

Facility Name & ID Number Skilled Nursing of Paris, Inc. d/b/a Paris Healthcare Center# 0045336 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

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	20	Skilled (SNF)	20	7,300	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	108	Intermediate (ICF)	108	39,420	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	128	TOTALS	128	46,720	7

B. Census-For the entire report period.

	1 Level of Care	3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Public Aid Recipient	Private Pay	Other	Total	
8	SNF	0	0	2,292	2,292	8
9	SNF/PED	0	0	0		9
10	ICF	19,157	9,507	0	28,664	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	19,157	9,507	2,292	30,956	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.26%D. How many bed-hold days during this year were paid by Public Aid? 11 (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 - NoneF. Does the facility maintain a daily midnight census? YESG. 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 4/19/2001

J. Was the facility purchased or leased after January 1, 1978?

YES Date 4/19/2001 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 20 and days of care provided 2,292Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

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

STATE OF ILLINOIS

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Facility Name & ID Number

Paris Health Care Center

0045336

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
	A. General Services										
1	Dietary	152,055	19,075	8,357	179,487		179,487		179,487		1
2	Food Purchase		157,037		157,037		157,037	(593)	156,444		2
3	Housekeeping	81,482	12,502	21	94,005		94,005		94,005		3
4	Laundry	37,596	9,475		47,071		47,071		47,071		4
5	Heat and Other Utilities			158,489	158,489		158,489	(10,868)	147,621		5
6	Maintenance	32,861	2,756	39,889	75,506		75,506		75,506		6
7	Other (specify):*			1,328	1,328		1,328		1,328		7
8	TOTAL General Services	303,994	200,845	208,084	712,923		712,923	(11,461)	701,462		8
	B. Health Care and Programs										
9	Medical Director			6,702	6,702		6,702	#VALUE!	#VALUE!		9
10	Nursing and Medical Records	1,377,043	105,612	11,145	1,493,800	1,003	1,494,803	#VALUE!	#VALUE!		10
10a	Therapy		22	141,836	141,858		141,858	#VALUE!	#VALUE!		10a
11	Activities	37,188	1,384	1,475	40,047		40,047	#VALUE!	#VALUE!		11
12	Social Services	39,435	27	1,475	40,937		40,937	#VALUE!	#VALUE!		12
13	Nurse Aide Training			1,528	1,528		1,528	#VALUE!	#VALUE!		13
14	Program Transportation			2,303	2,303		2,303	#VALUE!	#VALUE!		14
15	Other (specify):*							#VALUE!	#VALUE!		15
16	TOTAL Health Care and Programs	1,453,666	107,045	166,464	1,727,175	1,003	1,728,178	#VALUE!	#VALUE!		16
	C. General Administration										
17	Administrative	64,567		322	64,889		64,889	#VALUE!	#VALUE!		17
18	Directors Fees							#VALUE!	#VALUE!		18
19	Professional Services			249,698	249,698	(1,961)	247,737	#VALUE!	#VALUE!		19
20	Dues, Fees, Subscriptions & Promotions			12,274	12,274	1,961	14,235	#VALUE!	#VALUE!		20
21	Clerical & General Office Expenses	58,005	22,006	33,962	113,973	(1,003)	112,970	#VALUE!	#VALUE!		21
22	Employee Benefits & Payroll Taxes			311,080	311,080		311,080	#VALUE!	#VALUE!		22
23	Inservice Training & Education			4,496	4,496		4,496	#VALUE!	#VALUE!		23
24	Travel and Seminar			3,118	3,118		3,118	#VALUE!	#VALUE!		24
25	Other Admin. Staff Transportation							#VALUE!	#VALUE!		25
26	Insurance-Prop.Liab.Malpractice			237,638	237,638		237,638	#VALUE!	#VALUE!		26
27	Other (specify):*							#VALUE!	#VALUE!		27
28	TOTAL General Administration	122,572	22,006	852,588	997,166	(1,003)	996,163	#VALUE!	#VALUE!		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,880,232	329,896	1,227,136	3,437,264		3,437,264	#VALUE!	#VALUE!		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.

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Report Period Beginning:

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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	
	D. Ownership											
30	Depreciation			12,567	12,567		12,567	#VALUE!	#VALUE!			30
31	Amortization of Pre-Op. & Org.							#VALUE!	#VALUE!			31
32	Interest							#VALUE!	#VALUE!			32
33	Real Estate Taxes			65,464	65,464		65,464	#VALUE!	#VALUE!			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	#VALUE!	#VALUE!			34
35	Rent-Equipment & Vehicles			6,702	6,702		6,702	#VALUE!	#VALUE!			35
36	Other (specify):*							#VALUE!	#VALUE!			36
37	TOTAL Ownership			624,733	624,733		624,733	#VALUE!	#VALUE!			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							#VALUE!	#VALUE!			38
39	Ancillary Service Centers		66,684	2,700	69,384		69,384	#VALUE!	#VALUE!			39
40	Barber and Beauty Shops		1,039		1,039		1,039	#VALUE!	#VALUE!			40
41	Coffee and Gift Shops							#VALUE!	#VALUE!			41
42	Provider Participation Fee			70,100	70,100		70,100	#VALUE!	#VALUE!			42
43	Other (specify):*			3,397	3,397		3,397	#VALUE!	#VALUE!			43
44	TOTAL Special Cost Centers		67,723	76,197	143,920		143,920	#VALUE!	#VALUE!			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,880,232	397,619	1,928,066	4,205,917		4,205,917	#VALUE!	#VALUE!			45

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

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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	(10,868)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(593)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,556)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,624)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,691)	20		28
29	Other-Attach Schedule (See page 5a)	(392)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (25,724)		\$	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)			34
35	Other- Attach Schedule	(1,150)	21	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,150)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (26,874)		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.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5	Telephone, TV & Radio in Resident Rooms	(10,868)	5	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13	Sales Tax	(593)	2	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22	Special Legal Fees & Legal Retainers	(6,556)	19	22
23				23
24				24
25	Fund Raising, Advertising and Promotional	(1,624)	20	25
26				26
27				27
28				28
29	Yellow Page Advertising	(5,691)	20	29
30	Other - Miscellaneous Income	(392)	21	30
31	0	0	0	31
32	0	0	0	32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(25,724)		49

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Report Period Beginning:

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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
Omega Healthcare Investors, Inc.	100.00	Skilled Nursing Herrin, Inc. d/b/a Park Avenue Healthcare Center	Herrin			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Facility Lease	\$ 540,000	Omega Healthcare Investors, Inc.	100.00%	\$ 151,309	\$ * (388,691)
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		\$ 540,000			\$ 151,309	\$ * (388,691)

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

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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	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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.

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VII. RELATED PARTIES (continued)

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		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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.

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VII. RELATED PARTIES (continued)

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		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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.

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Report Period Beginning: 1/1/2002

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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

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1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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

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		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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.

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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

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		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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.

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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

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1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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.

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0045336

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

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	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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 Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

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

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

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

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Paris Health Care Center # 0045336 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Paris Health Care Center# 0045336

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

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		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
	Working Capital																			
6	Owner		Working Capital	None	N/A	842,657	203,584	N/A	None	N/A	6									
7											7									
8											8									
9	TOTAL Facility Related					\$ 842,657	\$ 203,584			\$	9									
	B. Non-Facility Related*																			
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 842,657	\$ 203,584			\$	15									

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

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

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

Facility Name & ID Number **Paris Health Care Center**# **0045336** Report Period Beginning: **1/1/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2001 report.			\$	32,711	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	34,576	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	1,865	3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	63,599	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	65,464	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1997	13,797	8		
		1998	28,445	9		
		1999	27,583	10		
		2000	27,583	11		
		2001	44,320	12		
					FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2001	\$		13
		14	PLUS APPEAL COST FROM LINE 5	\$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Paris Health Care Center COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0045336

CONTACT PERSON REGARDING THIS REPORT Chris Murphy, CPA, BKD, LLP

TELEPHONE (918) 584-2900 FAX #: (918) 584-2931

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-13-36-100-021</u>	<u>Nursing Facility</u>	<u>\$ 63599.16</u>	<u>\$ 63599.16</u>
2. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
4. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
5. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
	TOTALS	<u>\$ 63,599.16</u>	<u>\$ 63,599.16</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Paris Health Care Center# 0045336 Report Period Beginning:1/1/2002 Ending:12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,377 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning:

1/1/2002

Ending: 12/31/2002

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	85	1982		\$ Rent Related	\$	-	\$	\$	\$
5	43			Party 7/1/99					
6									
7									
8									
Improvement Type**									
9	Floor Covering/Carpet - Dwnpymt	07/18/01		1,296	259	5	259		367
10	Flooring/Carpet - Final Pymt	01/09/01		5,183	1,036	5	1,036		1,382
11	Asbestos Removal	11/19/01		62,575	3,127	20	3,127		3,388
12	Installation of Fire Dampers	05/17/02		3,895	228	10	228		228
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
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.

See Page 12A, Line 70 for total

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		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$		37	
38									38	
39									39	
40									40	
41									41	
42									42	
43									43	
44									44	
45									45	
46									46	
47									47	
48									48	
49									49	
50									50	
51									51	
52									52	
53									53	
54									54	
55									55	
56									56	
57									57	
58									58	
59									59	
60									60	
61									61	
62									62	
63	(DON'T ENTER BELOW THIS LINE)								63	
64	Total (This Page)								64	
65									65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)	\$	72,949	\$	4,650	\$	4,650	\$	5,365	70

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

STATE OF ILLINOIS

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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	TOTAL (lines 1 thru 33)	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		34

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

STATE OF ILLINOIS

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning:

1/1/2002

Ending:

Page 12C

12/31/2002

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		34

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

STATE OF ILLINOIS

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning:

1/1/2002

Ending:

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12/31/2002

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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11									11
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		34

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

STATE OF ILLINOIS

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning:

1/1/2002

Ending:

Page 12E

12/31/2002

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		34

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

STATE OF ILLINOIS

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning:

1/1/2002

Ending:

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12/31/2002

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		34

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

STATE OF ILLINOIS

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning:

1/1/2002

Ending:

Page 12G

12/31/2002

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		34

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

STATE OF ILLINOIS

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning:

1/1/2002

Ending:

Page 12H

12/31/2002

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		34

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

STATE OF ILLINOIS

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning:

1/1/2002

Ending:

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12/31/2002

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 72,949	\$ 4,650		\$ 4,650	\$	\$ 5,365		34

**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	
71	Purchased in Prior Years	\$ 42,978	\$ 5,459	\$ 5,459	\$	Various	\$ 8,306	71
72	Current Year Purchases	32,961	2,452	2,452		Various	2,452	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 75,939	\$ 7,911	\$ 7,911	\$		\$ 10,758	75

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	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 148,888	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,561	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,561	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 16,123	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - leased from related party
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
 If NO, see instructions.

		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:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	<u>/2003</u>	\$ _____
13.	<u>/2004</u>	\$ _____
14.	<u>/2005</u>	\$ _____

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: N/A *

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: \$ 6,702 Description: Nursing - 42, Plant - 204, Admin - 6,456
 (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>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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 checked="" type="checkbox"/> YES <input 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 checked="" 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 checked="" 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)				9,278
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$ 9,278
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	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	18

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a, 3	hrs	\$	851	\$ 34,036	\$ 0	851	\$ 34,036		851	\$ 34,036	1	
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		260	10,387	0	260	10,387	0	260	10,387	2	
3	Licensed Recreational Therapist		hrs		0	0	0			0			3	
4	Licensed Physical Therapist	10a, 3	hrs		2,426	97,035	22	2,426	97,035	22	2,426	97,057	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy		# of prescripts										9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify):												13	
14	TOTAL			\$	3,537	\$ 141,458	\$ 22	3,537	\$ 141,480	\$ 22	3,537	\$ 141,480	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.

STATE OF ILLINOIS

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Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning: 1/1/2002

Ending:

12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(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	\$ 233,885	\$	1
2 Cash-Patient Deposits	201		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	650,114		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	56,360		7
8 Accounts Receivable (owners or related parties)	4,047		8
9 Other(specify):	95,560		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,040,167	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost	72,949		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	74,685		16
17 Accumulated Depreciation (book methods)	(16,122)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 131,512	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,171,679	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 1,026,061	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	(6,728)		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	80,717		30
31 Accrued Taxes Payable (excluding real estate taxes)	15,653		31
32 Accrued Real Estate Taxes(Sch.IX-B)	34,576		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37 Management Fee Payable	11,744		37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,162,023	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	203,584		39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 203,584	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,365,607	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ (193,928)	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,171,679	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (151,643)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (151,643)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(42,292)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PRIOR YR ADJ - DEPREC	7	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (42,285)	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)	\$ (193,928)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

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	\$ 4,696,492	1
2	Discounts and Allowances for all Levels	(909,319)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,787,173	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	235,591	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 235,591	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 Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	48,236	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,424	19
20	Radiology and X-Ray		20
21	Other Medical Services	73,809	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 131,469	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental, Vending, Meals and Miscellaneous Revenue	9,392	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,392	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,163,625	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	712,923	31
32	Health Care	1,727,175	32
33	General Administration	997,166	33
B. Capital Expense			
34	Ownership	624,733	34
C. Ancillary Expense			
35	Special Cost Centers	73,820	35
36	Provider Participation Fee	70,100	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,205,917	40
41	Income before Income Taxes (line 30 minus line 40)**	(42,292)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (42,292)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Paris Health Care Center

0045336

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

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			\$	\$	1
2					2
3	12,895	13,632	271,848	19.94	3
4	27,518	27,518	465,212	16.91	4
5	65,569	72,131	630,659	8.74	5
6					6
7					7
8					8
9	1,572	1,572	17,926	11.40	9
10	429	632	19,261	30.48	10
11	1,096	1,205	39,435	32.73	11
12					12
13					13
14					14
15	16,128	17,051	152,055	8.92	15
16					16
17	2,363	2,446	32,861	13.43	17
18	8,797	9,263	81,482	8.80	18
19	6,836	6,836	37,596	5.50	19
20	2,080	2,080	64,567	31.04	20
21					21
22	6,535	7,108	57,003	8.02	22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31	1,488	1,574	10,327	6.56	31
32					32
33					33
34	153,306	163,048	\$ 1,880,232 *	\$ 11.53	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	208	\$ 8,316	1, 3	35
36	Monthly Fee	6,702	9, 3	36
37	16	607	10, 3	37
38	6	223	10, 3	38
39				39
40				40
41				41
42				42
43				43
44	37	1,475	11, 3	44
45	37	1,475	12, 3	45
46				46
47				47
48				48
49	304	\$ 18,798		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	228	\$ 9,133	10, 3	50
51	15	530	10, 3	51
52				52
53	243	\$ 9,663		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes - CNAs
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 2445 - Illinois Health Care Assoc.
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,219 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES No 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 70,100
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? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes, Airline exp, out-of-state travel
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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.