

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0042044</u></p> <p>Facility Name: <u>WASHINGTON HEIGHTS N H</u></p> <p>Address: <u>1010 WEST 95TH ST</u> <u>CHICAGO</u> <u>60643</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 298-1177</u> Fax # <u>(773) 298-1666</u></p> <p>IDPA ID Number: <u>364100431001</u></p> <p>Date of Initial License for Current Owners: <u>10/24/96</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>See Accountants' Compilation Report Attached</u> (Date) _____ (Print Name and Title) <u>EDWARD N. SLACK, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pffingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>See Accountants' Compilation Report Attached</u> (Date) _____ (Print Name and Title) <u>EDWARD N. SLACK, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pffingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	<u>228</u>	Skilled (SNF)	<u>228</u>	<u>83,220</u>	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	<u>228</u>	TOTALS	<u>228</u>	<u>83,220</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,689</u>	<u>268</u>	<u>6,158</u>	<u>13,115</u>	8
9	SNF/PED					9
10	ICF	<u>60,919</u>	<u>2,717</u>		<u>63,636</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>67,608</u>	<u>2,985</u>	<u>6,158</u>	<u>76,751</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.23%

D. How many bed-hold days during this year were paid by Public Aid?
2,576 (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 10/24/96

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/24/96 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 28 and days of care provided 6,158

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/02 Fiscal Year: 12/31/02

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

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/02 Ending: 12/31/02

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
	A. General Services										
1	Dietary	318,777	56,356	16,840	391,973		391,973	(19,483)	372,490		1
2	Food Purchase		282,415		282,415	(34,493)	247,923	4,876	252,799		2
3	Housekeeping	204,610	73,032		277,642		277,642	(6,650)	270,992		3
4	Laundry	97,541	31,173		128,714		128,714		128,714		4
5	Heat and Other Utilities			278,101	278,101		278,101	1,987	280,088		5
6	Maintenance	78,710		265,614	344,324		344,324	6,200	350,524		6
7	Other (specify):*							2,015	2,015		7
8	TOTAL General Services	699,638	442,976	560,555	1,703,169	(34,493)	1,668,677	(11,054)	1,657,622		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,669,407	100,796	80,918	2,851,121		2,851,121	6,233	2,857,354		10
10a	Therapy	79,621	3,039	12,218	94,878		94,878		94,878		10a
11	Activities	145,378	8,593	5,743	159,714		159,714	25	159,739		11
12	Social Services	155,385		35,376	190,761		190,761	17	190,778		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							17,242	17,242		15
16	TOTAL Health Care and Programs	3,049,791	112,428	143,255	3,305,474		3,305,474	23,517	3,328,991		16
	C. General Administration										
17	Administrative	78,545		276,498	355,043		355,043	40,512	395,555		17
18	Directors Fees										18
19	Professional Services			375,522	375,522		375,522	(316,374)	59,148		19
20	Dues, Fees, Subscriptions & Promotions			69,899	69,899		69,899	(42,712)	27,187		20
21	Clerical & General Office Expenses	88,698	26,239	190,896	305,833		305,833	35,114	340,947		21
22	Employee Benefits & Payroll Taxes			723,696	723,696	34,493	758,189	(81,749)	676,440		22
23	Inservice Training & Education			907	907		907		907		23
24	Travel and Seminar			1,520	1,520		1,520	1,679	3,199		24
25	Other Admin. Staff Transportation			9,987	9,987		9,987	(9,516)	471		25
26	Insurance-Prop.Liab.Malpractice			191,531	191,531		191,531	1,397	192,928		26
27	Other (specify):*							35,504	35,504		27
28	TOTAL General Administration	167,243	26,239	1,840,456	2,033,938	34,493	2,068,431	(336,145)	1,732,286		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,916,672	581,643	2,544,266	7,042,581		7,042,581	(323,683)	6,718,898		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

WASHINGTON HEIGHTS N H

#0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

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			78,610	78,610		78,610	562,428	641,038			30
31	Amortization of Pre-Op. & Org.			3,787	3,787		3,787		3,787			31
32	Interest			53,069	53,069		53,069	736,254	789,323			32
33	Real Estate Taxes			350,382	350,382		350,382	3,448	353,830			33
34	Rent-Facility & Grounds			1,266,222	1,266,222		1,266,222	(1,260,882)	5,340			34
35	Rent-Equipment & Vehicles			3,918	3,918		3,918	3,889	7,807			35
36	Other (specify):*											36
37	TOTAL Ownership			1,755,988	1,755,988		1,755,988	45,137	1,801,125			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		230,666	267,686	498,352		498,352	(7,033)	491,319			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,830	124,830		124,830		124,830			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		230,666	392,516	623,182		623,182	(7,033)	616,149			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,916,672	812,309	4,692,770	9,421,751		9,421,751	(285,578)	9,136,173			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	228,175	30		9
10	Interest and Other Investment Income	(168,798)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(108)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,000)	21		24
25	Fund Raising, Advertising and Promotional	(19,807)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(360)	20		28
29	Other-Attach Schedule	(92,430)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (137,328)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(148,251)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (148,251)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (285,578)		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

OHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

HW 0042044
Report Period Beginning: 01/01/02
Ending: 12/31/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line	Reference
1	Collection Expense	(1,727)	21	1
2	Bank Charges	(4,900)	21	2
3	Theft Loss	6,470	21	3
4	Prior Period Legal Invoices	(10,758)	19	4
5	L.C. Fees (Bldg Co)	(200)	20	5
6	Bank Charges	(99)	21	6
7	Miscellaneous Income	(239)	21	7
8	Ill. Council on LTC-COPE	(3,304)	20	8
9	Amortization (Loan Fees-Bldg Co)	(9,493)	31	9
10	Prior Period Adjustment (Pension Expense)	(48,596)	22	10
11	Prior Period Adjustment (General Med. A Expense)	(371)	20	11
12	Prior Period Adjustment (Housekeeping Expense)	(4,710)	03	12
13	Non Allowable Interest Expense	(1,826)	32	13
14				14
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100				100
101	Total	(92,430)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary					(2,268)	(5,577)	(11,638)					(19,483)	1
2	Food Purchase	(108)		(171)			5,155						4,876	2
3	Housekeeping	(4,710)						(1,940)					(6,650)	3
4	Laundry													4
5	Heat and Other Utilities			1,987									1,987	5
6	Maintenance			3,886		2,299	15						6,200	6
7	Other (specify):*				249	1,129	637						2,015	7
8	TOTAL General Services	(4,818)		5,702	249	1,160	230	(13,578)					(11,054)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(47)		14,245	9	(7,974)					6,233	10
10a	Therapy													10a
11	Activities			2	23								25	11
12	Social Services					17							17	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				15,280	1,962							17,242	15
16	TOTAL Health Care and Programs			(45)	15,303	16,224	9	(7,974)					23,517	16
	C. General Administration													
17	Administrative			468		39,795	249						40,512	17
18	Directors Fees													18
19	Professional Services	(10,795)		(306,080)			501						(316,374)	19
20	Fees, Subscriptions & Promotions	(23,671)	200	(19,268)			27						(42,712)	20
21	Clerical & General Office Expenses	(97,135)	(901)	19,165		113,626	359						35,114	21
22	Employee Benefits & Payroll Taxes	(48,596)			(33,153)								(81,749)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,143			536						1,679	24
25	Other Admin. Staff Transportation			(9,516)									(9,516)	25
26	Insurance-Prop.Liab.Malpractice			1,397									1,397	26
27	Other (specify):*				13,889	21,615							35,504	27
28	TOTAL General Administration	(180,197)	(701)	(312,691)	(19,264)	175,036	1,672						(336,145)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(185,015)	(701)	(307,034)	(3,712)	192,420	1,911	(21,552)					(323,683)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	228,175	320,558	13,695									562,428	30
31	Amortization of Pre-Op. & Org.	(9,493)	9,493											31
32	Interest	(170,624)	892,271	14,607									736,254	32
33	Real Estate Taxes			3,448									3,448	33
34	Rent-Facility & Grounds		(1,266,222)	5,326			14						(1,260,882)	34
35	Rent-Equipment & Vehicles			3,869			20						3,889	35
36	Other (specify):*													36
37	TOTAL Ownership	48,058	(43,900)	40,945			34						45,137	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(371)					(6,662)						(7,033)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(371)					(6,662)						(7,033)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(137,328)	(44,601)	(266,089)	(3,712)	192,420	(4,717)	(21,552)					(285,578)	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		
				WASHINGTON HEIGHTS PROPERTY, LLC	BUILDING CO.	

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 RENTAL INCOME	\$ 1,266,222	WASHINGTON HEIGHTS PROPERTY, LLC		\$	(1,266,222)	1
2	V	32 INTEREST INCOME/EXPENSE	48,418	WASHINGTON HEIGHTS PROPERTY, LLC		940,689	892,271	2
3	V	21 OFFICE EXPENSE	1,000	WASHINGTON HEIGHTS PROPERTY, LLC			(1,000)	3
4	V	30 DEPRECIATION		WASHINGTON HEIGHTS PROPERTY, LLC		320,558	320,558	4
5	V	20 LLC FEES		WASHINGTON HEIGHTS PROPERTY, LLC		200	200	5
6	V	21 BANK CHARGES		WASHINGTON HEIGHTS PROPERTY, LLC		99	99	6
7	V	31 AMORTIZATION		WASHINGTON HEIGHTS PROPERTY, LLC		9,493	9,493	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,315,640			\$ 1,271,039	\$ * (44,601)	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	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)		
15	V	05 Utilities	\$	Care Centers, Inc.	100.00%	\$ 1,987	\$	1,987	15
16	V	06 Maintenance		Care Centers, Inc.	100.00%	3,886		3,886	16
17	V	10 Nursing	57	Care Centers, Inc.	100.00%	10		(47)	17
18	V	11 Activities		Care Centers, Inc.	100.00%	2		2	18
19	V	19 Professional Fees	317,655	Care Centers, Inc.	100.00%	11,575		(306,080)	19
20	V	20 Dues and Subscriptions	20,805	Care Centers, Inc.	100.00%	1,537		(19,268)	20
21	V	21 Office & Clerical		Care Centers, Inc.	100.00%	19,165		19,165	21
22	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	1,143		1,143	22
23	V	26 Insurance		Care Centers, Inc.	100.00%	1,397		1,397	23
24	V	30 Depreciation		Care Centers, Inc.	100.00%	13,695		13,695	24
25	V	32 Interest		Care Centers, Inc.	100.00%	14,607		14,607	25
26	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	3,448		3,448	26
27	V	34 Rent - Building		Care Centers, Inc.	100.00%	5,326		5,326	27
28	V	35 Rent - Equipment & Auto		Care Centers, Inc.	100.00%	3,869		3,869	28
29	V	25 Bus Reimbursement	9,516	Care Centers, Inc.	100.00%			(9,516)	29
30	V	02 Food	171	Care Centers, Inc.	100.00%			(171)	30
31	V	17 Administration		Care Centers, Inc.	100.00%	468		468	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 348,204			\$ 82,115	\$ *	(266,089)	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	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)	
15	V	03 Housekeeping Salary	\$	Care Centers, Inc.	100.00%	\$	\$	15
16	V	06 Maintenance Salary	1,883	Care Centers, Inc.	100.00%	1,883		16
17	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	249	249	17
18	V	10 Nursing Salary	74,490	Care Centers, Inc.	100.00%	74,490		18
19	V	10a Rehab Salary	(70)	Care Centers, Inc.	100.00%	(70)		19
20	V	11 Activity Salary	4,243	Care Centers, Inc.	100.00%	4,266	23	20
21	V	12 Social Service Salary	35,376	Care Centers, Inc.	100.00%	35,376		21
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	15,280	15,280	22
23	V	17 Administration Salary	72,498	Care Centers, Inc.	100.00%	72,498		23
24	V	21 Office Salary	32,600	Care Centers, Inc.	100.00%	32,600		24
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	13,889	13,889	25
26	V	22 Employee Benefits	33,153	Care Centers, Inc.	100.00%		(33,153)	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		\$ 254,173			\$ 250,461	\$ * (3,712)	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	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)	
15	V	01 Dietary Salary	\$ 8,322	Care Centers, Inc.	100.00%	\$ 6,054	\$ (2,268)	15
16	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	2,299	2,299	16
17	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,129	1,129	17
18	V	10 Nursing Salary		Care Centers, Inc.	100.00%	14,245	14,245	18
19	V	12 Social Service Salary		Care Centers, Inc.	100.00%	17	17	19
20	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,962	1,962	20
21	V	17 Administration Salary		Care Centers, Inc.	100.00%	39,795	39,795	21
22	V	21 Office Salary		Care Centers, Inc.	100.00%	113,626	113,626	22
23	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	21,615	21,615	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		\$ 8,322			\$ 200,742	\$ * 192,420	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	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)	
15	V	01 Dietary	\$ 12,294	Care Centers, Inc. - Health Systems Division	100.00%	\$ 1,979	\$ (10,315)	15
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	5,155	5,155	16
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	15	15	17
18	V	10 Nursing		Care Centers, Inc. - Health Systems Division	100.00%	9	9	18
19	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	249	249	19
20	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	501	501	20
21	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	27	27	21
22	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	359	359	22
23	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	536	536	23
24	V	34 Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	14	14	24
25	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	20	20	25
26	V	39 Ancillary Enteral Supplies	11,472	Care Centers, Inc. - Health Systems Division	100.00%	4,810	(6,662)	26
27	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	4,738	4,738	27
28	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	637	637	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		\$ 23,766			\$ 19,049	\$ * (4,717)	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	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)	
15	V	01 Dietary	\$ 85,903	XCEL Medical Supply, LLC	100.00%	\$ 74,265	\$ (11,638)	15
16	V	03 Housekeeping	14,317	XCEL Medical Supply, LLC	100.00%	12,377	(1,940)	16
17	V	10 Nursing	58,859	XCEL Medical Supply, LLC	100.00%	50,885	(7,974)	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		\$ 159,079			\$ 137,527	\$ * (21,552)	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	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)	
15	V	22 EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 102,551	\$ 102,551	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INS.	102,551				(102,551)	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		\$ 102,551			\$ 102,551	\$ *	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		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)	
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			\$			\$	\$ *	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		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)	
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			\$			\$	\$ *	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		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)	
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			\$			\$	\$ *	39

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

Facility Name & ID Number

WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

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	David Aronin	Owner	Administrative	0.89%	See Attached	2.34	4.68%	Alloc. Salary	\$ 4,046	17-7	1
2	Eric Rothner	Relative	Administrative	0.00%	See Attached	2.29	3.18%	Mgmt. Fee	180,000	17-3	2
3	Norman Goldberg	Owner	Administrative	1.77%	See Attached	2.34	4.68%	Alloc. Salary	4,877	17-7	3
4	Melissa Rothner	Owner	Clerical	5.75%	See Attached			Alloc. Salary	47	21-7	4
5	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.34	4.68%	Alloc. Salary	2,118	17-7	5
6	Alan Abrams	Owner	Administrative	8.85%	See Attached	1	2.86%	Mgmt. Fee	12,000	17-3	6
7	Ron Abrams	Owner	Administrative	8.85%	See Attached	1	2.86%	Mgmt. Fee	12,000	17-3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 215,088		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning: 01/01/02

Ending: 12/31/02

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	05	Utilities	Patient Days	1,640,756	39	\$ 42,470	\$ 76,751	\$ 1,987	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080	76,751	3,886	2
3	10	Nursing	Patient Days	1,640,756	39	205	76,751	10	3
4	11	Activities	Patient Days	1,640,756	39	51	76,751	2	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437	76,751	11,575	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863	76,751	1,537	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698	76,751	19,165	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743	76,751	1,143	8
9	26	Insurance	Patient Days	1,640,756	39	29,875	76,751	1,397	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776	76,751	13,695	10
11	32	Interest	Patient Days	1,640,756	39	312,254	76,751	14,607	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702	76,751	3,448	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857	76,751	5,326	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710	76,751	3,869	14
15	17	Administration	Patient Days	1,640,756	39	10,000	76,751	468	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,784,721	\$	\$ 82,115	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending: 12/31/02

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 Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	03	Housekeeping Salary	Direct Cost		45,667	45,667			1
2	06	Maintenance Salary	Direct Cost		169,934	169,934		1,883	2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost		29,646			249	3
4	10	Nursing Salary	Direct Cost		895,582	895,582		74,490	4
5	10a	Rehab Salary	Direct Cost		128,376	128,376		(70)	5
6	11	Activity Salary	Direct Cost		57,201	57,201		4,266	6
7	12	Social Service Salary	Direct Cost		219,790	219,790		35,376	7
8	15	Emp. Ben. - Healthcare	Direct Cost		180,204			15,280	8
9	17	Administration Salary	Direct Cost		1,334,207	1,334,207		72,498	9
10	21	Office Salary	Direct Cost		584,278	584,278		32,600	10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost		267,060			13,889	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				\$ 3,911,943	\$ 3,435,033		\$ 250,461	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending: 12/31/02

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 Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary Salary	Patient Days	1,640,756	39	129,417	76,751	6,054	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	76,751	2,299	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132	76,751	1,129	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	76,751	14,245	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	76,751	17	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952	76,751	1,962	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	76,751	39,795	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	76,751	113,626	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069	76,751	21,615	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					\$ 4,291,386	\$ 3,763,233	\$ 200,742	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending: 12/31/02

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 Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary	Billable Income	2,191,458		182,448	23,766	1,979	1
2	02	Food	Billable Income	2,191,458		834,365	23,766	5,155	2
3	06	Maintenance	Billable Income	2,191,458		1,400	23,766	15	3
4	10	Nursing	Billable Income	2,191,458		850	23,766	9	4
5	17	Administration	Billable Income	2,191,458		23,000	23,766	249	5
6	19	Professional Fees	Billable Income	2,191,458		46,205	23,766	501	6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514	23,766	27	7
8	21	Office & Clerical	Billable Income	2,191,458		33,124	23,766	359	8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456	23,766	536	9
10	34	Rent - Building	Billable Income	2,191,458		1,300	23,766	14	10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830	23,766	20	11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436	23,766	4,810	12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887	4,738	13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714	23,766	637	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,756,530	\$ 436,887	\$ 19,049	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 Xcel Medical Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847) 328-7600
 Fax Number (847) 328-7615

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	01	Dietary	Direct Allocation		\$	\$		\$ 74,265	1
2	03	Housekeeping	Direct Allocation					12,377	2
3	10	Nursing	Direct Allocation					50,885	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				\$	\$		\$ 137,527	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending: 12/31/02

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

CCS EMPLOYEE BENEFITS GROUP, INC.

Street Address

2201 W. MAIN ST.

City / State / Zip Code

EVANSTON, IL 60202

Phone Number

(847) 905-4000

Fax Number

(847) 905-4040

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	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION		\$	\$		\$ 102,551	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				\$	\$		\$ 102,551	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending: 12/31/02

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning: 01/01/02

Ending: 12/31/02

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending: 12/31/02

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H # 0042044 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	CORUS BANK	X		MORTGAGE			\$	12,227,762		\$	991,932	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$	12,227,762		\$	991,932	9								
B. Non-Facility Related*																				
10	See Supplemental Schedule										(202,608)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$			\$	(202,608)	14								
15	TOTALS (line 9+line14)						\$	12,227,762		\$	789,324	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 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.) SEE ACCOUNTANTS' COMPILATION REPORT

** 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

WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

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			
1	Interest Income											\$	(168,798)	1						
2	Interest Income-(Bldg Co)												(48,418)	2						
3	Care Center Allocation												14,607	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												\$	(202,608)	21						

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 WASHINGTON HEIGHTS N H COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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>25-05-423-001-0000</u>	<u>LTC Property</u>	\$ <u>1,320.90</u>	\$ <u>1,320.90</u>
2. <u>25-05-423-002-0000</u>	<u>LTC Property</u>	\$ <u>1,458.16</u>	\$ <u>1,458.16</u>
3. <u>25-05-423-003-0000</u>	<u>LTC Property</u>	\$ <u>1,669.95</u>	\$ <u>1,669.95</u>
4. <u>25-05-423-004-0000</u>	<u>LTC Property</u>	\$ <u>1,616.39</u>	\$ <u>1,616.39</u>
5. <u>25-05-423-005-0000</u>	<u>LTC Property</u>	\$ <u>8,352.38</u>	\$ <u>8,352.38</u>
6. <u>25-05-423-006-0000</u>	<u>LTC Property</u>	\$ <u>42,720.52</u>	\$ <u>42,720.52</u>
7. <u>25-05-423-007-0000</u>	<u>LTC Property</u>	\$ <u>51,514.74</u>	\$ <u>51,514.74</u>
8. <u>25-05-423-008-0000</u>	<u>LTC Property</u>	\$ <u>133,041.55</u>	\$ <u>133,041.55</u>
9. <u>25-05-423-009-0000</u>	<u>LTC Property</u>	\$ <u>105,064.14</u>	\$ <u>105,064.14</u>
10. <u>Care Center Allocation</u>	<u>Home Office</u>	\$ <u>70,261.00</u>	\$ <u>3,286.69</u>
	TOTALS	\$ <u>417,019.73</u>	\$ <u>350,045.42</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 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 2001 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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WASHINGTON HEIGHTS N H COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02 Ending:

12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,255 B. General Construction Type: Exterior BRICK Frame MASONARY & STEE Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

NONE

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: 8,033 2. Number of Years Over Which it is Being Amortized: 2 YRS
 3. Current Period Amortization: 3,787 4. Dates Incurred: _____

Nature of Costs: Financing Fees

(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	<u>FACILITY</u>	<u>85,244</u>	<u>1994</u>	<u>\$ 251,898</u>	<u>1</u>
2	<u>ALLOC CCI</u>			<u>19,675</u>	<u>2</u>
3	TOTALS	<u>85,244</u>		<u>\$ 271,573</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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		1996		21,522		20	1,077	1,077	6,951	9
10	Various		1997		179,381		20	8,971	8,971	48,919	10
11	Various		1998		71,893		20	3,596	3,596	16,277	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								-		-	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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68	<u>Related Party Allocations (Page 12-REP & Page 12A-REP)</u>		<u>10,278,311</u>		<u>513,540</u>	<u>248,383</u>	<u>2,933,572</u>	68
69	<u>Financial Statement Depreciation</u>				<u>45,508</u>	<u>(45,508)</u>		69
70	TOTAL (lines 4 thru 69)		\$ 10,551,107		\$ 310,665	\$ 527,184	\$ 216,519	\$ 3,005,719 70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

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		\$ 10,551,107	\$ 310,665		\$ 527,184	\$ 216,519	\$ 3,005,719	1
2	<u>CERTIF OF NEED COMPL</u>	1999	2,326		20	116	116	465	2
3	<u>DOOR</u>	1999	1,064		20	53	53	212	3
4	<u>PLUMBING RENOV</u>	1999	2,727		20	136	136	510	4
5	<u>SIGN OVERHANG</u>	1999	1,750		20	88	88	323	5
6	<u>LANDSCAPING</u>	1999	2,079		20	104	104	373	6
7	<u>LANDSCAPING</u>	1999	2,610		20	131	131	469	7
8	<u>OVERHANG LOGO</u>	1999	1,750		20	88	88	315	8
9	<u>DOOR RENOV</u>	1999	2,496		20	125	125	448	9
10	<u>WINDOW RENOV</u>	1999	845		20	42	42	151	10
11	<u>RODDING</u>	1999	1,786		20	89	89	312	11
12	<u>RODDING</u>	1999	1,000		20	50	50	175	12
13	<u>LANDSCAPING</u>	1999	870		20	44	44	154	13
14	<u>PLUMBIN</u>	1999	1,800		20	90	90	315	14
15	<u>RODDING</u>	1999	600		20	30	30	103	15
16	<u>RODDING</u>	1999	1,223		20	61	61	208	16
17	<u>INSULATION</u>	1999	780		20	39	39	133	17
18	<u>PLUMBING</u>	1999	840		20	42	42	144	18
19	<u>LANDSCAPING</u>	1999	870		20	44	44	147	19
20	<u>INSULATION</u>	1999	780		20	39	39	130	20
21	<u>RODDING</u>	1999	549		20	27	27	90	21
22	<u>DUCT HEATER</u>	1999	1,884		20	94	94	313	22
23	<u>REDDING</u>	1999	625		20	31	31	103	23
24	<u>ELECTRICAL RENOV</u>	1999	950		20	48	48	160	24
25	<u>STEEL DOOR</u>	1999	2,496		20	125	125	417	25
26	<u>SEWER RENOV</u>	1999	844		20	42	42	137	26
27	<u>SEWER RENOV</u>	1999	745		20	37	37	120	27
28	<u>FLOOD CLEANING</u>	1999	2,927		20	146	146	462	28
29	<u>AQUARIUM RENOV</u>	1999	1,801		20	90	90	285	29
30	<u>MOTOR RENOV</u>	1999	688		20	34	34	108	30
31	<u>LANDSCAPING</u>	1999	870		20	44	44	136	31
32	<u>THERMOSTAT</u>	1999	1,028		20	51	51	157	32
33	<u>WANDERER SYSTEM</u>	1999	7,956		20	398	398	1,294	33
34	TOTAL (lines 1 thru 33)		\$ 10,602,666	\$ 310,665		\$ 529,762	\$ 219,097	\$ 3,014,588	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

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		\$ 10,602,666	\$ 310,665		\$ 529,762	\$ 219,097	\$ 3,014,588	1
2	3 POLE CONTRACTOR	1999	680		20	34	34	113	2
3	COMPRESSOR RENOV	1999	621		20	31	31	103	3
4	RODS	1999	580		20	29	29	106	4
5	WELL TANK	1999	669		20	33	33	124	5
6	PLUMBING RENOV	2000	875		20	44	44	132	6
7	SEWER RENOV	2000	1,330		20	67	67	201	7
8	GENERATOR RENOV	2000	551		20	55	55	165	8
9	CLEANING	2000	3,471		20	174	174	508	9
10	SEWER RENOV	2000	503		20	25	25	73	10
11	SEWER INSTALL	2000	8,200		20	410	410	1,196	11
12	PLUMBING RENOV	2000	1,370		20	69	69	201	12
13	BEDSPREADS	2000	1,717		20	86	86	251	13
14	HOT WATER HEATERS	2000	1,847		20	92	92	268	14
15	DOORS	2000	2,500		20	250	250	729	15
16	BEDSPREADS	2000	5,421		20	271	271	768	16
17	PIPE INSTALLATION	2000	11,000		20	550	550	1,513	17
18	RODDING	2000	2,030		20	102	102	281	18
19	FENCE REPAIR	2000	850		20	43	43	115	19
20	ELECTRICAL RENOV	2000	885		20	89	89	237	20
21	BASEMENT FLOOR	2000	34,650		20	1,733	1,733	4,477	21
22	FIRE ALARM PANEL	2000	4,064		20	406	406	1,049	22
23	SIGNS	2000	1,683		20	84	84	210	23
24	WATER HEATER REPAIR	2000	2,144		20	214	214	535	24
25	ELECTRIC WIRING	2000	985		20	49	49	123	25
26	LANDSCAPING	2000	1,200		20	60	60	150	26
27	LANDSCAPING	2000	2,085		20	104	104	260	27
28	HVAC REPAIR	2000	595		20	30	30	73	28
29	RODDING	2000	1,280		20	64	64	155	29
30	REPAIR & CLEAN DRAPE	2000	920		20	46	46	111	30
31	BACKFLOW CERTIFICATI	2000	840		20	42	42	102	31
32	DOORS	2000	1,614		20	81	81	196	32
33	HVAC REPAIR	2000	698		20	35	35	85	33
34	TOTAL (lines 1 thru 33)		\$ 10,700,524	\$ 310,665		\$ 535,164	\$ 224,499	\$ 3,029,198	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

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		\$ 10,700,524	\$ 310,665		\$ 535,164	\$ 224,499	\$ 3,029,198	1
2	INSPECT UNDERGROUND	2000	1,270		20	64	64	149	2
3	DOOR FRAMES	2000	2,000		20	100	100	233	3
4	OFFICE	2000	3,260		20	163	163	380	4
5	HVAC REPAIR	2000	638		20	32	32	75	5
6	HVAC REPAIR	2000	(329)		20	(16)	(16)	(37)	6
7	3RD FLOOR CORRIDOR	2001	11,766		20	588	588	1,176	7
8	CARPETING	2001	20,162		20	1,008	1,008	2,016	8
9	PUMP	2001	1,175		20	59	59	118	9
10	PUMP	2001	665		20	33	33	66	10
11	AMERICAN EAGLE DETEC	2001	1,450		20	73	73	140	11
12	HVAC REPAIR	2001	887		20	44	44	84	12
13	FIRE ALARM R&M	2001	2,282		20	114	114	219	13
14	HOT WATER HEATER	2001	6,520		20	326	326	598	14
15	AMERICAN EAGLE DETEC	2001	1,450		20	73	73	134	15
16	AMER EDGE DETECTOR E	2001	1,450		20	73	73	128	16
17	FENCE REPAIR	2001	562		20	28	28	47	17
18	BOILER R & M	2001	612		20	31	31	52	18
19	HOT WATER HEATER	2001	4,564		20	228	228	361	19
20	HVAC REPAIR	2001	767		20	38	38	60	20
21	HVAC REPAIR	2001	973		20	49	49	74	21
22	PLUMBING R&M	2001	625		20	31	31	44	22
23	INSPECT UNDERGROUND	2001	798		20	40	40	53	23
24	CLEANOUT SEWER	2001	2,980		20	149	149	199	24
25	BACKFLOW SERVICE	2001	860		20	43	43	57	25
26	PAINT	2001	690		20	35	35	41	26
27	LIFT	2002	2,149		20	215	215	215	27
28	STAIN GLASS	2002	695		20	70	70	70	28
29	BASEMENT RAMP EXIT DOOR	2002	1,116		20	112	112	112	29
30	PATIO AWNING	2002	4,400		20	440	440	440	30
31	3RD FLOOR CAFETERIA FLOOR	2002	5,772		20	577	577	577	31
32	REPAIR ON SPRINKLER SYSTEM	2002	1,233		20	247	247	247	32
33	REPLACE PUMP	2002	1,562		20	312	312	312	33
34	TOTAL (lines 1 thru 33)		\$ 10,785,528	\$ 310,665		\$ 540,543	\$ 229,878	\$ 3,037,638	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

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		\$ 10,785,528	\$ 310,665		\$ 540,543	\$ 229,878	\$ 3,037,638	1
2	CONCRETE PAVING	2002	561		20	51	51	51	2
3	ROOFING R&M	2002	950		20	87	87	87	3
4	A/C REPAIR	2002	506		20	93	93	93	4
5	A/C REPAIR	2002	816		20	150	150	150	5
6	VALVE REPAIR	2002	844		20	155	155	155	6
7	A/C REPAIR	2002	585		20	107	107	107	7
8	A/C REPAIR	2002	870		20	160	160	160	8
9	A/C REPAIR	2002	684		20	125	125	125	9
10	R&M FAN COIL UNITS	2002	1,562		20	286	286	286	10
11	R&M FAN COIL UNITS	2002	863		20	158	158	158	11
12	A/C REPAIR	2002	506		20	93	93	93	12
13	A/C REPAIR	2002	863		20	129	129	129	13
14	PHONE JACKS	2002	925		20	69	69	69	14
15	PHONE JACKS	2002	925		20	62	62	62	15
16	A/C REPAIR	2002	546		20	64	64	64	16
17	DRAPES	2002	932		20	54	54	54	17
18	R&M FAN COIL UNITS	2002	863		20	101	101	101	18
19	CARPETING	2002	29,566		20	1,478	1,478	1,478	19
20	R&M FAN COIL UNITS	2002	868		20	87	87	87	20
21	A/C REPAIR	2002	530		20	53	53	53	21
22	PLUMBING R&M	2002	860		20	72	72	72	22
23	FLOORING	2002	12,986		20	325	325	325	23
24	SIDEWALK R&M	2002	1,820		20	46	46	46	24
25	CARPETING, MATERIAL, LABOR & TAX	2002	4,381		20	110	110	110	25
26	PIPE R&M	2002	2,200		20	37	37	37	26
27	A/C REPAIR	2002	1,147		20	19	19	19	27
28	DRAPERIES	2002	774		20	13	13	13	28
29	CRACKFILLING	2002	4,174		20	70	70	70	29
30	DUCTWORK	2002	1,740		20	29	29	29	30
31	PARKWAY LIGHTING	2002	744		20	12	12	12	31
32	VALVE REPAIR	2002	781		20	26	26	26	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	1
2									2
3									3
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	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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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	1
2									2
3									3
4									4
5									5
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8									8
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	1
2									2
3									3
4									4
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	1
2									2
3									3
4									4
5									5
6									6
7									7
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,861,900	\$ 310,665		\$ 544,864	\$ 234,199	\$ 3,041,959	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **WASHINGTON HEIGHTS N H**

0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

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		1996		\$ 10,226,094	\$ 262,979	35	\$ 511,305	\$ 248,326	\$ 2,933,392	4
5	CCI ALLOC				1,245	35	1,388	143		5
6	CCI ALLOC	2002		27,113	51	35	75	24	75	6
7										7
8										8
Improvement Type**										
9										9
10	CARE CENTERS INC		2002		462	20	31	(431)		10
11	CARE CENTERS INC		2001		1	20	7	6		11
12	CARE CENTERS INC		2000		2	20	3	(1)		12
13	CARE CENTERS INC		1999		22	20	44	22		13
14	CARE CENTERS INC		1998		9	20	18	9		14
15	CARE CENTERS INC		1997		89	20	179	90		15
16	CARE CENTERS INC		1996		233	20	355	122		16
17	CARE CENTERS INC-Indiana		1997		1	20	30	29		17
18	CARE CENTERS INC		1994		11	20		(11)		18
19	CARE CENTERS INC		1993		5	20		(5)		19
20										20
21	CARE CENTERS INC		2002	25,104	47	20	105	58	105	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										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-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,278,311	\$ 265,157		\$ 513,540	\$ 248,381	\$ 2,933,572	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 886,340	\$ 95,382	\$ 87,936	\$ (7,446)	10	\$ 534,923	71
72	Current Year Purchases	41,379	1,516	3,646	2,130	10	3,646	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 927,719	\$ 96,898	\$ 91,582	\$ (5,316)		\$ 538,569	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	CCI ALLOCATION			\$ 31,512	\$ 5,301	\$ 4,593	\$ (708)	5	\$ 4,593	76
77										77
78										78
79										79
80	TOTALS			\$ 31,512	\$ 5,301	\$ 4,593	\$ (708)		\$ 4,593	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)	\$ 12,092,704	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 412,864	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 641,039	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 228,175	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,585,121	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: _____

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	CCI ALLOCATION			5,340			4
5								5
6								6
7	TOTAL				\$ 5,340			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: \$ 7,806 Description: Toshiba Copiers - \$3,515 Ecolab-\$403; Care Center Alloc.-\$3,889

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 156,696	\$		\$ 156,696	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			27,235			27,235	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			83,755			83,755	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				147,359		147,359	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						83,307		83,307	13
14	TOTAL			\$		\$ 267,686	\$ 230,666		\$ 498,352	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning: 01/01/02

Ending:

12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,793	\$ (1,257,673)	1
2	Cash-Patient Deposits	52,499	52,499	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,981,512	1,981,512	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	265,429	265,429	6
7	Other Prepaid Expenses	14,545	14,545	7
8	Accounts Receivable (owners or related parties)	(939,991)	(924,821)	8
9	Other(specify): <u>See Supplemental Schedule</u>	3,222,359	3,222,359	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,603,146	\$ 3,353,850	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		251,898	13
14	Buildings, at Historical Cost		10,226,094	14
15	Leasehold Improvements, at Historical Cost	506,259	506,259	15
16	Equipment, at Historical Cost	275,464	943,784	16
17	Accumulated Depreciation (book methods)	(330,202)	(2,569,631)	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): <u>See Supplemental Schedule</u>	1,414	59,166	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 452,935	\$ 9,417,570	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,056,081	\$ 12,771,420	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 576,896	\$ 576,894	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,514	51,514	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	255,099	255,099	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,880	20,880	31
32	Accrued Real Estate Taxes(Sch.IX-B)	364,097	364,097	32
33	Accrued Interest Payable		79,173	33
34	Deferred Compensation	488	488	34
35	Federal and State Income Taxes	2,000	2,000	35
	Other Current Liabilities(specify):			
36	<u>See Supplemental Schedule</u>	14,110	(920,769)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,285,084	\$ 429,376	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		12,227,762	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 12,227,762	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,285,084	\$ 12,657,138	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,770,997	\$ 114,282	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,056,081	\$ 12,771,420	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,011,226	1
2	Restatements (describe):		2
3	To Adjust Accumulated Depreciation to GAAP	(49,855)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,961,371	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	912,826	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	(103,200)	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)	\$ 809,626	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)	\$ 3,770,997	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning: 01/01/02

Ending:

12/31/02

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	\$ 9,797,975	1
2	Discounts and Allowances for all Levels	(1,495,872)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,302,103	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,478,010	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,478,010	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	150,679	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,705	19
20	Radiology and X-Ray	5,190	20
21	Other Medical Services	198,853	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 385,427	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	168,798	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 168,798	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	239	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 239	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,334,577	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,703,169	31
32	Health Care	3,305,474	32
33	General Administration	2,033,938	33
B. Capital Expense			
34	Ownership	1,755,988	34
C. Ancillary Expense			
35	Special Cost Centers	498,352	35
36	Provider Participation Fee	124,830	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,421,751	40
41	Income before Income Taxes (line 30 minus line 40)**	912,826	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 912,826	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning:

01/01/02

Ending:

12/31/02

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		\$	\$	1	
2	Assistant Director of Nursing	2,056	2,536	62,647	24.70	2
3	Registered Nurses	10,092	11,513	234,047	20.33	3
4	Licensed Practical Nurses	57,961	63,005	1,217,191	19.32	4
5	Nurse Aides & Orderlies	115,446	130,508	1,132,750	8.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,634	7,286	79,621	10.93	8
9	Activity Director	3,526	3,839	45,423	11.83	9
10	Activity Assistants	12,977	13,959	99,955	7.16	10
11	Social Service Workers	12,788	14,186	155,385	10.95	11
12	Dietician	1,909	2,077	24,630	11.86	12
13	Food Service Supervisor	1,888	2,226	29,515	13.26	13
14	Head Cook	5,610	5,966	53,910	9.04	14
15	Cook Helpers/Assistants	27,437	29,288	210,722	7.19	15
16	Dishwashers					16
17	Maintenance Workers	6,143	6,750	78,710	11.66	17
18	Housekeepers	26,530	28,554	204,610	7.17	18
19	Laundry	12,613	13,724	97,541	7.11	19
20	Administrator					20
21	Assistant Administrator	3,896	4,796	78,545	16.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,894	8,590	88,698	10.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,920	2,208	22,772	10.31	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	317,319	351,010	\$ 3,916,672 *	\$ 11.16	34

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	209	\$ 8,518	01-03	35
36	Medical Director	72	9,000	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,300	10-03	39
40	Physical Therapy Consultant	113	6,062	10a-03	40
41	Occupational Therapy Consultant	114	6,156	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,500	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>CCI SALARY/CONSULTANT</u>		122,431	Various	47
48					48
49	TOTAL (lines 35 - 48)	538	\$ 160,095		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Edith Ballard	Asst Administrator	0	\$ 78,545	Workers' Compensation Insurance	\$ 98,871	IDPH License Fee	\$	
				Unemployment Compensation Insurance	54,960	Advertising: Employee Recruitment	9,586	
				FICA Taxes	295,236	Health Care Worker Background Check (Indicate # of checks performed <u>350</u>)	3,500	
				Employee Health Insurance	159,351	Yellow Pages	360	
				Employee Meals	34,493	Due & Subscriptions	7,517	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	40,612	
						Licenses	5,020	
						Care Center Allocation	1,564	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,545	Mis Empl Benefits	14,401	Less: Public Relations Expense	()	
B. Administrative - Other				Pension	17,034	Non-allowable advertising	(40,612)	
Description			Amount	Drug Test Kits	2,094	Yellow page advertising	(360)	
Eric Rothner			\$ 180,000					
Alan Abrams			12,000					
Ron Abrams			12,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 204,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 676,440	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 27,187	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
FR&R	Accounting		\$ 15,988				Out-of-State Travel	\$
Crowe Chizek	Accounting		412					
Care Centers Inc	See Attached		317,655				In-State Travel	
Personnel Planners, Inc	Unemployment Consultant		2,497					
American Express Tax	Tax Consulting		712				Seminar Expense	
S&S Architects	Architect		119				Seminars	1,520
TEG Services Management	Utility Management Services		225				Care Center Allocation	1,679
Alpha Data Services	Data Processing		6,729					
See Attached Schedule	Legal Fees		31,148				Entertainment Expense	()
Cindy Zola Training	IOC Consulting		37				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,199
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 375,522	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON HEIGHTS N H

0042044

Report Period Beginning: 01/01/02

Ending: 12/31/02

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. Illinois Council on Long Term Care \$10,820.88
- (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? _____
- (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. \$ 4,728 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 124,830
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 benefit: on Schedule V. \$ 34,493 Has any meal income been offset against related costs? _____ 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. \$ 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? _____
Firm Name: NO 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

SEE ACCOUNTANTS' COMPILATION REPORT