

		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.

<p>I. IDPH Facility ID Number: <u>0040592</u></p> <p>Facility Name: <u>Chevy Chase Nrsng & Rehab Ctr</u></p> <p>Address: <u>3400 S. Indiana</u> <u>Chicago</u> <u>60616</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(312) 842-5000</u> Fax # <u>(312) 842-3790</u></p> <p>IDPA ID Number: <u>363964686001</u></p> <p>Date of Initial License for Current Owners: <u>07/01/94</u></p> <p>Type of Ownership:</p> <table border="0"> <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 checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input 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 checked="" type="checkbox"/> "Sub-S" Corp.			<input 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>01/01/03</u> to <u>12/31/03</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"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td>(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) _____ (Date) _____	(Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten 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 Chevy Chase Nrsg & Rehab Ctr

0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

1	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>322</u>		<u>117,530</u>	1
2	Skilled (SNF)	<u>322</u>		2
3	Skilled Pediatric (SNF/PED)			3
4	Intermediate (ICF)			4
5	Intermediate/DD			5
6	Sheltered Care (SC)			6
7	ICF/DD 16 or Less			6
7	<u>322</u>	<u>322</u>	<u>117,530</u>	7
	TOTALS			

B. Census-For the entire report period.

1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
	3 Public Aid Recipient	4 Private Pay	Other	Total	
8 SNF	<u>92,522</u>	<u>3,821</u>	<u>8,163</u>	<u>104,506</u>	8
9 SNF/PED					9
10 ICF					10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	<u>92,522</u>	<u>3,821</u>	<u>8,163</u>	<u>104,506</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.92%

D. How many bed-hold days during this year were paid by Public Aid? 1,672 (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 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/94 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 41 and days of care provided 5,256

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/03 Fiscal Year: 12/31/03
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	321,795	95,152	11,640	428,587		428,587		428,587		1
2	Food Purchase		472,083		472,083	(64,058)	408,026	(715)	407,310		2
3	Housekeeping		42,120	432,000	474,120		474,120		474,120		3
4	Laundry		28,013		28,013		28,013		28,013		4
5	Heat and Other Utilities			261,336	261,336		261,336	(16,996)	244,340		5
6	Maintenance	75,437	29,435	150,119	254,991		254,991	(14,293)	240,698		6
7	Other (specify):*							(45)	(45)		7
8	TOTAL General Services	397,232	666,803	855,095	1,919,130	(64,058)	1,855,073	(32,050)	1,823,022		8
B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	3,197,050	171,258	13,647	3,381,955		3,381,955	(586)	3,381,369		10
10a	Therapy	67,027		5,872	72,899		72,899		72,899		10a
11	Activities	95,332	8,526	2,063	105,921		105,921		105,921		11
12	Social Services	105,400		2,846	108,246		108,246		108,246		12
13	Nurse Aide Training	3,689	1,341		5,030		5,030		5,030		13
14	Program Transportation			1,705	1,705		1,705	3	1,708		14
15	Other (specify):*							28	28		15
16	TOTAL Health Care and Programs	3,468,498	181,125	56,133	3,705,756		3,705,756	(555)	3,705,201		16
C. General Administration											
17	Administrative	160,916		710,315	871,231		871,231	(612,659)	258,572		17
18	Directors Fees										18
19	Professional Services			92,310	92,310		92,310	(10,969)	81,341		19
20	Dues, Fees, Subscriptions & Promotions			79,659	79,659		79,659	(47,949)	31,710		20
21	Clerical & General Office Expenses	205,360	36,272	182,989	424,621		424,621	55,200	479,821		21
22	Employee Benefits & Payroll Taxes			669,516	669,516	64,058	733,574		733,574		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,968	6,968		6,968	(1,502)	5,466		24
25	Other Admin. Staff Transportation			3,233	3,233		3,233	345	3,578		25
26	Insurance-Prop.Liab.Malpractice			359,180	359,180		359,180	716	359,896		26
27	Other (specify):*							48,127	48,127		27
28	TOTAL General Administration	366,276	36,272	2,104,170	2,506,718	64,058	2,570,776	(568,692)	2,002,084		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,232,006	884,200	3,015,398	8,131,604		8,131,604	(601,297)	7,530,307		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 Chevy Chase Nrsg & Rehab Ctr #0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

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			147,333	147,333		147,333	105,717	253,050		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			52,362	52,362		52,362	1,049,350	1,101,712		32
33	Real Estate Taxes			467,367	467,367		467,367		467,367		33
34	Rent-Facility & Grounds			1,919,601	1,919,601		1,919,601	(1,697,479)	222,122		34
35	Rent-Equipment & Vehicles			7,839	7,839		7,839	10,546	18,385		35
36	Other (specify):*										36
37	TOTAL Ownership			2,594,502	2,594,502		2,594,502	(531,866)	2,062,636		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	17,036	230,209	201,866	449,111		449,111	(101)	449,010		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			176,295	176,295		176,295		176,295		42
43	Other (specify):*	32,562			32,562		32,562	(32,562)			43
44	TOTAL Special Cost Centers	49,598	230,209	378,161	657,968		657,968	(32,663)	625,305		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,281,604	1,114,409	5,988,061	11,384,074		11,384,074	(1,165,826)	10,218,248		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

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning: 01/01/03

Ending: 12/31/03

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	(173,417)	30		9
10	Interest and Other Investment Income	(44)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(173)	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	(5,600)	21		18
19	Entertainment				19
20	Contributions	(14,943)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,000)	21		24
25	Fund Raising, Advertising and Promotional	(25,797)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,293)	20		28
29	Other-Attach Schedule	(115,997)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (436,263)		\$	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)	(729,562)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (729,562)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,165,826)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Chevy Chase Nrg & Rehab Ctr

HW 0040992

Report Period Beginning: 01/01/03
Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1		1
2		2
3		3
4		4
5		5
6		6
7		7
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10		10
11		11
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98		98
99		99
100		100
101		101
Total	(115,997)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chevy Chase Nrsng & Rehab Ctr

0040592 Report Period Beginning:

01/01/03

Ending:

12/31/03

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(715)											(715)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(17,536)		540									(16,996)	5
6	Maintenance	(16,758)		2,465									(14,293)	6
7	Other (specify):*			(45)									(45)	7
8	TOTAL General Services	(35,010)		2,960									(32,050)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(835)		249									(586)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			3									3	14
15	Other (specify):*			28									28	15
16	TOTAL Health Care and Programs	(835)		280									(555)	16
	C. General Administration													
17	Administrative			(678,047)	57,644	7,744							(612,659)	17
18	Directors Fees													18
19	Professional Services	(3,072)		2,027		(9,924)							(10,969)	19
20	Fees, Subscriptions & Promotions	(49,664)		1,812		(97)							(47,949)	20
21	Clerical & General Office Expenses	(139,132)		193,608		724							55,200	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,527)		1,002		23							(1,502)	24
25	Other Admin. Staff Transportation			345									345	25
26	Insurance-Prop.Liab.Malpractice			716									716	26
27	Other (specify):*			42,340	4,098	1,689							48,127	27
28	TOTAL General Administration	(194,396)		(436,197)	61,742	159							(568,692)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(230,241)		(432,957)	61,742	159							(601,297)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr# 0040592

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	(173,417)	274,966	4,168									105,717	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(44)	1,050,525	(1,124)		(8)							1,049,350	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,713,948)	16,469									(1,697,479)	34
35	Rent-Equipment & Vehicles			10,546									10,546	35
36	Other (specify):*													36
37	TOTAL Ownership	(173,461)	(388,457)	30,059		(8)							(531,866)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(101)									(101)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(32,562)											(32,562)	43
44	TOTAL Special Cost Centers	(32,562)		(101)									(32,663)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(436,263)	(388,457)	(402,999)	61,742	151							(1,165,826)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
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	32 Interest Expense	\$	Chevy Chase Associates	100.00%	\$ 1,050,525	\$ 1,050,525 1
2	V	34 Rental Income	1,713,948	Chevy Chase Associates	100.00%		(1,713,948) 2
3	V	30 Depreciation Expense		Chevy Chase Associates	100.00%	274,966	274,966 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		\$ 1,713,948			\$ 1,325,491	\$ * (388,457) 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 540	\$ 540
16	V	6 REPAIRS AND MAINT.				2,465	2,465
17	V	7 EMPLOYEE BEN. GEN. SERV.				(45)	(45)
18	V	10 NURSING ADMIN.				249	249
19	V	14 PROGRAM TRANSPORTATION				3	3
20	V	15 HEALTHCARE EMPLOYEE BEN.				28	28
21	V	17 ADMINISTRATIVE - NON-OWNER				32,268	32,268
22	V	19 PROFESSIONAL FEES				2,027	2,027
23	V	20 FEES SUBSCRIPTIONS				1,812	1,812
24	V	21 CLERICAL & GENERAL				193,608	193,608
25	V	24 SEMINARS AND EDUCATION				1,002	1,002
26	V	25 ADMIN. STAFF TRAVEL				345	345
27	V	26 INSURANCE				716	716
28	V	27 EMPLOYEE BEN. GEN. ADMIN.				42,340	42,340
29	V	30 DEPRECIATION				4,168	4,168
30	V	32 INTEREST EXPENSE				(1,124)	(1,124)
31	V	34 BUILDING RENT				16,469	16,469
32	V	35 EQUIPMENT RENTAL				10,546	10,546
33	V	39 ANCILLARY				(101)	(101)
34	V	17 MANAGEMENT FEES	710,315				(710,315)
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 710,315			\$ 307,316	\$ * (402,999)

* 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	17 ADMIN. - R. HARTMAN	\$	NUCARE SERVICES CORP.	100.00%	\$ 28,016	\$ 28,016
16	V	17 ADMIN. - B. CARR				23,001	23,001
17	V	17 ADMIN. - D. HARTMAN				6,093	6,093
18	V	17 ADMIN. - E. DICKMAN				534	534
19	V						
20	V	27 EMP. BEN. - R. HARTMAN				2,482	2,482
21	V	27 EMP. BEN. - B. CARR				1,096	1,096
22	V	27 EMP. BEN. - D. HARTMAN				476	476
23	V	27 EMP. BEN. - E. DICKMAN				44	44
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 61,742	\$ * 61,742

* 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	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 7,744	\$ 7,744
16	V	19 PROFESSIONAL FEES				51	51
17	V	20 FEES, SUBSCRIPTIONS				(97)	(97)
18	V	21 CLERICAL AND GENERAL				724	724
19	V	24 SEMINARS				23	23
20	V	27 GEN ADMIN.- EMP. BEN.				1,689	1,689
21	V	32 INTEREST EXPENSE				(8)	(8)
22	V						
23	V						
24	V	19 MANAGEMENT FEES	9,975				(9,975)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,975			\$ 10,126	\$ * 151

* 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: 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		
15	V	22 Workmans Compensation	68,802	Diamond Insurance	40.00%	68,802	\$	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		\$ 68,802			\$ 68,802	\$ *	39

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

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	Robert Hartman	Owner	Administrative	60.75%	See Attached	5.56	11.12%	Alloc Salary	\$ 28,016	17-7	1
2	Barry Carr	Owner	Administrative	4.75%	See Attached	6.07	10.12%	Alloc Salary	23,001	17-7	2
3	David Hartman	Relative	Administrative	none	See Attached	1.20	2.50%	Alloc Salary	6,093	17-7	3
4	Eitan Dickman	Relative	Administrative	none	See Attached	0.52	1.20%	Alloc Salary	534	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 57,644		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 Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsrg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 NUCARE SERVICES CORP.
 Street Address 6677 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	AVAIL. CENSUS DAYS	755,108	9	\$ 3,469	\$	117,530	\$ 540	1
2	6 REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	755,108	9	15,840	(985)	117,530	2,465	2
3	7 EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	755,108	9	(289)		117,530	(45)	3
4	10 NURSING ADMIN.	AVAIL. CENSUS DAYS	755,108	9	1,600	1,600	117,530	249	4
5	14 PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	755,108	9	19		117,530	3	5
6	15 HEALTHCARE EMPLOYEE BENEFIT	AVAIL. CENSUS DAYS	755,108	9	180		117,530	28	6
7	17 ADMINISTRATIVE - NON-OWNED	AVAIL. CENSUS DAYS	755,108	9	207,317	202,582	117,530	32,268	7
8	19 PROFESSIONAL FEES	AVAIL. CENSUS DAYS	755,108	9	13,022		117,530	2,027	8
9	20 FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	755,108	9	11,642		117,530	1,812	9
10	21 CLERICAL & GENERAL	AVAIL. CENSUS DAYS	755,108	9	1,243,897	1,034,436	117,530	193,608	10
11	24 SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	755,108	9	6,435		117,530	1,002	11
12	25 ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	755,108	9	2,216		117,530	345	12
13	26 INSURANCE	AVAIL. CENSUS DAYS	755,108	9	4,598		117,530	716	13
14	27 EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	755,108	9	272,029		117,530	42,340	14
15	30 DEPRECIATION	AVAIL. CENSUS DAYS	755,108	9	26,781		117,530	4,168	15
16	32 INTEREST EXPENSE	AVAIL. CENSUS DAYS	755,108	9	(7,220)		117,530	(1,124)	16
17	34 BUILDING RENT	AVAIL. CENSUS DAYS	755,108	9	105,808		117,530	16,469	17
18	35 EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	755,108	9	67,754		117,530	10,546	18
19	39 ANCILLARY	AVAIL. CENSUS DAYS	755,108	9	(652)	(1,593)	117,530	(101)	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,974,446	\$ 1,236,040		\$ 307,316	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsng & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 NUCARE SERVICES CORP.
 Street Address 6677 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36	9	180,000	180,000	6	28,016	1
2	17 ADMIN. - B. CARR	AVG. HOURS WORKED	48	9	180,000	180,000	6	23,001	2
3	17 ADMIN. - D. HARTMAN	AVG. HOURS WORKED	8	9	40,623	40,000	1	6,093	3
4	17 ADMIN. - E. DICKMAN	AVG. HOURS WORKED	17	9	17,157	17,000	1	534	4
5									5
6	27 EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36	9	15,944		6	2,482	6
7	27 EMP. BEN. - B. CARR	AVG. HOURS WORKED	48	9	8,574		6	1,096	7
8	27 EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	8	9	3,170		1	476	8
9	27 EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	17	9	1,411		1	44	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				\$ 446,879	\$ 417,000		\$ 61,742	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 CAREPATH HEALTH NETWORK
 Street Address 6633 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (888) 707-6700
 Fax Number (847) 679-2150

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	339,037	13	\$ 263,221	\$ 9,975	\$ 7,744	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	339,037	13	1,730	9,975	51	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	339,037	13	(3,296)	9,975	(97)	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	339,037	13	24,604	9,975	724	4
5	24	SEMINARS	CARE PATH FEES	339,037	13	784	9,975	23	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	339,037	13	57,412	9,975	1,689	6
7	32	INTEREST EXPENSE	CARE PATH FEES	339,037	13	(286)	9,975	(8)	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					\$ 344,169	\$ 263,221	\$ 10,126	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 Diamond Insurance
 Street Address 40 Skokie Blvd Suite 105
 City / State / Zip Code Northbrook, IL 60062
 Phone Number (847)559-1002
 Fax Number ()

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workmans Compensation	Direct Allocation		\$	\$		\$ 68,802	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				\$	\$		\$ 68,802	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5	See Supplemental Schedule											5							
	Working Capital																		
6	LaSalle Bank		X	Working Capital	Interest Only	7/1 Annual				Prime +1	52,279	6							
7	Shareholder Loan	X		Working Capital	Interest Only			500,000			75	7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$	\$ 500,000			\$ 52,354	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13	See Supplemental Schedule										1,049,358	13							
14	TOTAL Non-Facility Related						\$	\$			\$ 1,049,358	14							
15	TOTALS (line 9+line14)						\$	\$ 500,000			\$ 1,101,712	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) 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 Chevy Chase Nrsg & Rehab Ctr # 0040592 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
6											6									
7	TOTAL Long-Term																			
	Working Capital																			
8						\$	\$			\$	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15	Interest Income		X			\$	\$			\$	(44)									
16	Alloc from Nucare		X								(1,124)									
17	Alloc from Chevy Associates		X								1,050,525									
18											18									
19											19									
20	TOTAL Non-Facility Related																			
											1,049,358									

* 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 **Chevy Chase Nrsg & Rehab Ctr**# **0040592** Report Period Beginning: **01/01/03** Ending: **12/31/03****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.			\$	479,709	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.)			\$	461,988	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(17,721)	3
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	485,088	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.			\$	467,367	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1998	455,106	8	FOR OHF USE ONLY	
		1999	450,527	9		
		2000	445,285	10	13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
		2001	456,866	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2002	461,988	12	15	LESS REFUND FROM LINE 6 \$ 15
2003 accrual = \$461,988 * 1.05% = \$485,087.64					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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Chevy Chase Nrsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040592

CONTACT PERSON REGARDING THIS REPORT : Steve 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 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>17-34-119-049-0000</u>	<u>long term care property</u>	\$ <u>308,486.44</u>	\$ <u>308,486.44</u>
2. <u>17/34-119-048-0000</u>	<u>long term care property</u>	\$ <u>153,501.84</u>	\$ <u>153,501.84</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>461,988.28</u>	\$ <u>461,988.28</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.

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.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chevy Chase Nrsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040592

CONTACT PERSON REGARDING THIS REPORT : Steve 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 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 Chevy Chase Nrsrg & Rehab Ctr

0040592 Report Period Beginning:

01/01/03 Ending:

12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,625 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 4C. 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).

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

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	80,457	1984	\$ 240,000	1
2					2
3	TOTALS	80,457		\$ 240,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chey Chase Nrsng & Rehab Ctr

0040592

Report Period Beginning:

01/01/03

Ending:

12/31/03

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		1994		17,938		20	897	897	8,207	9
10	Various		1995		20,890		20	1,044	1,044	8,924	10
11	Various		1996		87,605		20	4,381	4,381	32,372	11
12	Various		1997		40,122		20	2,037	(2,037)	13,706	12
13	Various		1998		132,735		20	6,639	6,639	35,488	13
14	Various		1999		419,788		20	20,993	20,993	89,902	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

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		4,564,559	274,966		130,416	(144,550)	2,300,262	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		3,709	148		186	38	833	68
69	Financial Statement Depreciation			69,097			(69,097)		69
70	TOTAL (lines 4 thru 69)		\$ 5,287,346	\$ 344,211		\$ 166,593	\$ (181,692)	\$ 2,489,694	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	\$ 5,287,346	\$ 344,211		\$ 166,593	\$ (177,618)	\$ 2,489,694		1
2	Fire Alarm Panel	2000 1,900		20	95	95	372		2
3	Corner Guards	2000 116		20	6	6	23		3
4	Instl Elec Panel Dev	2000 926		20	46	46	174		4
5	Temporary Tank Rentl	2000		20					5
6	Repl Sprinkler Heads	2000 560		20	28	28	107		6
7	Freight-Inv #18476	2000 123		20	6	6	22		7
8	Install Alarm System	2000 1,233		20	62	62	232		8
9	Wander Guard System	2000 11,180		20	559	559	2,236		9
10	In House Paging Sys	2000 3,511		20	176	176	674		10
11	Sprinkler Svs Repair	2000 1,109		20	55	55	221		11
12	Windows	2000 875		20	44	44	176		12
13	Install Wireless Nur	2000 3,238		20	162	162	513		13
14	Inst Hookup 4 Dial M	2000 19,600		20	980	980	3,430		14
15	Serv On Alarm System	2000 980		20	49	49	188		15
16	Install Elec Striker	2000 638		20	32	32	120		16
17	Repair A/C System	2000 1,387		20	69	69	237		17
18	Rebuilt Heat Exchang	2000 1,598		20	80	80	273		18
19	Fire Damper Cleaning	2000 1,450		20	73	73	248		19
20	Counters	2000 907		20	45	45	147		20
21	82 Overbed Fixtures	2000 5,904		20	295	295	983		21
22	83 Overbed Fixtures	2000 5,976		20	299	299	972		22
23	Locks	2000 705		20	35	35	118		23
24	Safety Loc System	2000 16,200		20	810	810	2,565		24
25	Elevator Work	2000 1,300		20	65	65	200		25
26	Elevator Work	2000 586		20	29	29	98		26
27	Cctv System	2000 1,079		20	54	54	180		27
28	Phone Wiring	2000 867		20	43	43	144		28
29	Fire Alarms	2000 632		20	32	32	103		29
30	Overbed Fixtures	2000 3,888		20	194	194	599		30
31	Telephone Sys Serv.	2000 992		20	50	50	170		31
32	Fire Alarm Repair	2000 1,144		20	57	57	190		32
33	Wandergaurd	2001 1,310		20	66	66	197		33
34	TOTAL (lines 1 thru 33)	\$ 5,379,260	\$ 344,211		\$ 171,189	\$ (173,022)	\$ 2,505,606		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	\$ 5,379,260	\$ 344,211		\$ 171,189	\$ (173,022)	\$ 2,505,606		1
2	Compressor	2001 6,412		20	321	321	909		2
3	Door Alarm	2001 950		20	48	48	131		3
4	Nursing Station	2001 11,700		20	585	585	1,609		4
5	Phone Outlet	2001 967		20	48	48	125		5
6	Electrical Circuit	2001 642		20	32	32	83		6
7	Wallpaper	2001 12,039		20	602	602	1,555		7
8	Wallpaper	2001 663		20	33	33	80		8
9	Wanderguard	2001 1,344		20	67	67	156		9
10	Wallpaper	2001 7,611		20	381	381	952		10
11	Water Heater	2001 4,330		20	217	217	505		11
12	Fire Alarm Repair	2001 1,087		20	54	54	127		12
13	Drain Outlet	2001 850		20	43	43	103		13
14	Wallpaper	2001 751		20	38	38	88		14
15	Phone Lines	2001 983		20	49	49	110		15
16	Phones Lines	2001 858		20	43	43	97		16
17	Fire Proof Board	2001 375		20	19	19	41		17
18	Curtain & Rods	2001 3,854		20	193	193	433		18
19	Wallpaper	2001 1,072		20	54	54	116		19
20	Painting	2001 2,376		20	119	119	248		20
21	Fire Alarm Repairs	2001 749		20	37	37	78		21
22	Curtains & Rods	2001 7,792		20	390	390	812		22
23	Signs	2001 2,466		20	123	123	278		23
24	Wallpaper	2001 5,096		20	255	255	595		24
25	Wallpaper	2001 5,109		20	255	255	596		25
26	Phone Lines	2001 774		20	39	39	80		26
27	Phone & Fax Lines	2001 515		20	26	26	54		27
28	Nurse Call System	2001 2,873		20	144	144	299		28
29	Phone Lines	2001 454		20	23	23	47		29
30	Sprinkler Sys. Repai	2001 725		20	36	36	100		30
31	Phone Line	2001 521		20	26	26	72		31
32	Install Cable Network	2002 1,045		20	105	105	209		32
33	Exit Signs	2002 695		20	70	70	133		33
34	TOTAL (lines 1 thru 33)	\$ 5,466,938	\$ 344,211		\$ 175,664	\$ (168,547)	\$ 2,516,427		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	\$ 5,466,938	\$ 344,211		\$ 175,664	\$ (168,547)	\$ 2,516,427		1
2	Telephone Lines Svc	2002 896		20	90	90	172		2
3	Magnetic Door Holders	2002 2,322		20	232	232	426		3
4	Telephone Lines Svc	2002 1,202		20	120	120	190		4
5	Alarm System	2002 1,081		20	108	108	171		5
6	Relocate Nurse Call Sys.	2002 751		20	75	75	119		6
7	Wallpaper Border	2002 1,621		20	811	811	1,621		7
8	Smoke Damper	2002 1,145		20	115	115	153		8
9	Wallcovering	2002 1,621		20	162	162	216		9
10	Alarm System Svc.	2002 1,029		20	103	103	137		10
11	Telephone Line Svc	2002 1,197		20	120	120	160		11
12	Hi-Densitiv Vcr System	2002 1,670		20	167	167	195		12
13	Telephone Line Svc	2002 1,432		20	143	143	155		13
14	Alarm System	2002 1,113		20	111	111	121		14
15	Elevator Repair	2002 3,740		20	374	374	623		15
16	Landscaping	2002 17,500		20	1,167	1,167	1,750		16
17	70 Pieces Of Lumber	2002 856		20	86	86	136		17
18	Tuckpointing	2002 2,900		20	290	290	459		18
19	Canopy Awning	2002 10,531		20	1,053	1,053	1,843		19
20	55 Pieces Of Lumber	2002 734		20	73	73	110		20
21	Sign And Installation	2002 2,504		20	250	250	459		21
22	Overpmt On 2001 Wallcovering	2002 (5,095)		20	(3,397)	(3,397)	(5,095)		22
23	Plumbing	2002 2,279		20	228	228	399		23
24	Painting	2002 2,985		20	299	299	323		24
25	Furnish And Install 2 Soft Starts	2003 5,000		20	500	500	500		25
26	Latching Alarm System	2003 1,113		20	159	159	159		26
27	Cctv To Monitor Front Lobby	2003 1,010		20	67	67	67		27
28	Cctv To Monitor Outside Patio	2003 1,331		20	78	78	78		28
29	Cctv To Monitor Staircase	2003 1,037		20	61	61	61		29
30	Wrought Iron Fence	2003 3,700		20	123	123	123		30
31	Door Detector	2003 1,630		20	68	68	68		31
32	Water Heater	2003 9,630		20	67	67	67		32
33	Latching Alarm System For Staircase	2003 1,153		20	137	137	137		33
34	TOTAL (lines 1 thru 33)	\$ 5,548,556	\$ 344,211		\$ 179,704	\$ (164,507)	\$ 2,522,530		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning:

01/01/03

Ending:

12/31/03

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		\$ 5,548,556	\$ 344,211		\$ 179,704	\$ (164,507)	\$ 2,522,530	1
2	Wanderguard System	2003	3,133		20	75	75	75	2
3	Tuckpointing	2003	2,800		20	280	280	280	3
4	Elevator Plate	2003	651		20	30	30		4
5	H2O Heater Ignition	2003	549		20	27	27		5
6	Bronze Screens	2003	550		20	25	25		6
7	Telephone Lines	2003	803		20	40	40		7
8	Telephone Lines	2003	1,222		20	41	41		8
9	Telephone Lines	2003	603		20	18	18		9
10	Shower Room Valve	2003	770		20	22	22		10
11	Elevator Buttons	2003	1,453		20	18	18		11
12	Door Detector	2003	1,400		20	12	12		12
13	Sills	2003	2,445		20	20	20		13
14	Sprinkler Valve	2003	2,100		20	26	26		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	TOTAL (lines 1 thru 33)		\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885	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	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		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	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		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
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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	TOTAL (lines 1 thru 33)	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		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	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 12G, Carried Forward	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		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	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		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	TOTAL (lines 1 thru 33)	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		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	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 12I, Carried Forward	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		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
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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	TOTAL (lines 1 thru 33)	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		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	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 12J, Carried Forward	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,567,036	\$ 344,211		\$ 180,338	\$ (163,873)	\$ 2,522,885		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chey Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	322	1986	1977	\$ 4,471,948	\$ 274,966	35	\$ 127,770	\$ (147,196)	\$ 2,204,693	4
5		1984	1984	92,611		35	2,646	2,646	57,441	5
6									38,128	6
7										7
8										8
Improvement Type**										
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

*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-BLDG, 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	2	3	4	5	6	7	8	9				
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$		37			
38									38			
39									39			
40									40			
41									41			
42									42			
43									43			
44									44			
45									45			
46									46			
47									47			
48									48			
49									49			
50									50			
51									51			
52									52			
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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)	\$	4,564,559	\$	274,966	\$	130,416	\$	(144,550)	\$	2,300,262	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chey Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning:

01/01/03

Ending:

12/31/03

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Allocated from NuCare	1997		717	18	20	36	18	223
10	Allocated from NuCare	1998		628	16	20	31	15	172
11	Allocated from NuCare	1999		880	76	20	44	(32)	195
12	Allocated from NuCare	2000		1,070	27	20	54	(27)	184
13	Allocated from NuCare	2001		414	11	20	21	10	59
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A-REP, 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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,709	\$ 148		\$ 186	\$ (16)	\$ 833		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	\$ 661,291	\$ 80,718	\$ 70,938	\$ (9,780)	10	\$ 332,316	71
72	Current Year Purchases	20,243	1,342	1,578	236	10	1,224	72
73	Fully Depreciated Assets	14,200	195	195		10	14,200	73
74								74
75	TOTALS	\$ 695,734	\$ 82,255	\$ 72,711	\$ (9,544)		\$ 347,740	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)	\$ 6,502,770	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 426,466	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 253,049	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (173,417)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,870,625	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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:	1977	322	10/16/98	\$ 1,919,601			3
4	Additions	NuCare Alloc			16,469			4
5		Chevy Chase			(1,713,948)			5
6								6
7	TOTAL		322		\$ 222,122			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2004 \$ _____

13. _____ /2005 \$ _____

14. _____ /2006 \$ _____

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: \$ 18,385

Description: See Attached Schedule

(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

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>120</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
---	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	1,050	\$	1,050
2	Books and Supplies		291		291
3	Classroom Wages (a)		2,213		2,213
4	Clinical Wages (b)		1,476		1,476
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	5,030	\$	5,030
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,030		

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	74,246	\$		\$	74,246	1		
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				23,255				23,255	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39 - 03	hrs				104,365				104,365	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						171,294		171,294	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				17,036				58,915		75,951	13		
14	TOTAL			\$	17,036	\$	201,866	\$	230,209	\$	449,111	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 Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(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	\$ 751	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,861,215		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	183,419		6
7 Other Prepaid Expenses	16,244		7
8 Accounts Receivable (owners or related parties)	1,845,482		8
9 Other(specify): See Attached Schedule	233,852		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,140,963	\$	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	1,006,326		15
16 Equipment, at Historical Cost	641,663		16
17 Accumulated Depreciation (book methods)	(974,443)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): See Attached Schedule	72,483		23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 746,029	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,886,992	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 1,085,442	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	6,757		28
29 Short-Term Notes Payable	500,000		29
30 Accrued Salaries Payable	348,446		30
31 Accrued Taxes Payable (excluding real estate taxes)	18,246		31
32 Accrued Real Estate Taxes(Sch.IX-B)	485,088		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes	27,964		35
Other Current Liabilities(specify):			
36 See Attached Schedule	489,812		36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,961,755	\$	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 See Attached Schedule			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,961,755	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 2,925,237	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,886,992	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,938,107	1
2	Restatements (describe):		2
3	<u>See Attached</u>	(52,193)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,885,914	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	39,323	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)	\$ 39,323	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)	\$ 2,925,237	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chevy Chase Nrsg & Rehab Ctr

0040592

Report Period Beginning: 01/01/03

Ending:

12/31/03

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	\$ 10,963,643	1
2	Discounts and Allowances for all Levels	(341,157)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,622,486	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	426,803	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 426,803	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	324,178	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,089	19
20	Radiology and X-Ray	1,380	20
21	Other Medical Services	25,324	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 372,971	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	44	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,093	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,093	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,423,397	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,919,130	31
32	Health Care	3,705,756	32
33	General Administration	2,506,718	33
B. Capital Expense			
34	Ownership	2,594,502	34
C. Ancillary Expense			
35	Special Cost Centers	481,673	35
36	Provider Participation Fee	176,295	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,384,074	40
41	Income before Income Taxes (line 30 minus line 40)**	39,323	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 39,323	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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 Chevy Chase Nrsng & Rehab Ctr

0040592

Report Period Beginning: 01/01/03

Ending:

12/31/03

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	1,861	2,177	\$ 84,581	\$ 38.85	1
2	Assistant Director of Nursing	1,957	2,086	61,154	29.32	2
3	Registered Nurses	20,148	21,776	534,150	24.53	3
4	Licensed Practical Nurses	50,268	54,840	1,065,217	19.42	4
5	Nurse Aides & Orderlies	151,368	164,648	1,379,625	8.38	5
6	Nurse Aide Trainees	367	495	3,689	7.45	6
7	Licensed Therapist	734	734	17,036	23.21	7
8	Rehab/Therapy Aides	8,816	8,936	67,027	7.50	8
9	Activity Director	1,914	2,086	35,700	17.11	9
10	Activity Assistants	6,866	7,498	59,632	7.95	10
11	Social Service Workers	6,087	6,515	105,400	16.18	11
12	Dietician	2,511	2,764	53,657	19.41	12
13	Food Service Supervisor					13
14	Head Cook	5,304	5,890	60,702	10.31	14
15	Cook Helpers/Assistants	25,236	27,292	207,436	7.60	15
16	Dishwashers					16
17	Maintenance Workers	3,822	4,011	75,437	18.81	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,996	2,080	89,882	43.21	20
21	Assistant Administrator					21
22	Other Administrative	4,729	4,171	71,034	17.03	22
23	Office Manager					23
24	Clerical	18,079	20,335	205,360	10.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	49	50	601	12.02	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,190	3,223	71,722	22.25	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,123	3,203	32,562	10.17	33
34	TOTAL (lines 1 - 33)	318,425	344,810	\$ 4,281,604 *	\$ 12.42	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	Monthly +120	\$ 11,640	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,796	10-03	39
40	Physical Therapy Consultant	72	3,884	10a-03	40
41	Occupational Therapy Consultant	37	1,988	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,063	11-03	44
45	Social Service Consultant	55	2,846	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	206	\$ 62,345		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	88	3,723	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	88	\$ 3,723		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Barbara Casey	Administrator	0	\$ 89,883	Workers' Compensation Insurance	\$ 68,802	IDPH License Fee	\$ 200	
Farhat Sharif	VP Operations	0	31,422	Unemployment Compensation Insurance	40,011	Advertising: Employee Recruitment	6,332	
Kathy Brander	Dir of Reg Mgt	0	16,234	FICA Taxes	310,919	Health Care Worker Background Check		
Ray Dolan	VP Risk Mgt	0	5,547	Employee Health Insurance	155,924	(Indicate # of checks performed <u>54</u>)	540	
Rusti Bauman	VP Medicare Reim	0	2,304	Employee Meals	64,058	Trade Association Dues	12,805	
Marilyn Flaherty	VP Medicare Reim	0	3,065	Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues	146	
See Supplemental Schedule			12,462	401 K Matching	4,655	Subscriptions	1,679	
TOTAL (agree to Schedule V, line 17, col. 1)				401 K Administrative Fees		Classified Advertising	4,121	
(List each licensed administrator separately.)			\$ 160,917	Chicago Head Tax	8,448	Licenses	3,110	
B. Administrative - Other				Union Pension Benefits	35,410	See Supplemental Schedule	32,867	
Description			Amount	Employee Benefits	45,347	Less: Public Relations Expense	()	
Management Fees			\$ 710,315			Non-allowable advertising	(25,797)	
						Yellow page advertising	(4,293)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 733,573	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 31,711	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 710,315	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount	G. Schedule of Travel and Seminar**	
C. Professional Services							Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Various Legal	See Attached		\$ 26,879					
Frost, Ruttenger & Rothblatt	Accounting		27,030				In-State Travel	
Dan Foley CPA	Accounting		200					
Various Computer	See Attached		23,309					
Purchasing Plus	Purchasing Service		600				Seminar Expense	4,441
Carepath Health Network	Network Fees		9,975				Alloc from NuCare	1,002
Personnel Planners	Unemployment Consulting		3,215				Alloc from Carepath	23
Morton Cohen	Purchasing Service		258				Entertainment Expense	()
Charles Ross-adj out on pg 5A	Marketing		844				(agree to Sch. V, line 24, col. 8)	\$ 5,466
				TOTAL		\$		
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 92,310					

* 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										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
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 Chevy Chase Nrsg & Rehab Ctr# 0040592Report Period Beginning: 01/01/03Ending: 12/31/03**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? _____
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL LTC Council \$4631.30
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,926 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? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Chevy Chase Nursing Center, #0034892, 7/01/94
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 176,295
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. \$ 64,058 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? 100% of line 14
- 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? Yes
- 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? Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT