

Facility Name & ID Number Mid America Care Center

0016618 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>310</u>	Skilled (SNF)	<u>310</u>	<u>113,150</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>310</u>	TOTALS	<u>310</u>	<u>113,150</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	<u>50,407</u>		<u>2,575</u>	<u>52,982</u>	8
9	SNF/PED					9
10	ICF	<u>27,870</u>	<u>951</u>		<u>28,821</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>78,277</u>	<u>951</u>	<u>2,575</u>	<u>81,803</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.30%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 1975

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 31 and days of care provided 2,524

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/03 Fiscal Year: 12/31/03

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

STATE OF ILLINOIS

Facility Name & ID Number Mid America Care Center # 0016618 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	292,082	84,539	16,800	393,421		393,421	393,421			1
2	Food Purchase		339,251		339,251	(39,749)	299,503	(2,279)	297,224		2
3	Housekeeping	277,463	75,395		352,858		352,858	1,482	354,340		3
4	Laundry	116,596	15,706		132,302		132,302		132,302		4
5	Heat and Other Utilities			210,023	210,023		210,023	1,198	211,221		5
6	Maintenance	172,515	44,599	65,777	282,891		282,891	(15,628)	267,263		6
7	Other (specify):*							57	57		7
8	TOTAL General Services	858,656	559,490	292,600	1,710,746	(39,749)	1,670,998	(15,170)	1,655,827		8
B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	2,409,959	109,875	134,175	2,654,009		2,654,009	(562)	2,653,447		10
10a	Therapy	225,570		21,228	246,798		246,798		246,798		10a
11	Activities	157,586	15,323	1,547	174,456		174,456		174,456		11
12	Social Services	126,803		3,768	130,571		130,571		130,571		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,919,918	125,198	163,718	3,208,834		3,208,834	(562)	3,208,272		16
C. General Administration											
17	Administrative	234,041		90,000	324,041		324,041	120,416	444,457		17
18	Directors Fees										18
19	Professional Services			530,535	530,535	(2,890)	527,645	(453,431)	74,214		19
20	Dues, Fees, Subscriptions & Promotions			58,443	58,443		58,443	(33,110)	25,333		20
21	Clerical & General Office Expenses	101,869	41,045	83,586	226,500		226,500	115,461	341,961		21
22	Employee Benefits & Payroll Taxes			709,254	709,254	39,749	749,003		749,003		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,431	7,431		7,431	(1,190)	6,241		24
25	Other Admin. Staff Transportation			1,727	1,727		1,727	228	1,955		25
26	Insurance-Prop.Liab.Malpractice			385,422	385,422		385,422	781	386,203		26
27	Other (specify):*							63,737	63,737		27
28	TOTAL General Administration	335,910	41,045	1,866,398	2,243,353	36,859	2,280,212	(187,108)	2,093,103		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,114,484	725,733	2,322,716	7,162,933	(2,890)	7,160,043	(202,840)	6,957,203		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.

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			131,983	131,983		131,983	18,543	150,526			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,477	58,477		58,477	(19,335)	39,142			32
33	Real Estate Taxes			382,574	382,574	2,890	385,464	6	385,470			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,974	7,974		7,974	348	8,322			35
36	Other (specify):*											36
37	TOTAL Ownership			581,008	581,008	2,890	583,898	(438)	583,460			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,352	209,137	283,489		283,489		283,489			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,725	169,725		169,725		169,725			42
43	Other (specify):*	75,539		2,000	77,539		77,539	(77,539)	(0)			43
44	TOTAL Special Cost Centers	75,539	74,352	380,862	530,753		530,753	(77,539)	453,214			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,190,023	800,085	3,284,586	8,274,694		8,274,694	(280,818)	7,993,876			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 Mid America Care Center

0016618

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	(10,124)	30		9
10	Interest and Other Investment Income	(24,532)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	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	(55)	21		18
19	Entertainment				19
20	Contributions	(10,554)	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	(49,980)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(163,793)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (259,077)		\$	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)	(21,741)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (21,741)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (280,818)		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

Mid-America Care Center
 IHW 0016618
 Report Period Beginning: 01/01/03
 Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Vending Income	(2,240) 02 1
2	Barry Durr Income	(138) 21 2
3	Rental Income	(14,400) 05 3
4	Building 4930 Utilities	(3,909) 05 4
5	Building 4930 Repair & Maintenance	2811 05 5
6	Building 4930 Insurance	(210) 25 6
7	Marketing Salaries	(78,539) 43 7
8	Advertising Promotion	(8,939) 29 8
9	Travel & Loss	(100) 23 9
10	Marketing Consultant	(2,000) 43 10
11	Ill. Council EYC - COPE	(4,459) 20 11
12	Capitalized Repairs & Maintenance	(11,159) 05 12
13	Building 4930 Depreciation	(5,890) 20 13
14	Prepaid Expenses	(562) 10 14
15	Marketing Seminar Expense	(2,966) 24 15
16	Nonallowable Legal Fees	(1,550) 19 16
17	Collections	(11,330) 19 17
18	Accounting Fees (non-care)	(4,000) 19 18
19	Building 4930 Real Estate Tax	(4,076) 33 19
20		20
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22		22
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98		98
99		99
100		100
101	Total	(163,793) 101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mid America Care Center# 0016618 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	(2,279)											(2,279)	2
3	Housekeeping				1,482								1,482	3
4	Laundry													4
5	Heat and Other Utilities	(3,909)			2,216	2,891							1,198	5
6	Maintenance	(25,940)			8,505	1,807							(15,628)	6
7	Other (specify):*					57							57	7
8	TOTAL General Services	(32,128)			12,203	4,755							(15,170)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(562)											(562)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(562)											(562)	16
	C. General Administration													
17	Administrative			2,667	116,600	1,149							120,416	17
18	Directors Fees													18
19	Professional Services	(16,889)		1,235	(438,393)	616							(453,431)	19
20	Fees, Subscriptions & Promotions	(33,947)		59	758	20							(33,110)	20
21	Clerical & General Office Expenses	(50,273)		176	165,439	119							115,461	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,906)			1,716								(1,190)	24
25	Other Admin. Staff Transportation				228								228	25
26	Insurance-Prop.Liab.Malpractice	(210)			753	238							781	26
27	Other (specify):*			3,178	60,559								63,737	27
28	TOTAL General Administration	(104,225)		7,315	(92,340)	2,142							(187,108)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(136,915)		7,315	(80,137)	6,897							(202,840)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mid America Care Center# 0016618 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	(16,014)		320	31,497	2,740							18,543	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(24,532)			484	4,713							(19,335)	32
33	Real Estate Taxes	(4,076)				4,082							6	33
34	Rent-Facility & Grounds				22,026	(22,026)								34
35	Rent-Equipment & Vehicles				348								348	35
36	Other (specify):*													36
37	TOTAL Ownership	(44,622)		320	54,355	(10,491)							(438)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(77,539)											(77,539)	43
44	TOTAL Special Cost Centers	(77,539)											(77,539)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(259,077)		7,635	(25,782)	(3,594)							(280,818)	45

Facility Name & ID Number Mid America Care Center

0016618

Report Period Beginning:

01/01/03

Ending:

12/31/03

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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
1	V		\$			\$	\$		1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$			\$	\$ *		14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center

0016618

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	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	\$	INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 92,667	\$ 92,667
16	V	19 PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,235	1,235
17	V	20 FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	59	59
18	V	21 CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	176	176
19	V	27 EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	3,178	3,178
20	V	30 DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	320	320
21	V						
22	V	17 MANAGEMENT FEES	90,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(90,000)
23	V						
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		\$ 90,000			\$ 97,635	\$ * 7,635

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	MANAGCARE, INC.	100.00%	\$ 1,482	\$ 1,482
16	V	5 UTILITIES		MANAGCARE, INC.	100.00%	2,216	2,216
17	V	6 REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	8,505	8,505
18	V	10 NURSING SALARIES		MANAGCARE, INC.	100.00%		
19	V	17 ADMINISTRATIVE		MANAGCARE, INC.	100.00%	116,600	116,600
20	V	19 PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	567	567
21	V	20 FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	758	758
22	V	21 CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	150,847	150,847
23	V	24 SEMINARS		MANAGCARE, INC.	100.00%	1,716	1,716
24	V	25 ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	228	228
25	V	26 INSURANCE		MANAGCARE, INC.	100.00%	753	753
26	V	27 GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	60,559	60,559
27	V	30 DEPRECIATION		MANAGCARE, INC.	100.00%	31,497	31,497
28	V	32 INTEREST EXPENSE		MANAGCARE, INC.	100.00%	484	484
29	V	34 RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	22,026	22,026
30	V	35 EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	348	348
31	V	19 HOME OFFICE	438,960	MANAGCARE, INC.	100.00%		(438,960)
32	V	21 CLER. SAL.-CHASIDA DAVIS		MANAGCARE, INC.	100.00%	14,592	14,592
33	V			MANAGCARE, INC.	100.00%		
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 438,960			\$ 413,178	\$ * (25,782)

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

Facility Name & ID Number Mid America Care Center

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Report Period Beginning: 01/01/03

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VII. RELATED PARTIES (continued)

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

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

1	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	\$	MAZEL MANAGEMENT	100.00%	\$ 2,891	\$ 2,891
16	V	6 REPAIRS & MAINT.		MAZEL MANAGEMENT		1,807	1,807
17	V	7 EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		57	57
18	V	17 ADMIN.-M. WOLF		MAZEL MANAGEMENT		1,149	1,149
19	V	19 PROFESSIONAL FEES		MAZEL MANAGEMENT		616	616
20	V	20 FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		20	20
21	V	21 CLERICAL & GENERAL		MAZEL MANAGEMENT		119	119
22	V	26 INSURANCE		MAZEL MANAGEMENT		238	238
23	V	30 DEPRECIATION		MAZEL MANAGEMENT		2,740	2,740
24	V	32 INTEREST EXPENSE		MAZEL MANAGEMENT		4,713	4,713
25	V	33 REAL ESTATE TAXES		MAZEL MANAGEMENT		4,082	4,082
26	V	34 RENT	22,026	MAZEL MANAGEMENT			(22,026)
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		\$ 22,026			\$ 18,432	\$ * (3,594)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center

0016618

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.

Facility Name & ID Number Mid America Care Center

0016618

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 Mid America Care Center

0016618

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 Mid America Care Center

0016618

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 Mid America Care Center

0016618

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 Mid America Care Center

0016618

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 Mid America Care Center # 0016618 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	Yosef Davis	Relative	Administrative	0	See Attached	20.00	33.33%	Intercare,Sal	\$ 107,816	17-1,17-7	1
2	Moshe Davis	Operations Dir	Administrative	0.53%	See Attached	5.00	8.33%	Salary	16,360	17-1	2
3	Yehoshua Davis	Director	Administrative	0.53%	See Attached	39.00	65.00%	Salary	126,421	17-1	3
4	Shoshana Braun	Clinical Support	Nursing Clerical	0.53%	See Attached	20.00	50.00%	Salary	7,299	10-1	4
5	Chasida Davis	Bookkeeper	Clerical	0.00%	See Attached	14.00	50.00%	Managcare	14,592	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 272,488		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 Mid America Care Center # 0016618 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 Mid America Care Center

0016618 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 INTERCARE, LTD. C/O MANAGCARE
 Street Address 3553 W. PETERSON AVE. 3RD FLOOR
 City / State / Zip Code CHICAGO, IL. 60659
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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	AVG. HOURS WORKED	60	6	\$ 278,000	\$ 278,000	20	\$ 92,667	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	6	3,705		20	1,235	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	6	178		20	59	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	6	528		20	176	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	6	9,535		20	3,178	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	6	959		20	320	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					\$ 292,905	\$ 278,000		\$ 97,635	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 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 MANAGCARE, INC.
 Street Address 3553 W. PETERSON AVE. 3RD FLR
 City / State / Zip Code CHICAGO, IL. 60659
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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	3	HOUSEKEEPING	BOOKEEPING INC.	1,022,352	4	\$ 3,451	\$ 438,960	\$ 1,482	1	
2	5	UTILITIES	BOOKEEPING INC.	1,022,352	4	5,161	438,960	2,216	2	
3	6	REPAIRS AND MAINT.	BOOKEEPING INC.	1,022,352	4	19,808	438,960	8,505	3	
4	10	NURSING SALARIES	BOOKEEPING INC.	1,022,352	4		438,960		4	
5	17	ADMINISTRATIVE	BOOKEEPING INC.	1,022,352	4	271,566	438,960	116,600	5	
6	19	PROFESSIONAL FEES	BOOKEEPING INC.	1,022,352	4	1,320	438,960	567	6	
7	20	FEES, SUBSCRIPTIONS	BOOKEEPING INC.	1,022,352	4	1,766	438,960	758	7	
8	21	CLERICAL AND GENERAL	BOOKEEPING INC.	1,022,352	4	351,328	438,960	150,847	8	
9	24	SEMINARS	BOOKEEPING INC.	1,022,352	4	3,997	438,960	1,716	9	
10	25	ADMIN. STAFF TRANS.	BOOKEEPING INC.	1,022,352	4	532	438,960	228	10	
11	26	INSURANCE	BOOKEEPING INC.	1,022,352	4	1,754	438,960	753	11	
12	27	GEN. ADMIN. EMP. BEN.	BOOKEEPING INC.	1,022,352	4	141,045	438,960	60,559	12	
13	30	DEPRECIATION	BOOKEEPING INC.	1,022,352	4	73,357	438,960	31,497	13	
14	32	INTEREST EXPENSE	BOOKEEPING INC.	1,022,352	4	1,126	438,960	484	14	
15	34	RENT - BUILDING (RELATED)	BOOKEEPING INC.	1,022,352	4	51,300	438,960	22,026	15	
16	35	EQUIPMENT RENTAL	BOOKEEPING INC.	1,022,352	4	811	438,960	348	16	
17									17	
18	21	CLER. SAL.-CHASIDA DAVIS	AVG HRS WORKED	40	4	41,690	41,690	14	14,592	18
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 970,012	\$ 604,301	\$ 413,178	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center

0016618 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 MANAGCARE, INC.
 Street Address 3553 W. PETERSON AVE -3RD FLR
 City / State / Zip Code CHICAGO, IL. 60659
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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	MNGCR. BOOKPNG. INC.	1,022,352	4	\$ 6,733	\$	438,960	\$ 2,891	1
2	6 REPAIRS & MAINT.	MNGCR. BOOKPNG. INC.	1,022,352	4	4,208		438,960	1,807	2
3	7 EMPLOYEE BEN.-R&M SAL.	MNGCR. BOOKPNG. INC.	1,022,352	4	134		438,960	57	3
4	17 ADMIN.-M. WOLF	MNGCR. BOOKPNG. INC.	1,022,352	4	2,675		438,960	1,149	4
5	19 PROFESSIONAL FEES	MNGCR. BOOKPNG. INC.	1,022,352	4	1,435		438,960	616	5
6	20 FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG. INC.	1,022,352	4	47		438,960	20	6
7	21 CLERICAL & GENERAL	MNGCR. BOOKPNG. INC.	1,022,352	4	278		438,960	119	7
8	26 INSURANCE	MNGCR. BOOKPNG. INC.	1,022,352	4	554		438,960	238	8
9	30 DEPRECIATION	MNGCR. BOOKPNG. INC.	1,022,352	4	6,381		438,960	2,740	9
10	32 INTEREST EXPENSE	MNGCR. BOOKPNG. INC.	1,022,352	4	10,977		438,960	4,713	10
11	33 REAL ESTATE TAXES	MNGCR. BOOKPNG. INC.	1,022,352	4	9,506		438,960	4,082	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				\$ 42,928	\$ 1,433		\$ 18,432	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center

0016618 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 Mid America Care Center

0016618 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0016618 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 Mid America Care Center

0016618 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 Mid America Care Center

0016618 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 Mid America Care Center # 0016618 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 Mid America Care Center# 0016618

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	MB Financial		X	Line of Credit			650,000			41,685	6									
7	MB Financial		X	Line of Credit			500,000			16,792	7									
8	See Supplemental Schedule						20,645				8									
9	TOTAL Facility Related					\$	\$ 1,170,645			\$ 58,477	9									
	B. Non-Facility Related*																			
10											10									
11											11									
12	Interest Income		X							(24,532)	12									
13	See Supplemental Schedule									5,197	13									
14	TOTAL Non-Facility Related					\$	\$			\$ (19,335)	14									
15	TOTALS (line 9+line14)					\$	\$ 1,170,645			\$ 39,142	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

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						
		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	Automobile Loan						\$	\$ 20,645			\$	8						
9												9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital																	
	B. Non-Facility Related*																	
15	Alloc Managcare	X					\$	\$			\$	484						
16	Alloc Mazel	X										4,713						
17												17						
18												18						
19												19						
20	TOTAL Non-Facility Related																	
												5,197						

* 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 **Mid America Care Center**# **0016618** 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.			\$	390,000	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.)			\$	382,580	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(7,420)	3
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	390,000	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.)			\$	2,890	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 \$ 269 For 1996 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.			\$	385,470	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1998	376,141	8		
		1999	373,617	9		
		2000	368,742	10		
		2001	378,332	11		
		2002	378,498	12		
					FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2002	\$		13
		14	PLUS APPEAL COST FROM LINE 5	\$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$		16
		382,574*1.025=392,138.43, rounded to \$390,000				
		Expense allocated from Mazel = 4032.28				
		The Real Estate Tax refund does not have to be offset since it relates to a tax bill which was not used for rate setting				

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 Mid America Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0016618

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>14-08-410-018-0000</u>	<u>4928 N Kenmore</u>	\$ <u>104,957.55</u>	\$ <u>104,957.55</u>
2. <u>14-08-410-019-0000</u>	<u>4922 N Kenmore</u>	\$ <u>104,957.55</u>	\$ <u>104,957.55</u>
3. <u>14-08-410-020-0000</u>	<u>4918 N Kenmore</u>	\$ <u>104,957.55</u>	\$ <u>104,957.55</u>
4. <u>14-08-410-021-0000</u>	<u>4912 N Kenmore</u>	\$ <u>63,625.29</u>	\$ <u>63,625.29</u>
5. <u>14-08-410-017-0000</u>	<u>4930 N Kenmore</u>	\$ <u>4,076.14</u>	\$
6. <u>See Attached</u>	<u>See Attached</u>	\$ <u>4,032.28</u>	\$ <u>4,032.28</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>386,606.36</u>	\$ <u>382,530.22</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? X 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 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 Mid America Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0016618

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.

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		
	Bed ^s *	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		1978		2,575		20	-		2,575	9
10	Various		1979		33,995		20	-		33,995	10
11	Various		1980		13,673		20	-		13,673	11
12	Various		1981		107,932		20	4,205	(4,205)	98,828	12
13	Various		1982		4,750		20	-		4,750	13
14	Various		1983		1,787		20	-		1,787	14
15	Various		1984		25,291		20	242	242	24,840	15
16	Various		1985		17,828		20	487	487	17,572	16
17	Various		1986		62,698		20	3,203	3,203	59,655	17
18	Various		1987		18,422		20	501	501	14,522	18
19	Various		1988		33,825		20	1,353	1,353	21,273	19
20	Various		1989		23,916		20	1,201	1,201	19,343	20
21	Various		1990		23,550		20	1,178	1,178	15,914	21
22	Various		1991		20,020		20	429	429	8,605	22
23	Various		1992		51,260		20	2,563	2,563	29,219	23
24	Various		1993		7,134		20	357	357	3,994	24
25	Various		1994		32,273		20	1,613	1,613	14,952	25
26	Various		1995		227,831		20	11,547	11,547	98,230	26
27	Various		1996		136,732		20	6,837	6,837	51,767	27
28	Various		1997		26,804		20	1,340	1,340	8,763	28
29	Various		1998		81,506		20	4,077	4,077	22,237	29
30	Various		1999		113,499		20	5,676	5,676	25,682	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		3,258,613					3,258,613	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		113,621	5,918		4,910	(1,008)	80,939	68
69	Financial Statement Depreciation			46,251			(46,251)		69
70	TOTAL (lines 4 thru 69)		\$ 4,439,535	\$ 52,169		\$ 51,719	\$ (8,860)	\$ 3,931,728	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center

0016618

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		\$ 4,439,535	\$ 52,169		\$ 51,719	\$ (450)	\$ 3,931,728	1
2	Fire Alarm System	2000	68,998		20	3,450	3,450	12,650	2
3	Lndy & Ktchn Htg Sys	2000	17,700		20	885	885	3,393	3
4	Elevator Generator	2000	3,374		20	337	337	1,040	4
5	Iron Railing	2000	600		20	30	30	100	5
6	Nse Station Bumpers	2000	1,326		20	66	66	238	6
7	Sprinklers System	2000	9,544		20	477	477	1,749	7
8	Nse Station Remodel	2000	124,573		20	6,229	6,229	22,320	8
9	Fire Proofing	2000	1,845		20	92	92	361	9
10	Drains & Vents	2000	6,470		20	324	324	1,241	10
11	Go Ampere	2000	9,800		20	490	490	1,878	11
12	Wanderguard	2000	6,180		20	309	309	927	12
13	Cubicle Curtains	2000	4,171		20	209	209	626	13
14	Therapy Rm Cabinets	2000	1,400		20	70	70	210	14
15	Ceiling Tile	2000	332		20	17	17	50	15
16	Ceramic Tile	2000	1,267		20	63	63	190	16
17	Nse Cal System	2000	6,887		20	344	344	1,033	17
18	Annunciator System	2000	15,568		20	778	778	2,335	18
19	Telephone Wiring	2000	2,619		20	131	131	393	19
20	Carpeting & Trim	2000	4,070		20	204	204	611	20
21	Runner Mats	2000	2,648		20	132	132	397	21
22	New Curcuits	2000	13,300		20	665	665	1,995	22
23	Window Treatment	2000	3,121		20	156	156	468	23
24	Cctv To Monitoring	2000	2,812		20	141	141	422	24
25	Lock System	2001	2,862		20	143	143	417	25
26	Doors & Locks	2001	6,519		20	326	326	951	26
27	Monitor	2001	1,875		20	94	94	259	27
28	Monitor	2001	4,021		20	201	201	519	28
29	Humiguard & Tile	2001	1,814		20	91	91	219	29
30	Monitor	2001	1,931		20	97	97	233	30
31	Monitor	2001	1,206		20	60	60	141	31
32	Monitor	2001	1,695		20	85	85	198	32
33	Masonary Work	2001	2,600		20	130	130	293	33
34	TOTAL (lines 1 thru 33)		\$ 4,772,663	\$ 52,169		\$ 68,545	\$ 16,376	\$ 3,989,585	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center

0016618

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		\$ 4,772,663	\$ 52,169		\$ 68,545	\$ 16,376	\$ 3,989,585	1
2	Transmitter	2001	1,073		20	54	54	121	2
3	Wall Repair	2001	6,800		20	340	340	737	3
4	Door Operator	2001	4,606		20	230	230	672	4
5	Steel Selector Tape	2001	2,113		20	106	106	238	5
6	Roof Repair	2001	2,750		20	138	138	298	6
7	Elec. Cir. & Outlet	2001	2,845		20	142	142	297	7
8	Patio Area Fence	2001	1,784		20	89	89	200	8
9	Motors	2001	549		20	27	27	60	9
10	Turbine Pump	2001	2,943		20	147	147	429	10
11	Alarm/Transmitter	2001	1,244		20	62	62	129	11
12	Fire Alarm System	2001	1,091		20	55	55	132	12
13	Asphalt Repair	2001	2,740		20	137	137	354	13
14	Paint	2001	1,456		20	73	73	213	14
15	Install Ceramic Tile	2002	4,000		20	400	400	767	15
16	Flooring	2002	1,818		20	182	182	364	16
17	Carpentry Work	2002	2,700		20	270	270	495	17
18	Flooring	2002	1,407		20	141	141	270	18
19	Carpentry Work	2002	4,420		20	442	442	700	19
20	Flooring	2002	1,786		20	179	179	327	20
21	Carpentry	2002	9,318		20	932	932	1,631	21
22	Carpentry	2002	2,620		20	262	262	459	22
23	Floor Tile	2002	5,809		20	581	581	1,017	23
24	Monitoring Cameras	2002	1,556		20	311	311	493	24
25	A/C	2002	9,960		20	1,992	1,992	3,486	25
26	A/C Circuits	2002	3,686		20	737	737	1,044	26
27	Doors	2002	613		20	61	61	66	27
28	Doors	2002	613		20	61	61	72	28
29	Elevator	2002	4,180		20	209	209	226	29
30	Fence	2002	2,207		20	147	147	245	30
31	Fence Installation	2002	2,207		20	110	110	193	31
32	Electrical	2002	1,173		20	59	59	93	32
33	Fan Blade	2002	1,824		20	91	91	122	33
34	TOTAL (lines 1 thru 33)		\$ 4,866,554	\$ 52,169		\$ 77,312	\$ 25,143	\$ 4,005,535	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 12C, Carried Forward	\$ 4,866,554	\$ 52,169		\$ 77,312	\$ 25,143	\$ 4,005,535		1
2	Door Transmitter	2002 2,180		20	109	109	136		2
3	Door Screens	2002 1,210		20	61	61	76		3
4	Elevator Repairs	2002 1,540		20	77	77	109		4
5	Control Panel	2003 2,810		20	281	281	281		5
6	Annuciator Panel	2003 3,105		20	181	181	181		6
7	Elevator Key Pad	2003 1,092		20	55	55	55		7
8	Water Heater	2003 6,650		20	508	508	508		8
9	Smoke Dampers	2003 2,380		20	198	198	198		9
10	Air Handler	2003 3,975		20	33	33	33		10
11	Fire Alarm	2003 4,081		20	34	34	34		11
12	Elevator Flooring	2003 1,185		20	54	54	54		12
13	Fire Alarm Duct	2003 930		20	47	47	47		13
14	Fire Alarm Repair	2003 618		20	28	28	28		14
15	Air Filter Motor	2003 1,403		20	64	64	64		15
16	Door Locking System	2003 699		20	32	32	32		16
17	Fire Dampers	2003 1,016		20	47	47	47		17
18	Smoke Dampers	2003 519		20	26	26	26		18
19	Evaporator Fan Motor	2003 591		20	17	17	17		19
20	Latching Alarm System	2003 697		20	17	17	17		20
21	Alarm Bell	2003 602		20	10	10	10		21
22	Fire Alarm Repair	2003 720		20	3	3	3		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)	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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 12D, Carried Forward	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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)	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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		\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491	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)		\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491	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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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)	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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)	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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)	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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)	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12J, Carried Forward	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		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)	\$ 4,904,557	\$ 52,169		\$ 79,194	\$ 27,025	\$ 4,007,491		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center

0016618

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 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5				1971	3,258,613					3,258,613	5
6											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
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)		\$ 3,258,613	\$		\$	\$	\$	3,258,613	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center

0016618

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	Allocation Mazel	1985	1985	\$ 44,297	\$ 2,303		\$ 1,477	\$ (826)	\$ 26,947	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Allocation Managcare		1997	5,164	461		516	55	3,314	9
10	Allocation Managcare		1993	405	-		20	20	214	10
11	Allocation Managcare		1988	632	20		31	11	481	11
12	Allocation Managcare		1986	47,905	2,447		2,194	253	42,061	12
13										13
14	Allocation Mazel		2001	930	24		47	23	116	14
15	Allocation Mazel		2000	470	12		24	12	77	15
16	Allocation Mazel		1998	1,657	57		83	26	473	16
17	Allocation Mazel		1997	1,545	40		77	37	489	17
18	Allocation Mazel		1996	1,054	12		53	41	399	18
19	Allocation Mazel		1995	238	6		12	6	102	19
20	Allocation Mazel		1994	940	17		47	30	398	20
21	Allocation Mazel		1993	555	16		28	12	290	21
22	Allocation Mazel		1991	416	13		20	7	244	22
23	Allocation Mazel		1990	647	13		32	19	432	23
24	Allocation Mazel		1989	405	9		17	8	247	24
25	Allocation Mazel		1987	919	18		-	(18)	919	25
26	Allocation Mazel		1986	3,713	193		158	(35)	3,306	26
27	Allocation Mazel		1985	258	-				258	27
28										28
29	Allocation Intercare		2001	1,471	257		74	(183)	172	29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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)		\$ 113,621	\$ 5,918		\$ 4,910	\$ (502)	\$ 80,939		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 472,928	\$ 39,537	\$ 45,861	\$ 6,324	10	\$ 260,954	71
72	Current Year Purchases	36,757	33,017	4,604	(28,413)	10	4,604	72
73	Fully Depreciated Assets	687,266				10	687,172	73
74								74
75	TOTALS	\$ 1,196,951	\$ 72,554	\$ 50,465	\$ (22,089)		\$ 952,730	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		MITSUBISHI	2003	\$ 22,522	\$ 10,710	\$ 3,378	\$ (7,332)	5	\$ 3,378	76
77		Alloc from Managcare		77,032	25,215	17,487	(7,728)	5		77
78										78
79										79
80	TOTALS			\$ 99,554	\$ 35,925	\$ 20,865	\$ (15,060)		\$ 3,378	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)	\$ 6,508,935	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 160,648	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 150,524	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,124)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,963,599	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	1994 ALTIMA - 1994	\$ 17,799	\$	\$	86
87	4930 BLDG - 1998	159,035	5,980	46,387	87
88	4930 LAND - 1998	17,500			88
89					89
90					90
91	TOTALS	\$ 194,334	\$ 5,980	\$ 46,387	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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: \$ 348 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	<u>Facility</u>	<u>2002 Lexus</u>	\$ <u>569.70</u>	\$ <u>5,761</u>	17
18	<u>Facility</u>	<u>1999 Dodge Caravan</u>	<u>245.81</u>	<u>2,212</u>	18
19					19
20					20
21	TOTAL		\$ 815.51	\$ 7,973	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 type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$	61,252	\$			\$	61,252			1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					15,339					15,339			2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					36,480					36,480			4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 03	# of prescripts					92,904					92,904			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Exceptional Care Program	39 - 03						115		19,817			19,932			12
13	Other (specify): See Supplemental							3,047		54,535			57,582			13
14	TOTAL			\$			\$	209,137	\$	74,352		\$	283,489			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 Mid America Care Center

0016618

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	\$ 153,505	1
2	Cash-Patient Deposits	6,813	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	647,524	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	359,167	6
7	Other Prepaid Expenses	9,299	7
8	Accounts Receivable (owners or related parties)	737,397	8
9	Other(specify): See Attached Schedule	169,649	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,083,354	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	325,374	13
14	Buildings, at Historical Cost	3,417,648	14
15	Leasehold Improvements, at Historical Cost	1,292,625	15
16	Equipment, at Historical Cost	1,256,214	16
17	Accumulated Depreciation (book methods)	(5,000,023)	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	83,675	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,375,513	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,458,867	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 415,340	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	102,347	28
29	Short-Term Notes Payable	504,504	29
30	Accrued Salaries Payable	121,619	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,337	31
32	Accrued Real Estate Taxes(Sch.IX-B)	390,000	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes	29,992	35
Other Current Liabilities(specify):			
36	See Attached Schedule	3,489	36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,585,628	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	666,141	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)	\$ 666,141	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,251,769	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,207,098	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,458,867	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,612,510	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,612,510	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	223,638	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) Treasury Stock	(1,629,050)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,405,412)	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)	\$ 1,207,098	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center

0016618

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	\$ 8,354,132	1
2	Discounts and Allowances for all Levels	(292,646)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,061,486	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	228,626	6
7	Oxygen	1,512	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 230,138	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	96,236	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,077	19
20	Radiology and X-Ray	1,535	20
21	Other Medical Services	51,281	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 165,129	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	24,532	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,532	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17,047	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,047	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,498,332	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,710,746	31
32	Health Care	3,208,834	32
33	General Administration	2,243,353	33
B. Capital Expense			
34	Ownership	581,008	34
C. Ancillary Expense			
35	Special Cost Centers	361,028	35
36	Provider Participation Fee	169,725	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,274,694	40
41	Income before Income Taxes (line 30 minus line 40)**	223,638	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 223,638	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 Mid America Care Center # 0016618

0016618

Report Period Beginning: 01/01/03

Ending: 12/31/03

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	1,780	2,064	\$ 73,055	\$ 35.39	1
2	Assistant Director of Nursing	2,022	2,300	55,213	24.01	2
3	Registered Nurses	31,167	33,120	708,954	21.41	3
4	Licensed Practical Nurses	18,717	20,015	362,166	18.09	4
5	Nurse Aides & Orderlies	136,353	132,147	1,164,621	8.81	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,217	17,852	225,570	12.64	8
9	Activity Director	1,960	2,176	41,442	19.05	9
10	Activity Assistants	13,463	14,506	116,144	8.01	10
11	Social Service Workers	11,895	12,822	126,803	9.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,179	31,598	292,082	9.24	15
16	Dishwashers					16
17	Maintenance Workers	13,558	14,882	172,515	11.59	17
18	Housekeepers	35,076	37,462	277,463	7.41	18
19	Laundry	13,725	14,932	116,596	7.81	19
20	Administrator	1,840	2,028	126,252	62.25	20
21	Assistant Administrator	2,024	2,240	75,036	33.50	21
22	Other Administrative	1,272	1,301	32,753	25.18	22
23	Office Manager					23
24	Clerical	16,210	17,225	101,869	5.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,052	3,377	45,950	13.61	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,300	2,364	75,539	31.95	33
34	TOTAL (lines 1 - 33)	351,810	364,411	\$ 4,190,023 *	\$ 11.50	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	408	\$ 16,800	01-03	35
36	Medical Director	Monthly	3,000	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant	3,034	121,993	10-03	38
39	Pharmacist Consultant	Monthly	1,800	10-03	39
40	Physical Therapy Consultant	18	5,474	10a-03	40
41	Occupational Therapy Consultant	18	6,554	10a-03	41
42	Respiratory Therapy Consultant	64	2,295	10a-03	42
43	Speech Therapy Consultant	11	6,905	10a-03	43
44	Activity Consultant	30	1,547	11-03	44
45	Social Service Consultant	69	3,768	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,652	\$ 174,264		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	182	\$ 6,254	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	182	\$ 6,254		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	
Yehoshua Davis	Administrator	.44	\$ 127,496	Workers' Compensation Insurance	\$ 87,383	IDPH License Fee	\$ 7,569	
Michael Applebaum	Asst Admin	0	75,038	Unemployment Compensation Insurance	30,448	Advertising: Employee Recruitment	7,569	
Yosef Davis	Director	44.92	15,149	FICA Taxes	320,453	Health Care Worker Background Check (Indicate # of checks performed <u>129</u>)	904	
Moshe Davis	Director	.44	16,360	Employee Health Insurance	160,572	Licenses/Permits	3,069	
				Employee Meals	39,749	Corporate Annual Fees	325	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising/Promotion	18,935	
				Chicago Head Tax	7,892	Dues/Subscriptions	12,628	
				Disability Insurance	6,494	See Supplemental Schedule	837	
				Employee Pension	46,450	Less: Public Relations Expense ()		
				Employee Benefits	49,561	Non-allowable advertising (18,935)		
						Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 234,043	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
Management Fees-Intercare			\$ 90,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 90,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
See Attached	Legal		\$ 5,750				Out-of-State Travel	\$
FR&R	Accounting		54,613				In-State Travel	
Commitment (adj on 5A)	Collections		11,339					
Gonnella/Managcare	Mgt Consulting		4,253				Seminar Expense	4,525
Cox Ltd	Architecture		1,049				Alloc from Managcare	1,716
Personnel Planners	Unemployment Cslt		6,551					
Econocare	Purchasing		5,220				Entertainment Expense ()	
Managcare Fees	Bookkeeping		438,960				(agree to Sch. V, line 24, col. 8)	
Midwest Appraisal	Appraisal Fees		2,800				TOTAL	\$ 6,241
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 530,535	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5										
				6										
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 Mid America Care Center

0016618

Report Period Beginning: 01/01/03

Ending: 12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council LTC - \$12,628
- (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? No
- (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. \$ 22,068 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 169,725
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 39,749 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT