

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

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

I. IDPH Facility ID Number: 0041897

Facility Name: CARE CENTRE OF URBANA

Address: 907 N. LINCOLN AVE URBANA 61801
 Number City Zip Code

County: CHAMPAIGN

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-4082501

Date of Initial License for Current Owners: 6/1/96

Type of Ownership:

<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 checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____
	(Type or Print Name) <u>BRADLEY ALTER</u> (Date) _____
Paid Preparer	(Title) <u>SECRETARY</u>
	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____
Paid Preparer	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>
	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CARE CENTRE OF URBANA

0041897 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	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			777	777	8
9	SNF/PED					9
10	ICF	19,134	1,411	57	20,602	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,134	1,411	834	21,379	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.16%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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 06/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/01/96 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 12 and days of care provided 777

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

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

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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	135,832	3,737	6,589	146,158		146,158		146,158		1
2	Food Purchase		83,527		83,527		83,527	(176)	83,351		2
3	Housekeeping	67,369	24,840		92,209		92,209	254	92,463		3
4	Laundry	41,821	7,124		48,945		48,945		48,945		4
5	Heat and Other Utilities			66,947	66,947		66,947		66,947		5
6	Maintenance	33,624	14,778	13,860	62,262		62,262	44	62,306		6
7	Other (specify):*			4,194	4,194		4,194		4,194		7
8	TOTAL General Services	278,646	134,006	91,590	504,242		504,242	122	504,364		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	755,173	44,996	177,627	977,796		977,796	10,496	988,292		10
10a	Therapy	56,282		1,186	57,468		57,468		57,468		10a
11	Activities	22,989	2,786		25,775		25,775		25,775		11
12	Social Services	38,260		14,567	52,827		52,827		52,827		12
13	Nurse Aide Training										13
14	Program Transportation			1,213	1,213		1,213		1,213		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	872,704	47,782	203,593	1,124,079		1,124,079	10,496	1,134,575		16
	C. General Administration										
17	Administrative	40,763		23,880	64,643		64,643	1,527	66,170		17
18	Directors Fees										18
19	Professional Services			69,328	69,328		69,328	(41,380)	27,948		19
20	Dues, Fees, Subscriptions & Promotions			6,833	6,833		6,833	(928)	5,905		20
21	Clerical & General Office Expenses	70,500	19,558	92,534	182,592		182,592	(31,337)	151,255		21
22	Employee Benefits & Payroll Taxes			221,487	221,487		221,487	13,970	235,457		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,533	5,533		5,533	1,706	7,239		24
25	Other Admin. Staff Transportation			873	873		873	3,334	4,207		25
26	Insurance-Prop.Liab.Malpractice			72,544	72,544		72,544	1,449	73,993		26
27	Other (specify):*			2,902	2,902		2,902	(2,902)			27
28	TOTAL General Administration	111,263	19,558	495,914	626,735		626,735	(54,561)	572,174		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,262,613	201,346	791,097	2,255,056		2,255,056	(43,943)	2,211,113		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,024
	REPAIRS & MAINTENANCE	565
		0
		6,589
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	13,524
	ELECTRICITY	42,359
	WATER	10,551
	CABLE TV - LOBBY	513
		0
		66,947
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,686
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,324
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,020
	FIRE SERVICE	2,830
		0
		0
		0
		13,860
7	OTHER	
	SCAVENGER	4,194
	SECURITY SERVICE	0
		4,194
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	176,052
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	675
	PHARMACY CONSULTANT XVIII B 39-2	900
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		177,627
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	600
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	163
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	423
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		1,186
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	14,567
		0
		14,567
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,213
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	23,880
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	5,766
	ADMINISTRATIVE CONSULTANTS XIX C	42,323
	PROFESSIONAL FEES XIX C	21,239
		0
		69,328
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	847
	EMPLOYEE WANT ADS XIX F	3,941
	CONTRIBUTIONS VI 20 XIX F	100
	DUES & SUBSCRIPTIONS XIX F	15
	LICENSES & PERMITS XIX F	1,930
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		6,833
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	242
	OUTSIDE CLERICAL SERVICES	73,810
	PENALTIES / OVERDRAFT CHARGES VI 18	5,003
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	11,537
	MESSENGER SERVICE	1,942
		0
		92,534

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	94,287
	UNEMPLOYMENT COMPENSATION XIX D	37,834
	WORKERS COMPENSATION INSURANCE XIX D	50,444
	HOSPITALIZATION INSURANCE XIX D	35,380
	EMPLOYEE BENEFITS - OTHER XIX D	
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	3,542
	CHICAGO HEAD TAX XIX D	0
		221,487
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,410
	TRAVEL XIX G	2,123
		0
		0
		5,533
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	873
		873
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	72,544
		72,544
27	OTHER	
	BAD DEBTS VI 24	2,902
		0
		2,902

GRAND TOTAL COLUMN 3 OTHER

791,097

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			28,530	28,530		28,530	(91)	28,439			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,158	82,158		82,158		82,158			32
33	Real Estate Taxes			45,591	45,591		45,591		45,591			33
34	Rent-Facility & Grounds			393,721	393,721		393,721	4,510	398,231			34
35	Rent-Equipment & Vehicles			4,332	4,332		4,332	234	4,566			35
36	Other (specify):* rent storage/staff			6,010	6,010		6,010		6,010			36
37	TOTAL Ownership			560,342	560,342		560,342	4,653	564,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,802	8,689	26,491		26,491		26,491			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		17,802	62,892	80,694		80,694		80,694			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,262,613	219,148	1,414,331	2,896,092		2,896,092	(39,290)	2,856,802			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,640)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(176)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(5,003)	21		18
19	Entertainment		20		19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,902)	27		24
25	Fund Raising, Advertising and Promotional	(847)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(5,500)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (16,168)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(23,122)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (23,122)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (39,290)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

CARE CENTRE OF URBANA

ID# 0041897

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (5,500)	21	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,500)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(176)	0	0	0	0	0	0	0	0	0	0	(176)	2
3	Housekeeping	0	0	254	0	0	0	0	0	0	0	0	254	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	44	0	0	0	0	0	0	0	0	44	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(176)	0	298	0	122	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	10,496	0	0	0	0	0	0	0	0	10,496	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	10,496	0	10,496	16							
	C. General Administration													
17	Administrative	0	(23,880)	25,407	0	0	0	0	0	0	0	0	1,527	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(42,323)	943	0	0	0	0	0	0	0	0	(41,380)	19
20	Fees, Subscriptions & Promotions	(947)	0	19	0	0	0	0	0	0	0	0	(928)	20
21	Clerical & General Office Expenses	(10,503)	(73,810)	52,976	0	0	0	0	0	0	0	0	(31,337)	21
22	Employee Benefits & Payroll Taxes	0	0	13,970	0	0	0	0	0	0	0	0	13,970	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,706	0	0	0	0	0	0	0	0	1,706	24
25	Other Admin. Staff Transportation	0	0	3,334	0	0	0	0	0	0	0	0	3,334	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,449	0	0	0	0	0	0	0	0	1,449	26
27	Other (specify):*	(2,902)	0	0	0	0	0	0	0	0	0	0	(2,902)	27
28	TOTAL General Administration	(14,352)	(140,013)	99,804	0	(54,561)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,528)	(140,013)	110,598	0	(43,943)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARE CENTRE OF URBANA# 0041897

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,640)	0	1,549	0	0	0	0	0	0	0	0	(91)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	4,510	0	0	0	0	0	0	0	0	4,510	34
35	Rent-Equipment & Vehicles	0	0	234	0	0	0	0	0	0	0	0	234	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,640)	0	6,293	0	4,653	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(16,168)	(140,013)	116,891	0	(39,290)	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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEALTH SKOKIE		BOOKKEEPING
				MANAGEMENT		MANAGEMENT

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$ 23,880	CERTIFIED HEALTH MANAGEMENT		\$	\$ (23,880)	1
2	V	21 BOOKKEEPING	73,810				(73,810)	2
3	V	19 ADMIN. CONSULTING FEES	42,323				(42,323)	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 140,013			\$	\$ *	(140,013) 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	3 HOUSEKEEPING	\$	CERTIFIED HEALTH MANAGEMENT		\$ 254	\$ 254	15
16	V	5 ELECTRIC & GAS		" " "				16
17	V	6 MAINTENANCE		" " "		44	44	17
18	V	10 NURSING/MEDICAL RECORDS		" " "		10,496	10,496	18
19	V	17 ADMIN SALARIES		" " "		25,407	25,407	19
20	V	19 PROFESSIONAL FEES		" " "		943	943	20
21	V	20 FEE, SUBSCRIPTIONS		" " "		19	19	21
22	V	21 OFFICE EXP.		" " "		52,976	52,976	22
23	V	22 EMPLOYEE BENEFITS		" " "		13,970	13,970	23
24	V	24 TRAVEL/SEMINAR		" " "		1,706	1,706	24
25	V	25 TRANSPORTATION		" " "		3,334	3,334	25
26	V	26 INSURANCE		" " "		1,449	1,449	26
27	V	30 DEPRECIATION		" " "		1,549	1,549	27
28	V	32 INTEREST		" " "				28
29	V	34 OFFICE RENT		" " "		4,510	4,510	29
30	V	35 EQUIPMENT RENTAL		" " "		234	234	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		\$			\$ 116,891	\$ * 116,891	39

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

Facility Name & ID Number

CARE CENTRE OF URBANA

0041897

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	BRADLEY ALTER		ADMINISTRATION		NONE			SALARY	\$ 20,487	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 20,487		13

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

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

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning:

01/01/2003

Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization CERTIFIED HEALTH MANAGEMENT
 Street Address 3856 OAKTON SUTIE 200
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-4700
 Fax Number (847) 674-4733

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	252,049	8	\$ 3,000	21,379	\$ 254	1
2	5	ELECTRIC & GAS	" "	252,049	8	0	21,379	0	2
3	6	MAINTENANCE	" "	252,049	8	520	21,379	44	3
4	10	NURSING/MEDICAL RECORDS	" "	252,049	8	123,747	21,379	10,496	4
5	17	ADMIN SALARIES	" "	252,049	8	299,543	21,379	25,407	5
6	19	PROFESSIONAL FEES	" "	252,049	8	11,116	21,379	943	6
7	20	FEE, SUBSCRIPTIONS	" "	252,049	8	225	21,379	19	7
8	21	OFFICE EXP.	" "	252,049	8	624,560	21,379	52,976	8
9	22	EMPLOYEE BENEFITS	" "	252,049	8	164,697	21,379	13,970	9
10	24	TRAVEL/SEMINAR	" "	252,049	8	20,108	21,379	1,706	10
11	25	TRANSPORTATION	" "	252,049	8	39,310	21,379	3,334	11
12	26	INSURANCE	" "	252,049	8	17,081	21,379	1,449	12
13	30	DEPRECIATION	" "	252,049	8	18,257	21,379	1,549	13
14	32	INTEREST	" "	252,049	8	0	21,379	0	14
15	34	OFFICE RENT	" "	252,049	8	53,167	21,379	4,510	15
16	35	EQUIPMENT RENTAL	" "	252,049	8	2,754	21,379	234	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,378,085	\$ 965,512	\$ 116,891	25

Facility Name & ID Number

CARE CENTRE OF URBANA

0041897

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6	BANK FINANCIAL		X	WORKING CAPITAL				275,118		PRIME+	8,021	6				
7	SHAREHOLDER LOANS	X		WORKING CAPITAL				1,271,000			73,083	7				
8	AICC		X	INS FINANCING							1,054	8				
9	TOTAL Facility Related															
							\$	\$ 1,546,118			\$ 82,158	9				
	B. Non-Facility Related*															
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related															
							\$	\$			\$	14				
15	TOTALS (line 9+line14)															
							\$	\$ 1,546,118			\$ 82,158	15				

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2002 report.	\$	45,526	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	45,107	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(419)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	46,010	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	45,591	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	42,808	8
	1999	42,830	9
	2000	43,440	10
	2001	44,633	11
	2002	45,107	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 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 2003 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.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARE CENTRE OF URBANA COUNTY CHAMPAIGN

FACILITY IDPH LICENSE NUMBER 0041897

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

	(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>91-21-07-282-021</u>	<u>NURSING HOME</u>	\$ <u>45,107.00</u>	\$ <u>45,107.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>45,107.00</u>	\$ <u>45,107.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning:

01/01/2003 Ending:

12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior Frame Number of Stories

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Land. Row 2: 1. Row 3: 2. Row 4: 3 TOTALS

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

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		TILES,WALLPAPER,PAINTING,HANDRAILS	1997		30,742	788	39	788	0	5,219	9
10		REPAIR PARKING LOT	1997		5,347	356	15	356	0	2,318	10
11		ROOF EXHAUSTER, VENTILATION	1997		4,926	126	39	126	0	800	11
12		CEILING,DUCTWORK,DOOR	1998		10,864	279	39	279	(0)	1,556	12
13		TILE/INSTALLATION	1998		4,650	119	39	119	0	650	13
14		HVAC UNIT	1998		6,162	158	39	158		859	14
15		NURSES STATION REPAIR	1998		12,552	322	39	322	(0)	2,044	15
16		300 WING RENOVATION	1998		7,859	202	39	202	(0)	1,069	16
17		FIRE PROTECTION SYSTEM/DAMPERS	1999		37,334	957	39	957	0	3,971	17
18		LANDSCAPING/SIDEWALK	1999		17,035	437	39	437	(0)	1,813	18
19		WALL REPAIR/TILE/HANDRAIS/BUMPERS	2000		8,740	248	27.5	318	70	1,110	19
20		BASEBOARD HEAT	2000		2,306	123	27.5	84	(39)	347	20
21		NEW WATER SERVICE/WATER HEATER	2000		10,597	415	27.5	385	(30)	1,459	21
22		FIRE ALARM WORK	2000		9,647	351	27.5	351	(0)	1,303	22
23		ROOF REPAIR	2001		11,820	430	27.5	430	(0)	1,129	23
24		ROOF REPAIR	2001		3,056	111	27.5	111	0	254	24
25		WALL REPAIR AND TILE	2001		2,301	84	27.5	84	(0)	178	25
26		AIR CONDITIONERS	2002		11,670	424	27.5	424	0	636	26
27		DOORS-ALZ UNIT	2002		5,922	215	27.5	215	0	323	27
28		ALARMS SYSTEM	2002		1,982	72	27.5	72	0	108	28
29		WINDOW TREATMENTS	2003		1,851	648	5	648		648	29
30		KITCHEN SINK RELOCATION	2003		3,850	64	27.5	64		64	30
31		WALLCOVERING	2003		1,926	289	5	289		289	31
32		WALLCOVERING	2003		2,419	121	5	242	121	242	32
33		RES.PRIVACY TRACKS/INSTALL	2003		4,383	219	5	438	219	438	33
34		WALL A/C UNITS	2003		14,819	247	27.5	247		247	34
35		HEAT/COOL UNIT	2003		5,203	87	27.5	87		87	35
36		PANIC DEVICE	2003		1,440	24	27.5	24		24	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**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	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)	\$ 241,403	\$ 7,916		\$ 8,258	\$ 342	\$ 29,186	70

**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	\$ 119,847	\$ 11,863	\$ 17,755	\$ 5,892	5-7 YRS	\$ 67,468	71
72	Current Year Purchases	16,151	8,749	875	(7,874)	5	875	72
73	Fully Depreciated Assets	1,631					1,631	73
74	RELATED PARTY		1,551	1,551				74
75	TOTALS	\$ 137,629	\$ 22,163	\$ 20,181	\$ (1,982)		\$ 69,974	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 379,032	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 30,079	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,439	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,640)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 99,160	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: CARE CENTER OF URBANA

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:		99	6/1/96	\$ 393,721			3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$ 393,721			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: PURCH AFTER 6/1/16 *

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: \$ 4,332 Description: SEE SCHEDULE ATTACHED

(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			N/A		19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 6/1/96

Ending 5/31/21

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

Fiscal Year Ending Annual Rent

12. 12/31/04 \$ 409,256

13. 12/31/05 \$ 411,788

14. 12/31/06 \$ 415,553

* 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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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

	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	39-3	hrs	\$		\$ 2,575	\$		\$ 2,575	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,876			3,876	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			2,238			2,238	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				13,982		13,982	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LAB	39-2 39-2					3,505 315		3,505 315	13
14	TOTAL			\$		\$ 8,689	\$ 17,802		\$ 26,491	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.

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>36,000</u>)	298,163		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,587		6
7	Other Prepaid Expenses	418		7
8	Accounts Receivable (owners or related parties)	35,577		8
9	Other(specify): <u>R/E TAX ESCROW</u>	36,224		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 391,969	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	229,732		15
16	Equipment, at Historical Cost	149,298		16
17	Accumulated Depreciation (book methods)	(139,168)		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>OPTION DEPOSIT</u>	297,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 536,862	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 928,831	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 217,325	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,000		28
29	Short-Term Notes Payable	2,360,526		29
30	Accrued Salaries Payable	3,441		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,588		31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,010		32
33	Accrued Interest Payable	342,657		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,984,547	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,984,547	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,055,716)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 928,831	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,473,932)	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,473,931)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(581,785)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (581,785)	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)	\$ (2,055,716)	24 *

* This must agree with page 17, line 47.

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	\$ 2,259,137	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,259,137	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	53,237	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 53,237	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	246	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 246	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,687	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,687	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,314,307	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	504,242	31
32	Health Care	1,124,079	32
33	General Administration	626,735	33
B. Capital Expense			
34	Ownership	560,342	34
C. Ancillary Expense			
35	Special Cost Centers	26,491	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,896,092	40
41	Income before Income Taxes (line 30 minus line 40)**	(581,785)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (581,785)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

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	1,397	1,440	\$ 33,677	\$ 23.39	1
2	Assistant Director of Nursing	2,037	2,080	38,267	18.40	2
3	Registered Nurses	4,470	4,470	91,703	20.52	3
4	Licensed Practical Nurses	6,610	6,778	109,475	16.15	4
5	Nurse Aides & Orderlies	38,882	39,075	440,138	11.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,455	3,927	56,282	14.33	8
9	Activity Director	2,852	2,936	22,989	7.83	9
10	Activity Assistants					10
11	Social Service Workers	2,219	2,363	38,260	16.19	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	37,448	18.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,803	6,140	55,018	8.96	15
16	Dishwashers	5,441	5,599	43,366	7.75	16
17	Maintenance Workers	1,917	2,120	33,624	15.86	17
18	Housekeepers	8,741	8,912	67,369	7.56	18
19	Laundry	4,893	5,202	41,821	8.04	19
20	Administrator	1,710	1,750	40,763	23.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,772	1,975	28,135	14.25	23
24	Clerical	5,933	5,763	42,365	7.35	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	1,643	1,830	17,380	9.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord</u>	2,002	2,080	24,533	11.79	33
34	TOTAL (lines 1 - 33)	103,857	106,520	\$ 1,262,613 *	\$ 11.85	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	150	\$ 6,024	1-3	35
36	Medical Director	MONTHLY	9,000	9-3	36
37	Medical Records Consultant	27	675	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	20	900	10-3	39
40	Physical Therapy Consultant	13	600	10a-3	40
41	Occupational Therapy Consultant	4	163	10a-3	41
42	Respiratory Therapy Consultant	10	423	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	380	14,567	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	604	\$ 32,352		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	575	\$ 23,996	10-3	50
51	Licensed Practical Nurses	3,911	126,845	10-3	51
52	Nurse Aides	961	25,211	10-3	52
53	TOTAL (lines 50 - 52)	5,447	\$ 176,052		53

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTHCARE ASSOC \$1,980
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES 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. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees