367	16	
17	V	6	REPAIRS AND MAINT.			MANAGCARE, INC.	100.00%	5,304		5,304	17	
18	V	10	NURSING SALARIES			MANAGCARE, INC.	100.00%	(973)		(973)	18	
19	V	17	ADMINISTRATIVE			MANAGCARE, INC.	100.00%	105,443		105,443	19	
20	V	19	PROFESSIONAL FEES			MANAGCARE, INC.	100.00%	781		781	20	
21	V	20	FEES, SUBSCRIPTIONS			MANAGCARE, INC.	100.00%	511		511	21	
22	V	21	CLERICAL AND GENERAL			MANAGCARE, INC.	100.00%	157,488		157,488	22	
23	V	24	SEMINARS			MANAGCARE, INC.	100.00%	3,273		3,273	23	
24	V	25	ADMIN. STAFF TRANS.			MANAGCARE, INC.	100.00%	304		304	24	
25	V	26	INSURANCE			MANAGCARE, INC.	100.00%	1,482		1,482	25	
26	V	27	GEN. ADMIN. EMP. BEN.			MANAGCARE, INC.	100.00%	53,299		53,299	26	
27	V	30	DEPRECIATION			MANAGCARE, INC.	100.00%	14,145		14,145	27	
28	V	32	INTEREST EXPENSE			MANAGCARE, INC.	100.00%	199		199	28	
29	V	34	RENT - BUILDING (RELATED)			MANAGCARE, INC.	100.00%	19,579		19,579	29	
30	V	35	EQUIPMENT RENTAL			MANAGCARE, INC.	100.00%	1,717		1,717	30	
31	V	19	HOME OFFICE		427,800	MANAGCARE, INC.	100.00%	0		(427,800)	31	
32	V	17	ADMIN. SALARY - MOSHE DAVIS			MANAGCARE, INC.	100.00%	(621)		(621)	32	
33	V	17	ADMIN. SALARY - AHUYA WEINREB			MANAGCARE, INC.	100.00%	(801)		(801)	33	
34	V	17	ADMIN. SALARY - JOSHUA DAVIS			MANAGCARE, INC.	100.00%	(2,529)		(2,529)	34	
35	V										35	
36	V										36	
37	V										37	
38	V										38	
39	Total			\$	427,800			\$	362,436	\$ *	(65,364)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization						
15	V	17	ADMINISTRATIVE	\$		INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 56,650	\$ 56,650	15
16	V	19	PROFESSIONAL FEES			INTERCARE, LTD. C/O MANAGCARE	100.00%	1,281	1,281	16
17	V	20	FEES, SUBSCRIPTIONS			INTERCARE, LTD. C/O MANAGCARE	100.00%	14	14	17
18	V	21	CLERICAL & GENERAL			INTERCARE, LTD. C/O MANAGCARE	100.00%	24	24	18
19	V	27	EMPLOYEE BENEFITS			INTERCARE, LTD. C/O MANAGCARE	100.00%	3,480	3,480	19
20	V	30	DEPRECIATION			INTERCARE, LTD. C/O MANAGCARE	100.00%	52	52	20
21	V									21
22	V	17	MANAGEMENT FEES		78,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(78,000)	22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$	78,000			\$ 61,501	\$ * (16,499)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization						
15	V	5	UTILITIES	\$		MAZEL MANAGEMENT	100.00%	\$ 2,628	\$	2,628	15
16	V	6	REPAIRS & MAINT.			MAZEL MANAGEMENT		1,898		1,898	16
17	V	7	EMPLOYEE BEN.-R&M SAL.			MAZEL MANAGEMENT		60		60	17
18	V	17	ADMIN.-M. WOLF			MAZEL MANAGEMENT		1,959		1,959	18
19	V	19	PROFESSIONAL FEES			MAZEL MANAGEMENT		266		266	19
20	V	20	FEES, SUBSCRIPTIONS			MAZEL MANAGEMENT		19		19	20
21	V	21	CLERICAL & GENERAL			MAZEL MANAGEMENT		202		202	21
22	V	26	INSURANCE			MAZEL MANAGEMENT		236		236	22
23	V	30	DEPRECIATION			MAZEL MANAGEMENT		2,745		2,745	23
24	V	32	INTEREST EXPENSE			MAZEL MANAGEMENT		5,224		5,224	24
25	V	33	REAL ESTATE TAXES			MAZEL MANAGEMENT		4,548		4,548	25
26	V	34	RENT		19,579	MAZEL MANAGEMENT		0		(19,579)	26
27	V										27
28	V										28
29	V										29
30	V										30
31	V										31
32	V										32
33	V										33
34	V										34
35	V										35
36	V										36
37	V										37
38	V										38
39	Total			\$	19,579			\$ 19,785	\$ *	206	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$	0 \$ *	39

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

Facility Name & ID Number MID-AMERICA CONVALESCENT CENT # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	YOSEF DAVIS	PRESIDENT	ADMINISTRATIVE	44.92	SEE ATTACHED	33	55.00	SALARY	\$ 15,577	17-1	1
2						SALARY ALLOCATED - INTERCARE			56,650	17-7	2
3	MOSHE DAVIS	OPERATIONS DIR.	ADMINISTRATIVE	0.42	SEE ATTACHED	7.1	18.00	SALARY	22,769	17-1	3
4						SALARY ALLOCATED - MANAGCARE			(704)	17-7	4
5	JOSHUA DAVIS	ADMINISTRATOR	ADMINISTRATIVE	0.42	SEE ATTACHED	28.6	72.00	SALARY	90,038	17-1	5
6						SALARY ALLOCATED - MANAGCARE			(3,537)	17-7	6
7	AHUVA WEINREB	ADMINISTRATOR	ADMINISTRATIVE	0.42	SEE ATTACHED	5	40.00	SALARY	13,462	17-1	7
8						SALARY ALLOCATED - MANAGCARE			(92)	17-7	8
9	SHOSHANA BRAUN	CLERICAL	CLERICAL	0.42	SEE ATTACHED	6	43.00	SALARY	0		9
10						SALARY ALLOCATED - MANAGCARE			3,653	21-7	10
11											11
12											12
13								TOTAL	\$ 197,816		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 MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 MANAGCARE, INC.
 Street Address 3553 W. PETERSON AVE -3RD FLR
 City / State / Zip Code CHICAGO, IL. 60659
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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	3	HOUSEKEEPING	996,360	4	\$ 3,420	\$	427,800	\$ 1,468	1	
2	5	UTILITIES	996,360	4	5,512		427,800	2,367	2	
3	6	REPAIRS AND MAINT.	996,360	4	12,353		427,800	5,304	3	
4	10	NURSING SALARIES	996,360	4	(2,266)	(2,266)	427,800	(973)	4	
5	17	ADMINISTRATIVE	996,360	4	245,581	245,581	427,800	105,443	5	
6	19	PROFESSIONAL FEES	996,360	4	1,820		427,800	781	6	
7	20	FEES, SUBSCRIPTIONS	996,360	4	1,190		427,800	511	7	
8	21	CLERICAL AND GENERAL	996,360	4	366,796	292,203	427,800	157,488	8	
9	24	SEMINARS	996,360	4	7,624		427,800	3,273	9	
10	25	ADMIN. STAFF TRANS.	996,360	4	708		427,800	304	10	
11	26	INSURANCE	996,360	4	3,452		427,800	1,482	11	
12	27	GEN. ADMIN. EMP. BEN.	996,360	4	124,135		427,800	53,299	12	
13	30	DEPRECIATION	996,360	4	32,945		427,800	14,145	13	
14	32	INTEREST EXPENSE	996,360	4	464		427,800	199	14	
15	34	RENT - BUILDING (RELATED)	996,360	4	45,600		427,800	19,579	15	
16	35	EQUIPMENT RENTAL	996,360	4	4,000		427,800	1,717	16	
17									17	
18	17	ADMIN. SALARY - MOSHE DA	AVG HRS WORKED	40	4	(3,475)	(3,475)	7	(621)	18
19	17	ADMIN. SALARY - AHUVA WE	AVG HRS WORKED	20	4	(3,205)	(3,205)	5	(801)	19
20	17	ADMIN. SALARY - JOSHUA DA	AVG HRS WORKED	40	4	(3,537)	(3,537)	29	(2,529)	20
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 843,117	\$ 525,301		\$ 362,436	25	

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 INTERCARE, LTD. C/O MANAGCARE
 Street Address 3553 W. PETERSON AVE. 3RD FLOOR
 City / State / Zip Code CHICAGO, IL. 60659
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	6	\$ 103,000	\$ 103,000	33	\$ 56,650	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	6	2,330	33		1,281	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	6	25	33		14	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	6	44	33		24	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	6	6,328	33		3,480	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	6	95	33		52	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					\$ 111,822	\$ 103,000		\$ 61,501	25

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 MAZEL MANAGEMENT
 Street Address 3553 W.PETERSON AVE.
 City / State / Zip Code CHICAGO, IL. 60659
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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	5	UTILITIES	MNGCR. BOOKPNG. INC. 996,360	4	\$ 6,120	\$	427,800	\$ 2,628	1
2	6	REPAIRS & MAINT.	MNGCR. BOOKPNG. INC. 996,360	4	4,420	1,820	427,800	1,898	2
3	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. BOOKPNG. INC. 996,360	4	139		427,800	60	3
4	17	ADMIN.-M. WOLF	MNGCR. BOOKPNG. INC. 996,360	4	4,562		427,800	1,959	4
5	19	PROFESSIONAL FEES	MNGCR. BOOKPNG. INC. 996,360	4	620		427,800	266	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG. INC. 996,360	4	44		427,800	19	6
7	21	CLERICAL & GENERAL	MNGCR. BOOKPNG. INC. 996,360	4	470		427,800	202	7
8	26	INSURANCE	MNGCR. BOOKPNG. INC. 996,360	4	549		427,800	236	8
9	30	DEPRECIATION	MNGCR. BOOKPNG. INC. 996,360	4	6,392		427,800	2,745	9
10	32	INTEREST EXPENSE	MNGCR. BOOKPNG. INC. 996,360	4	12,167		427,800	5,224	10
11	33	REAL ESTATE TAXES	MNGCR. BOOKPNG. INC. 996,360	4	10,593		427,800	4,548	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				\$ 46,076	\$ 1,820		\$ 19,785	25

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 MID-AMERICA CONVALESCENT CENTER, INC. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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

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	MANUFACTURERS BANK		X	LINE OF CREDIT			\$	625,000		\$	35,618	1								
2	FIRST CHICAGO BANK		X	PHONE EQUIPMENT	\$391.00	8/95		16,737			161	2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$391.00		\$	16,737	\$	625,000	\$	35,779	9							
B. Non-Facility Related*																				
10	Supplemental Schedule										(35,779)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$		\$		\$	(35,779)	14							
15	TOTALS (line 9+line14)						\$	16,737	\$	625,000	\$		15							

* 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 MID-AMERICA CONVALESCENT CENTER. # 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	11	
		YES	NO				Original	Balance					
1							\$	\$			\$	1	
2	ALLOCATED FROM MANAGE	X										199	2
3	ALLOCATED FROM MAZEL	X										5,224	3
4													4
5	INTEREST INCOME		X									(41,202)	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							\$	\$			\$	(35,779)	21

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.# 0016618

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	310		1979	1971	\$ 3,258,613	\$ 141,679	35	\$ 141,679	\$	\$ 3,116,937	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1978		2,575		20			2,575	9
10	Various		1979		33,995		20			33,995	10
11	Various		1980		13,673		20			13,673	11
12	Various		1981		107,932	1,610	20	4,205	2,595	86,214	12
13	Various		1982		4,750		20			4,750	13
14	Various		1983		1,787		20			1,787	14
15	Various		1984		25,291	163	20	395	232	23,836	15
16	Various		1985		17,828	810	20	938	128	15,237	16
17	Various		1986		62,698	3,412	20	3,223	(189)	50,009	17
18	Various		1987		18,422	387	20	501	114	13,021	18
19	Various		1988		33,825	1,074	20	1,353	279	17,214	19
20	Various		1989		23,916	759	20	1,201	442	15,737	20
21	Various		1990		23,550	684	20	1,178	494	12,381	21
22	Various		1991		20,020	272	20	1,573	1,301	6,269	22
23	Various		1992		51,260	1,155	20	2,563	1,408	21,530	23
24											24
25	PAGE I2-I REP TOTALS				111,218	5,846		4,831	(1,015)	66,023	25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE I2D TOTALS				316,359	5,711		10,304	4,593	10,601	32
33	PAGE I2C TOTALS				91,589	6,330		4,579	(1,751)	7,080	33
34	PAGE I2B TOTALS				119,654	3,158		5,985	2,827	15,496	34
35	PAGE I2A TOTALS				403,970	16,331		20,354	4,023	107,879	35
36	TOTAL (lines 4 thru 35)				\$ 4,742,925	\$ 189,381		\$ 204,862	\$ 15,481	\$ 3,642,244	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.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.# 0016618

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1993		7,134	52	20	357	305	2,923	9
10	Various		1994		32,273	468	20	1,613	1,145	10,111	10
11	Various		1995		227,831	11,939	20	11,547	(392)	63,589	11
12	SPEAKER WIRING		1996		1,288	33	20	64	31	299	12
13											13
14											14
15	REMODELING		1996		2,600	136	20	130	(6)	596	15
16	REDECORATING		1996		12,250	488	20	613	125	2,810	16
17	HALL LIGHTING		1996		929	24	20	46	22	196	17
18											18
19	ELEVATOR CABLES		1996		2,680	69	20	134	65	637	19
20	SEAL PARKING LOT		1996		2,725	189	20	136	(53)	612	20
21	BASEBOARD COVERS		1996		1,741	45	20	87	42	399	21
22	EMERGENCY GENERATOR		1996		10,901	280	20	545	265	2,407	22
23	LAUNDRY ROOM		1996		1,665	43	20	83	40	394	23
24											24
25	ALUMINUM WALL		1996		3,000	77	20	150	73	650	25
26	LAVATORY FAUCETS		1996		7,823	201	20	391	190	1,792	26
27	ELECTRICAL WORK		1996		3,290	84	20	165	81	770	27
28											28
29	BSEMENT DROP CEILING		1996		26,000	669	20	1,300	631	6,189	29
30	REMODELING		1996		53,375	1,348	20	2,669	1,321	11,911	30
31	CHAIR RAIL		1996		562	35	20	28	(7)	226	31
32	SPRINKLER HEADS		1996		1,331	34	20	67	33	335	32
33	INDOOR SIGNS		1996		2,591	66	20	130	64	596	33
34	DOOR LOCKING SYSTEM		1996		1,981	51	20	99	48	437	34
35											35
36	TOTAL (lines 4 thru 35)				\$ 403,970	\$ 16,331		\$ 20,354	\$ 4,023	\$ 107,879	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.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.# 0016618

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		A/C CONDENSER		1997	4,465	114	20	223	109	781	9
10		FIRE ALARM REPAIRS		1997	2,006		20	100	100	308	10
11		DRAPERIES		1997	1,353		20	68	68	266	11
12		HOT WATER HEATER		1997	4,009	103	20	200	97	683	12
13		BLDG RENOV-LSC-AUD		1997	3,604		20	180	180	360	13
14		DISHWASHER MOTOR		1997	2,730	314	20	137	(177)	752	14
15		STARTER		1997	1,747		20	87	87	276	15
16		KITCHEN PUMP		1997	1,490		20	75	75	448	16
17		MANHOLE RING		1997	3,000		20	150	150	488	17
18		ELEVATOR DOOR RESTRI		1997	2,400		20	120	120	380	18
19		WATER TOWER		1998	13,150	337	20	658	321	1,755	19
20		SMOKE DAMPER		1998	7,100	182	20	355	173	976	20
21		DOORS		1998	4,795	123	20	240	117	540	21
22		LIFE SAFETY CODE IMP		1998	17,077	438	20	854	416	1,779	22
23											23
24		HOT WATER TANKS		1998	12,300	315	20	615	300	1,435	24
25		WATER HEATER		1998	2,975	76	20	149	73	397	25
26		DRAIN & VENTS		1998	6,485	166	20	324	158	972	26
27		LINEN CHUTE		1998	2,494	64	20	125	61	365	27
28		BLDG RENOV-LSC-AUD		1998	7,395	282	20	370	88	740	28
29		WATER TOWER		1998	1,721	44	20	86	42	229	29
30		PLASTER BOARD		1998	2,039	52	20	102	50	255	30
31		ELEV DOOR DETECTORS		1998	3,975	102	20	199	97	564	31
32		ENTRY DOOR IMP.		1999	7,510	193	20	376	183	470	32
33		WANDERGARD SYSTEM		1999	500		20	25	25	38	33
34		WALL MOUNTED MONITOR		1999	674		20	34	34	51	34
35		ASPHALT STRIPPING		1999	2,660	253	20	133	(120)	188	35
36		TOTAL (lines 4 thru 35)			\$ 119,654	\$ 3,158		\$ 5,985	\$ 2,827	\$ 15,496	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.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.# 0016618

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		ELECTRIC DOOR HOLDER		1999	576		20	29	29	39	9
10		INSPECTION & REPORT		1999	1,400	36	20	70	34	117	10
11		WALLS & DOORS		1999	4,000	103	20	200	97	333	11
12		VENTILATOR & PIPING		1999	3,805	98	20	190	92	269	12
13		WANDERGARD SYSTEM		1999	1,280		20	64	64	96	13
14		SECURITY LINK		1999	15,000	385	20	750	365	1,000	14
15		WANDERGARD VOICE PRC		1999	468		20	23	23	38	15
16		CCTV SYSTEM		1999	1,447		20	72	72	78	16
17		CCTV SYSTEM		1999	1,355		20	68	68	96	17
18		TELEPHONE SYSTEM		1999	697		20	35	35	50	18
19		CCTV SYSTEM		1999	892		20	45	45	64	19
20		ELECTRIC DOOR HOLDER		1999	748		20	37	37	49	20
21		DINING ROOM OPENING		1999	3,584	92	20	179	87	224	21
22		LIFE SAFETY CONSULT		1999	4,040	104	20	202	98	337	22
23		FIRE DAMPERS		1999	10,920	280	20	546	266	910	23
24		WANDERGARD SYSTEM		1999	674		20	34	34	51	24
25		FIRE DAMPERS & DOORS		1999	7,348	188	20	367	179	612	25
26		DAMPERS & FANS		1999	4,238	109	20	212	103	353	26
27		GATE LOCKS		1999	2,774	71	20	139	68	243	27
28		NEW DRAIN PIPE		1999	625		20	31	31	49	28
29		LAMPS & FIXTURES		1999	5,161	1,264	20	258	(1,006)	409	29
30		CARPET & LAMPS		1999	5,121	1,254	20	256	(998)	405	30
31		WALL MOUNTED MONITOR		1999	437		20	22	22	33	31
32		GAS THERMOSTAT		1999	1,265	32	20	63	31	121	32
33		CCTV		1999	479		20	24	24	36	33
34		LAMPS & CUBICLE CURT		1999	9,005	2,205	20	450	(1,755)	713	34
35		EXHAUST SYSTEM		1999	4,250	109	20	213	104	355	35
36		TOTAL (lines 4 thru 35)			\$ 91,589	\$ 6,330		\$ 4,579	\$ (1,751)	\$ 7,080	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.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.# 0016618

Report Period Beginning:

01/01/00 Ending:12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		CIRCUIT BREAKER BOX		1999	2,450		20	123	123	205	9
10		HALLWAY FIRE DOORS		1999	6,126	157	20	306	149	459	10
11		WANDERGARD CABLE		1999	790		20	40	40	67	11
12		VACUUM BREAKER		1999	1,200		20	60	60	95	12
13		NSE STATION REMODEL (#)		2000	124,573	1,730	20	3,634	1,904	3,634	13
14		LNDY & KITCHN HTG SYS (#)		2000	17,700	359	20	738	379	738	14
15		IRON RAILING		2000	600	4	20	10	6	10	15
16		NSE STATION BUMPERS		2000	1,326	18	20	39	21	39	16
17		NSE CALL SYSTEM		2000	6,887	66	20	143	77	143	17
18		SPRINKLERS SYSTEM		2000	9,544	153	20	318	165	318	18
19		ANNOUNCIATOR SYSTEM (#)		2000	15,568	216	20	454	238	454	19
20		WINDOW TREATMENT		2000	3,121	17	20	39	22	39	20
21		NEW CURCUITS		2000	13,300	185	20	388	203	388	21
22		CARPETING & TRIM		2000	4,070	82	20	170	88	170	22
23		FIRE PROOFING (#)		2000	1,845	41	20	84	43	84	23
24		RUNNER MATS		2000	2,648	530	20	243	(287)	243	24
25		DRAINS & VENTS (#)		2000	6,470	131	20	270	139	270	25
26		GO AMPERE (#)		2000	9,800	199	20	408	209	408	26
27		TELEPHONE WIRING		2000	2,619	42	20	87	45	87	27
28		ELEVATOR GENERATOR		2000	3,374	675	20	28	(647)	28	28
29		FIRE ALARM SYSTEM (#)		2000	68,998	1,106	20	2,300	1,194	2,300	29
30		WANDERGUARD POWER & MONITORS (#)		2000	6,180		20	63	63	63	30
31		CUBICLE CURTAINS (#)		2000	4,171		20	209	209	209	31
32		THERAPY ROOM CABINETS (#)		2000	1,400		20	70	70	70	32
33		CEILING TILE (#)		2000	332		20	17	17	17	33
34		CERAMIC TILE (#)		2000	1,267		20	63	63	63	34
35		(#) CAPITAL PROJECTION									35
36		TOTAL (lines 4 thru 35)			\$ 316,359	\$ 5,711		\$ 10,304	\$ 4,593	\$ 10,601	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.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.

0016618

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.

0016618

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.

0016618

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.

0016618

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1985	ALLOC-MAZ	\$ 44,297	\$ 2,303	30	\$ 1,477	\$ (826)	\$ 22,517	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		ALLOCATION - MANAGCARE		1997	5,164	645	20	516	(129)	1,765	9
10		ALLOCATION - MANAGCARE		1993	405	22	20	20	(2)	153	10
11		ALLOCATION - MANAGCARE		1988	632	20	20	31	11	389	11
12		ALLOCATION - MANAGCARE		1986	47,905	2,447	20	2,194	(253)	35,480	12
13											13
14		ALLOCATION - MAZEL MANAGEMENT		2000	470	3	20	6	3	6	14
15		ALLOCATION - MAZEL MANAGEMENT		1998	1,657	57	20	83	26	24	15
16		ALLOCATION - MAZEL MANAGEMENT		1997	1,545	40	20	77	37	258	16
17		ALLOCATION - MAZEL MANAGEMENT		1996	1,054	24	20	53	29	241	17
18		ALLOCATION - MAZEL MANAGEMENT		1995	238	6	20	12	6	67	18
19		ALLOCATION - MAZEL MANAGEMENT		1994	940	17	20	47	30	257	19
20		ALLOCATION - MAZEL MANAGEMENT		1993	555	16	20	28	12	207	20
21		ALLOCATION - MAZEL MANAGEMENT		1991	416	13	20	20	7	183	21
22		ALLOCATION - MAZEL MANAGEMENT		1990	647	13	20	32	19	335	22
23		ALLOCATION - MAZEL MANAGEMENT		1989	405	9	20	17	8	196	23
24		ALLOCATION - MAZEL MANAGEMENT		1987	919	18	20	23	5	880	24
25		ALLOCATION - MAZEL MANAGEMENT		1986	3,713	193	20	195	2	2,807	25
26		ALLOCATION - MAZEL MANAGEMENT		1985	256		20			258	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 111,218	\$ 5,846		\$ 4,831	\$ (1,015)	\$ 66,023	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.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.

0016618

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 366,705	\$ 50,078	\$ 34,699	\$ (15,379)		\$ 145,265	37
38	Current Year Purchases	94,908	34,365	13,157	(21,208)		13,157	38
39	Fully Depreciated Assets	660,202	52	2,396	2,344		660,201	39
40								40
41	TOTALS	\$ 1,121,815	\$ 84,495	\$ 50,252	\$ (34,243)		\$ 818,623	41

D. Vehicle Depreciation (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	
42	ALLOCATION FROM MANAGCARE			\$ 19,466	\$ 2,017	\$ 2,078	\$ 61		\$ 12,224	42
43										43
44										44
45										45
46	TOTALS			\$ 19,466	\$ 2,017	\$ 2,078	\$ 61		\$ 12,224	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 6,192,080	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 275,893	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 257,192	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (18,701)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 4,473,091	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	1994 ALTIMA	\$ 17,799	\$ 1,675	\$ 17,799	52
53	BUILDING	159,035	5,890	22,531	53
54	LAND	17,500			54
55					55
56					56
57	TOTALS	\$ 194,334	\$ 7,565	\$ 40,330	57

G. Construction-in-Progress

	Description	Cost	
58			58
59			59
60			60
61			61

* 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.

MID-AMERICA CONVALESCENT CENTER, INC.
0016618
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
MID AMERICA	322,178	42,639	29,891	(12,748)	127,242
MANAGCARE	44,319	7,407	4,787	(2,620)	17,945
INTERCARE					
MAZEL MANAGEMENT	208	32	21	(11)	78
TOTALS	366,705	50,078	34,699	(15,379)	145,265

LINE 29: CURRENT YEAR

MID AMERICA	93,321	32,778	13,050	(19,728)	13,050
MANAGCARE	1,587	1,587	107	(1,480)	107
INTERCARE					
MAZEL MANAGEMENT					
TOTALS	94,908	34,365	13,157	(21,208)	13,157

LINE 30: FULLY DEPRECIATED

MID AMERICA	592,092		1,367	1,367	592,092
MANAGCARE	59,291		964	964	59,291
INTERCARE	8,457	52	65	13	8,456
MAZEL MANAGEMENT	362				362
TOTALS	660,202	52	2,396	2,344	660,201

TOTALS (Should Tie to Totals on Page 13)

MID AMERICA	1,007,591	75,417	44,308	(31,109)	732,384
MANAGCARE	105,197	8,994	5,858	(3,136)	77,343
INTERCARE	8,457	52	65	13	8,456
MAZEL MANAGEMENT	570	32	21	(11)	440
TOTALS	1,121,815	84,495	50,252	(34,243)	818,623

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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 _____.

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: \$ 1,717 Description: ALLOCATED FROM MANAGCARE

(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	<u>FACILITY</u>	<u>1998 DODGE CARAVAN</u>	\$ <u>369.00</u>	\$ <u>4,059</u>	17
18	<u>FACILITY</u>	<u>1999 DODGE CARAVAN</u>	<u>365.35</u>	<u>4,384</u>	18
19					19
20					20
21	TOTAL		\$ <u>734.35</u>	\$ <u>8,443</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* 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.

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

<p>1. HAVE YOU TRAINED AIDES 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. CLASSROOM PORTION:</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 AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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 Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 68,476	\$		\$ 68,476	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,279			15,279	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			73,554			73,554	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 prescripts				77,458		77,458	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program						7,244		7,244	12
13	Other (specify): SCHEDULE**						55,208		55,208	13
14	TOTAL			\$		\$ 157,309	\$ 139,910		\$ 297,219	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 nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	13,251
2 Complex Medical Equip	
3 Oxygen	
4 Equipment Rental	36,438
5 LAB	4,524
6 XRAY	995
7	
8	
9	
10	
	<u>55,208</u>
	<u>55,208</u>
 <u>Outside Therapies (Column 5 - Other)</u>	 <u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u> </u>
	<u> </u>

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.

0016618

Report Period Beginning: 01/01/00

Ending:

12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

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

	1	2	
	Operating	After	
		Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 78,635	\$ 1
2	Cash-Patient Deposits	88,850	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,827,885	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	178,017	6
7	Other Prepaid Expenses	3,684	7
8	Accounts Receivable (owners or related parties)	3,400,799	8
9	Other(specify): See supplemental schedule	43	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,577,913	\$ 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	325,374	13
14	Buildings, at Historical Cost	3,417,648	14
15	Leasehold Improvements, at Historical Cos	1,037,613	15
16	Equipment, at Historical Cost	1,292,188	16
17	Accumulated Depreciation (book methods)	(4,459,893)	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): See supplemental schedule		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,612,930	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,190,843	\$ 25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 1,410,844	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	245,173	30
31	Accrued Taxes Payable (excluding real estate taxes)	42,762	31
32	Accrued Real Estate Taxes(Sch.IX-B)	382,000	32
33	Accrued Interest Payable	495	33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	See supplemental schedule	31,776	36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,113,050	\$ 38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	625,000	39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43	See supplemental schedule		43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 625,000	\$ 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,738,050	\$ 46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,452,793	\$ #REF! 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,190,843	\$ #REF! 48

*(See instructions.)

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:

Real Estate Tax Escrow

EMPLOYEE ADVANCE

Amount

Amount

43

43

OTHER CURRENT LIABILITIES:

Accrued Expenses

Accrued R. E. Tax -

Non Care Property

Amount

Amount

31,776

31,776

OTHER NON CURRENT ASSETS:

Construction In Progress

Utility Deposit

Loan Costs

OTHER NON CURRENT LIABILITIES:

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,615,121	1
2	Restatements (describe):		2
3	<u>Schedule attached</u>	40,000	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,655,121	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,662,672	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	(865,000)	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)	\$ 797,672	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)	\$ 5,452,793	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MID-AMERICA CONVALESCENT CE# 0016618 Report Period Beginning: 01/01/00 Ending: 12/31/00

Balance per General Ledger 4,655,121

Adjustments:

-

-

-

REVERSAL OF PRIOR YEAR BAD DEBT (40,000)

Total adjustments (40,000)

Balance - Beginning of Year 4,615,121

Equity(Deficit) from Page 17 Col 1 5,452,793

Related Party

Equity(Deficit) 0

Income 0

-

Combined Equity - End of Year 5,452,793

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, IN # 0016618 Report Period Beginning: 01/01/00

Ending: 12/31/00

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	\$ 9,541,713	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,541,713	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	369,458	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 369,458	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	77,136	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,172	19
20	Radiology and X-Ray	2,355	20
21	Other Medical Services	37,105	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 135,768	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	175,297	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 175,297	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	18,246	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,246	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,240,482	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,765,964	31
32	Health Care	3,162,746	32
33	General Administration	2,345,726	33
B. Capital Expense			
34	Ownership	692,181	34
C. Ancillary Expense			
35	Special Cost Centers	441,003	35
36	Provider Participation Fee	170,190	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,577,810	40
41	Income before Income Taxes (line 30 minus line 40)**	1,662,672	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,662,672	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? not completed 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.

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

<u>DESCRIPTION</u>	<u>AMOUNT</u>
1 Vending Commissions	2,453
2 Rental Income	9,000
3 Uniforms	1,437
4 Officers Life Insurance Credit	5,356
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u>18,246</u>

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	2,056	2,280	\$ 72,674	\$ 31.87	1
2	Assistant Director of Nursing	2,872	3,096	73,126	23.62	2
3	Registered Nurses	39,956	42,006	903,110	21.50	3
4	Licensed Practical Nurses	24,253	26,063	390,260	14.97	4
5	Nurse Aides & Orderlies	114,062	120,676	1,025,480	8.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,414	13,660	176,389	12.91	8
9	Activity Director	2,088	2,320	36,228	15.62	9
10	Activity Assistants	19,899	21,171	146,165	6.90	10
11	Social Service Workers	9,422	10,273	115,093	11.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,104	34,422	268,619	7.80	15
16	Dishwashers					16
17	Maintenance Workers	13,124	15,361	161,634	10.52	17
18	Housekeepers	40,718	42,814	252,181	5.89	18
19	Laundry	16,456	17,479	109,569	6.27	19
20	Administrator	1,524	1,676	60,457	36.07	20
21	Assistant Administrator	2,088	2,320	67,929	29.28	21
22	Other Administrative	5,007	5,007	174,566	34.86	22
23	Office Manager					23
24	Clerical	19,890	21,002	193,181	9.20	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					31
32	Other Health Care(specify)					32
33	Other(specify)	4,852	5,740	128,671	22.42	33
34	TOTAL (lines 1 - 33)	362,785	387,366	\$ 4,355,332 *	\$ 11.24	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	514	\$ 22,475	1-3	35
36	Medical Director		3,000	9-3	36
37	Medical Records Consultant	96	4,032	10-3	37
38	Nurse Consultant	327	13,648	10-3	38
39	Pharmacist Consultant		1,800	10-3	39
40	Physical Therapy Consultant	170	9,171	10A-3	40
41	Occupational Therapy Consultant	107	5,337	10A-3	41
42	Respiratory Therapy Consultant	16	1,140	10A-3	42
43	Speech Therapy Consultant	2	100	10A-3	43
44	Activity Consultant	12	574	11-3	44
45	Social Service Consultant	96	6,944	12-3	45
46	Other(specify) REHAB CONSULT		11,400	10a-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,340	\$ 79,621		49

C. CONTRACT NURSES

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

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
MARKETING SALARIES	4,852	5,740	\$ 128,671	\$ 22.42
	<u>4,852</u>	<u>5,740</u>	<u>\$ 128,671</u>	<u>\$ 22.42</u>

Facility Name & ID Number **MID-AMERICA CONVALESCENT CENTER, I**
XIX. SUPPORT SCHEDULES

0016618

Report Period Beginning: **01/01/00**

Ending: **12/31/00**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
YOSEF MEYSTEL (1/1-10/27/00)	ADMINISTRATOR		\$ 61,161	Workers' Compensation Insurance	\$ 45,871	IDPH License Fee	\$	
ELI TROPPER	ADMINISTRATOR		231	Unemployment Compensation Insurance	44,803	Advertising: Employee Recruitment	21,738	
MICHAEL APPLEBAUM	ASSISTANT ADMIN		69,500	FICA Taxes	326,601	Health Care Worker Background Check (Indicate # of checks performed)		
SEE ATTACHED	SEE ATTACHED		172,059	Employee Health Insurance	202,999	DUES & SUBSCRIPTIONS	12,280	
				Employee Meals	41,109	LICENSES, PERMITS, FEES	3,386	
				Illinois Municipal Retirement Fund (IMRF)*		PROFESSIONAL SECURITY FEES	1,218	
				CHICAGO HEAD TAX	6,768	ALLOC-MGCR 511; INTRC 14; MZL 19	544	
				HOLIDAY EXPENSE	4,348	ILL ASSOC OF HEALTHCARE	310	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 302,951	TOTAL (agree to Schedule V, line 22, col.8)	\$ 672,499	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 39,476	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEES - INTERCARE			\$ 78,000			\$	Out-of-State Travel	\$
JCAHO COSTS			2,630				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 80,630				Seminar Expense	3,190
							ALLOC FROM MANANGCARE	3,273
							Entertainment Expense	()
							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,463
C. Professional Services				TOTAL				
Vendor/Payee	Type		Amount			\$		
ECONOCARE	PURCHASING		\$ 5,220					
COMMITMENT CONSULTING	ADMIN CONSULT		5,710					
MIDWEST APPRAISAL CO.	APPRAISAL FEES		2,500					
MANAGCARE	BOOKKEEPING FEES		427,800					
SEE ATTACHED	LEGAL		26,568					
FR&R	ACCOUNTING		61,322					
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULT		5,335					
JACOBS HEALTHCARE SYST.	COMPUTER COSTS		3,060					
COMMITMENT CONSULTING	MANAGEMENT CONSULT		34,699					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 572,214			\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MID-AMERICA CONVALESCENT CENTER, INC.

0016618

Report Period Beginning: 01/01/00

Ending: 12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$11,269
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,895 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES _____ NO X
- (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 of Public Aid during this cost report period. \$ 170,190
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 41,109 Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (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? NONE
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, 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.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 1/2 by 14 size white paper with an 8 1/2 by 14 image on the paper. To ensure an 8 1/2 by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 1/2 by 11. We cannot accept a report with an 8 1/2 by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw