

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER

0028480 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	140	Skilled (SNF)	140	51,100	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	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	33,772	2,824	6,178	42,774	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,772	2,824	6,178	42,774	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.71%

D. How many bed-hold days during this year were paid by Public Aid? _____ (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 02/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/84 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 35 and days of care provided 5,580

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **MOMENCE MEADOWS NURSING CENTE** # **0028480** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	237,119	13,561	11,493	262,173		262,173		262,173		1
2	Food Purchase		216,950		216,950	(27,010)	189,940	(77)	189,863		2
3	Housekeeping	135,794	22,243		158,037		158,037		158,037		3
4	Laundry	99,075	20,791		119,866		119,866		119,866		4
5	Heat and Other Utilities			111,387	111,387		111,387	206	111,593		5
6	Maintenance	67,017	21,356	37,707	126,080		126,080	2,036	128,116		6
7	Other (specify):*			14,817	14,817		14,817		14,817		7
8	TOTAL General Services	539,005	294,901	175,404	1,009,310	(27,010)	982,300	2,165	984,465		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	2,156,138	93,706	79,935	2,329,779		2,329,779		2,329,779		10
10a	Therapy	149,112	6,695	16,169	171,976		171,976		171,976		10a
11	Activities	61,934	13,258	1,000	76,192		76,192		76,192		11
12	Social Services	97,268		4,760	102,028		102,028		102,028		12
13	Nurse Aide Training										13
14	Program Transportation			7,836	7,836		7,836		7,836		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,464,452	113,659	124,700	2,702,811		2,702,811		2,702,811		16
	C. General Administration										
17	Administrative	51,154		452,281	503,435		503,435	(428,835)	74,600		17
18	Directors Fees										18
19	Professional Services			111,191	111,191		111,191	1,033	112,224		19
20	Dues, Fees, Subscriptions & Promotions			66,670	66,670		66,670	(50,265)	16,405		20
21	Clerical & General Office Expenses	164,561	17,404	355,311	537,276		537,276	(211,522)	325,754		21
22	Employee Benefits & Payroll Taxes			480,221	480,221	27,010	507,231		507,231		22
23	Inservice Training & Education										23
24	Travel and Seminar			56,428	56,428		56,428	(52,187)	4,241		24
25	Other Admin. Staff Transportation			12,160	12,160		12,160		12,160		25
26	Insurance-Prop.Liab.Malpractice			168,451	168,451		168,451		168,451		26
27	Other (specify):*							13,961	13,961		27
28	TOTAL General Administration	215,715	17,404	1,702,713	1,935,832	27,010	1,962,842	(727,815)	1,235,027		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,219,172	425,964	2,002,817	5,647,953		5,647,953	(725,650)	4,922,303		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	11,493
	REPAIRS & MAINTENANCE	0
		0
		11,493
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	32,564
	ELECTRICITY	52,647
	WATER	18,582
	CABLE TV - LOBBY	7,594
		0
		111,387
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,071
	PAINTING & DECORATING	478
	BUILDING REPAIRS	5,528
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	19,003
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,595
	FIRE SERVICE	5,032
		0
		0
		0
		37,707
7	OTHER	
	SCAVENGER	14,817
	SECURITY SERVICE	0
		14,817
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	15,000
		15,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	4,420
	PURCHASED SERVICES	35,671
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,392
	PHARMACY CONSULTANT XVIII B 39-2	2,788
	UTILIZATION REVIEW FEES XVIII B __-2	9,750
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B -2	6,000
	RN CONSULTANT XVIII B 38-2	14,514
	DENTAL	2,400
		0
		79,935
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	16,169
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		16,169
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,000
		0
		1,000
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,760
		0
		4,760
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	7,836
		7,836
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	452,281
		452,281
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,046
	ADMINISTRATIVE CONSULTANTS XIX C	2,800
	PROFESSIONAL FEES XIX C	96,345
		0
		111,191
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	39,871
	EMPLOYEE WANT ADS XIX F	4,467
	CONTRIBUTIONS VI 20 XIX F	50
	DUES & SUBSCRIPTIONS XIX F	9,059
	LICENSES & PERMITS XIX F	2,879
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	8,288
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,056
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		66,670
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,949
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	329,000
	PENALTIES / OVERDRAFT CHARGES VI 18	956
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,289
	MESSENGER SERVICE	1,215
	PERSONNEL COSTS	1,902
		355,311

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	244,767
	UNEMPLOYMENT COMPENSATION XIX D	51,948
	WORKERS COMPENSATION INSURANCE XIX D	85,629
	HOSPITALIZATION INSURANCE XIX D	89,160
	EMPLOYEE BENEFITS - OTHER XIX D	8,717
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		480,221
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	4,241
	TRAVEL XIX G	0
	NON ALLOWABLE TRAVEL	52,187
		0
		56,428
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	12,160
		12,160
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	168,451
		168,451
27	OTHER	
	BAD DEBTS VI 24	0
		0
		0

GRAND TOTAL COLUMN 3 OTHER 2,002,817

Facility Name & ID Number

MOMENCE MEADOWS NURSING CENTER

#0028480

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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			70,484	70,484		70,484	118,485	188,969			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,141	35,141		35,141	463,166	498,307			32
33	Real Estate Taxes			53,080	53,080		53,080		53,080			33
34	Rent-Facility & Grounds			510,771	510,771		510,771	(510,771)				34
35	Rent-Equipment & Vehicles			39,300	39,300		39,300	3,473	42,773			35
36	Other (specify):*											36
37	TOTAL Ownership			708,776	708,776		708,776	74,353	783,129			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		169,358	316,542	485,900		485,900		485,900			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,650	76,650		76,650		76,650			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		169,358	393,192	562,550		562,550		562,550			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,219,172	595,322	3,104,785	6,919,279		6,919,279	(651,297)	6,267,982			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	23,216	30		9
10	Interest and Other Investment Income	(66)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(956)	21		18
19	Entertainment		20		19
20	Contributions	(2,106)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(39,871)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(8,288)	20		28
29	Other-Attach Schedule	(54,100)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,248)		\$	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)	(569,049)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (569,049)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (651,297)		37

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

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

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

ID# 0028480

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 2,036	6	1
2	NON ALLOWABLE TRAVEL	(52,187)	24	2
3	BANK CHARGES	(3,949)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(54,100)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER# 0028480

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(77)	0	0	0	0	0	0	0	0	0	0	(77)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	206	0	0	0	0	0	0	0	0	0	206	5
6	Maintenance	2,036	0	0	0	0	0	0	0	0	0	0	2,036	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,959	206	0	2,165	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(428,835)	0	0	0	0	0	0	0	0	0	(428,835)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,033	0	0	0	0	0	0	0	0	0	1,033	19
20	Fees, Subscriptions & Promotions	(50,265)	0	0	0	0	0	0	0	0	0	0	(50,265)	20
21	Clerical & General Office Expenses	(4,905)	(206,617)	0	0	0	0	0	0	0	0	0	(211,522)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(52,187)	0	0	0	0	0	0	0	0	0	0	(52,187)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	13,961	0	0	0	0	0	0	0	0	0	13,961	27
28	TOTAL General Administration	(107,357)	(620,458)	0	(727,815)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(105,398)	(620,252)	0	(725,650)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER# 0028480

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	23,216	0	95,269	0	0	0	0	0	0	0	0	118,485	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(66)	0	463,232	0	0	0	0	0	0	0	0	463,166	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(510,771)	0	0	0	0	0	0	0	0	(510,771)	34
35	Rent-Equipment & Vehicles	0	3,473	0	0	0	0	0	0	0	0	0	3,473	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	23,150	3,473	47,730	0	74,353	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(82,248)	(616,779)	47,730	0	(651,297)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SKOKIE MEADOWS 1	SKOKIE	PREMIER	SKOKIE	MANAGEMENT
		SKOKIE MEADOWS 2	SKOKIE	MANAGEMENT		BOOKKEEPING
		SHELDON MEADOWS	SHELDON			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 OUTSIDE CLERICAL	\$ 308,000	PREMIER MANAGEMENT		\$	\$ (308,000)	1
2	V	21 OUTSIDE SERVICES	21,000	1139 BEVERLY			(21,000)	2
3	V	17 OFFICER SALARY	452,281	PREMIER MANAGEMENT			(452,281)	3
4	V	5 UTILITIES				206	206	4
5	V	17 OFFICER SALARIES				23,446	23,446	5
6	V	19 PROFESSIONAL FEES				1,033	1,033	6
7	V	21 CLERICAL SALARIES				12,996	12,996	7
8	V	21 CLERICAL SALARIES				56,498	56,498	8
9	V	21 CLERICAL SALARIES				41,179	41,179	9
10	V	21 CLERICAL				11,710	11,710	10
11	V	27 PAYR.TAXES/HEALTH INS.				13,961	13,961	11
12	V	35 OFFICE RENTAL				3,473	3,473	12
13	V							13
14	Total		\$ 781,281			\$ 164,502	\$ * (616,779)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 RENT	\$ 510,771	M O MOMENCE	100.00%	\$	(510,771)	15
16	V	30 DEPRECIATION				95,269	95,269	16
17	V	32 INTEREST				463,232	463,232	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		\$ 510,771			\$ 558,501	\$ * 47,730	39

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

Facility Name & ID Number MOMENCE MEADOWS NURSING CENT # 0028480 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACOB GRAFF	PRESIDENT	Administrative	26.60	Skokie 1-\$27,368			Salary	\$ 23,446	17-7	1
2					Skokie 2-\$27,571						2
3					Sheldon - \$7,384						3
4					Cal.Homes-\$74,231						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 23,446		13

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

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

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER

0028480

Report Period Beginning:

01/01/2003

Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PREMIER MANAGEMENT
 Street Address 9933 N. LAWLER
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 679-7733
 Fax Number (847) 679-7736

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	5	UTILITIES	230,059	5	\$ 1,409	\$	33,712	\$ 206	1
2	17	OFFICER SALARIES	230,059	5	160,000	160,000	33,712	23,446	2
3	19	PROFESSIONAL FEES	230,059	5	7,047		33,712	1,033	3
4	21	CLERICAL SALARIES	10	4	43,320	43,320	3	12,996	4
5	21	CLERICAL SALARIES	4	3	112,996	112,996	2	56,498	5
6	21	CLERICAL SALARIES	230,059	5	281,019	281,019	33,712	41,179	6
7	21	CLERICAL	230,059	5	79,909		33,712	11,710	7
8	27	PAYR.TAXES/HEALTH INS.	230,059	5	95,272		33,712	13,961	8
9	35	OFFICE RENTAL	230,059	5	23,699		33,712	3,473	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				\$ 804,671	\$ 597,335		\$ 164,502	25

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER

0028480

Report Period Beginning:

01/01/2003

Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization M O MOMENCE
 Street Address 9933 N LAWLER SUITE 350
 City / State / Zip Code SKOKIE,IL 60077
 Phone Number (847)679-7733
 Fax Number (847)679-7734

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	30	DEPRECIATION	DIRECT	1	1	\$ 95,269	\$ 1	\$ 95,269	1
2	32	INTEREST	DIRECT	1	1	463,232	1	463,232	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					\$ 558,501	\$	\$ 558,501	25

Facility Name & ID Number

MOMENCE MEADOWS NURSING CENTE

0028480

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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	CAMBRIDGE REALTY		X	HUD MORTGAGE	\$42,564.00	7/25/01	6,526,000	6,420,782	7/25/36	0.0719	463,232	2						
3												3						
4												4						
5												5						
Working Capital																		
6	BANK FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV		397,865	REVOLV		32,347	6						
7	BANK FINANCIAL		X	BUS LOAN	\$1,239.10	1/1/02	64,340	43,596			2,794	7						
8												8						
9	TOTAL Facility Related				\$43,803.10		\$ 6,590,340	\$ 6,862,243			\$ 498,373	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 6,590,340	\$ 6,862,243			\$ 498,373	15						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2002 report.

\$ **54,612** 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.)

\$ **53,846** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(766)** 3

4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **53,846** 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **53,080** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	55,642	8
	1999	55,005	9
	2000	54,076	10
	2001	54,613	11
	2002	53,846	12

FOR OHF USE ONLY

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

13 FROM R. E. TAX STATEMENT FOR 2002 \$ 13

14 PLUS APPEAL COST FROM LINE 5 \$ 14

15 LESS REFUND FROM LINE 6 \$ 15

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

16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOMENCE MEADOWS NURSING CENTER COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0028480

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>05-11-19-306-007</u>	<u>NURSING HOME</u>	\$ <u>53,845.88</u>	\$ <u>53,845.88</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>53,845.88</u>	\$ <u>53,845.88</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,850 B. General Construction Type: Exterior Frame Number of Stories

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>			\$ <u>32,183</u>	1
2					2
3	TOTALS			\$ 32,183	3

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER

0028480

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	78	1983		\$ 1,071,430	\$	20	\$ 51,331	\$ 51,331	\$ 1,071,430	4
5		1983		28,288		19	237	237	28,288	5
6	50	1989		1,359,883	43,171	31.5	43,171		613,351	6
7	12	1994		381,788	9,789	39	9,789		95,863	7
8										8
	Improvement Type**									
9	IMPROVEMENTS		1984	11,728		15			11,728	9
10	IMPROVEMENTS		1985	10,412	541	10	255	(286)	10,412	10
11	IMPROVEMENTS		1986	8,150	424	20	408	(16)	7,140	11
12	IMPROVEMENTS		1987	1,655	53	20	83	30	1,370	12
13	IMPROVEMENTS		1987	513	16	20	26	10	429	13
14	IMPROVEMENTS		1988	33,260	1,056	31.5	1,056		16,412	14
15	IMPROVEMENTS		1989	9,914	315	31.5	315		4,443	15
16	IMPROVEMENTS		1990	7,043	224	31.5	224		2,962	16
17	IMPROVEMENTS		1991	66,745	2,118	31.5	2,118		26,518	17
18	IMPROVEMENTS		1992	14,756	468	31.5	468		5,429	18
19	IMPROVEMENTS		1993	3,240	103	31.5	103		1,120	19
20	IMPROVEMENTS		1993	18,662	479	39	479		4,810	20
21	IMPROVEMENTS		1994	2,799	72	39	72		693	21
22	BOOSTER PUMP & MIXING VALVE		1995	7,865	202	39	202		1,707	22
23	TWO WATER HEATERS		1995	6,886	177	39	177		1,555	23
24	HALLWAY HEATER		1995	815	21	39	21		169	24
25	STEEL DOOR		1996	1,679	43	39	43		335	25
26	PLUMBING		1996	3,219	83	39	83		618	26
27	TILE,WALL BUMPERS,HAND RAIL & RIGIWALL		1996	26,342	675	39	675		4,753	27
28	CORNERGUARDS,WALL BUMPER & HANDRAIL		1997	1,584	41	39	41		281	28
29	REWIRE NURSE STATION ROOFTOP UNIT		1997	4,298	110	39	110		757	29
30	ALZHEIMERS REMODELING		1997	11,002	282	39	282		1,939	30
31	ROOF TOP UNITS		1997	7,875	202	39	202		1,389	31
32	CONCRETE WORK		1997	1,650	42	39	42		278	32
33	HVAC		1997	3,912	100	39	100		638	33
34	EMERGENCY LIGHTING		1997	4,125	106	39	106		676	34
35	ROOF TOP HEATING/AC UNIT		1997	6,500	167	39	167		1,074	35
36	ROOF TOP UNITS,CORNER GUARDS,CORRIDER CALL LIFES		1998	12,400	318	39	318		1,867	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

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER

0028480

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	NEW DRIVEWAY,FIRE DRAWER,BACKFLOW PREVENTOR	1998	\$ 16,667	\$ 427	39	\$ 427	\$	\$ 2,401	37
38	ROOF TOP UNITS	1998	13,126	337	39	337		1,810	38
39	ROOF INSULATION,RUBBER COVE BOX,ROOF TOP UNIT	1998	23,942	614	39	614		3,147	39
40	ROOF TOP A/C UNIT	1999	6,673	171	39	171		777	40
41	DOORS	1999	2,892	74	39	74		336	41
42	COUNTERTOPS WITH SINKS & FAUCETS	1999	3,460	89	39	89		403	42
43	LIFT STATION FOR DRAIN PLUMBING	1999	2,971	76	39	76		345	43
44	DOORS	1999	1,635	42	39	42		191	44
45	FIRE ALARM PANEL	1999	1,585	41	39	41		185	45
46	EXHAUST FAN	1999	870	22	39	22		100	46
47	ALARM	1999	2,123	54	39	54		245	47
48	EXHAUST FAN	1999	900	23	39	23		105	48
49	COMPRESSOR	1999	2,942	76	39	76		344	49
50	PANNING CAMERA	1999	1,940	50	39	50		226	50
51	BOOSTER FOR WATER HEATER	1999	3,114	80	39	80		363	51
52	CUSTOM NURSING DESK	2000	6,567	239	27.5	239		836	52
53	WATER SOFTENER	2000	5,850	213	27.5	213		745	53
54	TREES	2000	10,974	732	15	732		2,562	54
55	BASEBOARD HEATERS	2000	4,773	169	27.5	169		594	55
56	CARPETING	2000	10,858	1,356	10	1,086	(270)	6,947	56
57	BORDER INSTALLATION & PAINTING	2000	23,938	2,990	10	2,394	(596)	15,317	57
58	LIGHT FIXTURES	2001	6,297	229	27.5	229		582	58
59	RUBBER ROOF	2001	7,500	273	27.5	273		694	59
60	ALARM SYSTEM	2001	34,963	1,271	27.5	1,271		3,231	60
61	DOOR	2001	1,975	72	27.5	72		183	61
62	LIGHT FIXTURES	2001	4,440	162	27.5	162		410	62
63	NURSE STATION	2001	6,647	242	27.5	242		615	63
64	ROOFTOP UNIT	2001	5,149	187	27.5	187		475	64
65	WATER HEATER	2001	4,853	176	27.5	176		448	65
66	SMOKE DETECTORS	2001	1,625	59	27.5	59		150	66
67	WANDERGUARDS ON MAINT DOOR	2001	3,900	142	27.5	142		361	67
68	CARPETING	2001	12,777	2,453	5	2,555	102	7,665	68
69	IMPROVEMENTS TO FACILITY BY PRIOR OWNER		18,872		20	944	944	18,408	69
70	TOTAL (lines 4 thru 69)		\$ 3,387,216	\$ 74,539		\$ 126,025	\$ 51,486	\$ 1,991,635	70

**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 12A, Carried Forward		\$ 3,387,216	\$ 74,539		\$ 126,025	\$ 51,486	\$ 1,991,635	1
2	FIRE DOORS	2002	3838	140	27.5	140		216	2
3	TILING IN MEN'S SHOWER ROOM	2002	11499	418	27.5	418		645	3
4	GUTTERS	2002	2050	75	27.5	75		115	4
5	VCT & COVE BASE IN DINING & DAY ROOM	2002	6255	227	27.5	227		350	5
6	ROOF TOP UNIT	2002	8408	306	27.5	306		472	6
7	BLOWER COIL T BAR UNIT	2002	5184	188	27.5	188		290	7
8	RUBBER COVE BASE	2002	2192	80	27.5	80		123	8
9	DOOR DELAY CONTROL	2002	3000	109	27.5	109		168	9
10	WATER HEATER	2002	4081	148	27.5	148		228	10
11	PAINTING & WALLPAPER COVERING	2002	8,458	1,895	5	1,692	(203)	3,384	11
12	ROOF TOP UNIT	2003	9,400	185	27.5	185		185	12
13	MIXING VALUE	2003	6,493	128	27.5	128		128	13
14	WATER HEATER	2003	4,377	86	27.5	86		86	14
15	BUILDING AN OFFICE AREA	2003	1,456	29	27.5	29		29	15
16	ROOF	2003	26,724	526	27.5	526		526	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)		\$ 3,490,631	\$ 79,079		\$ 130,362	\$ 51,283	\$ 1,998,580	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 439,518	\$ 45,401	\$ 42,186	\$ (3,215)	10	\$ 225,784	71
72	Current Year Purchases	43,068	25,293	2,153	(23,140)	10	2,153	72
73	Fully Depreciated Assets	616,496					616,496	73
74								74
75	TOTALS	\$ 1,099,082	\$ 70,694	\$ 44,339	\$ (26,355)		\$ 844,433	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	HSKP,DIET,MAINT.NSG	93 FORD SUPREME	1994	\$ 39,109	\$	\$	\$	5	\$ 39,109	76
77	HSKP,DIET,MAINT.NSG	02 FORD CHALLENGER VAN	2002	71,340	15,980	14,268	(1,712)	5	21,402	77
78										78
79										79
80	TOTALS			\$ 110,449	\$ 15,980	\$ 14,268	\$ (1,712)		\$ 60,511	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)	\$ 4,732,345	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 165,753	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 188,969	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 23,216	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,903,524	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 27,132 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18	ADMINISTRATOR	2001 LEXUS RX300	#####	12,168	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ #####	\$ 12,168	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2004 \$ _____

13. _____ /2005 \$ _____

14. _____ /2006 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	\$		\$ 118,089	\$		\$ 118,089	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			11,247			11,247	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			151,828			151,828	4
5	Physician Care		visits							5
6	Dental Care	39-8	visits			10,170			10,170	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				158,073		158,073	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB,IV THERAPY	39-8				25,208	11,285		36,493	13
14	TOTAL			\$		\$ 316,542	\$ 169,358		\$ 485,900	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER

0028480

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	912,321		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,771		6
7	Other Prepaid Expenses	2,478		7
8	Accounts Receivable (owners or related parties)	344,992		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,340,562	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	172,306		15
16	Equipment, at Historical Cost	264,740		16
17	Accumulated Depreciation (book methods)	(198,075)		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): JACOB HEALTH CARE CTR	700,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 938,971	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,279,533	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 363,670	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	441,461		29
30	Accrued Salaries Payable	112,109		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,846		32
33	Accrued Interest Payable	1,641		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 972,727	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,882,782		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,882,782	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,855,509	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,575,976)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,279,533	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,824,727)	1
2	Restatements (describe):		2
3	POST CLOSING ENTRIES	(22,874)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,847,601)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(728,375)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (728,375)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,575,976)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,007,029	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,007,029	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	183,809	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 183,809	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	66	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 66	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,190,904	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,009,310	31
32	Health Care	2,702,811	32
33	General Administration	1,935,832	33
B. Capital Expense			
34	Ownership	708,776	34
C. Ancillary Expense			
35	Special Cost Centers	485,900	35
36	Provider Participation Fee	76,650	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,919,279	40
41	Income before Income Taxes (line 30 minus line 40)**	(728,375)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (728,375)	43

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

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

TAX RETURN NOT COMPLETED YET

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

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

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER

0028480

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	6,485	6,781	\$ 120,328	\$ 17.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,525	6,275	221,872	35.36	3
4	Licensed Practical Nurses	29,537	34,638	685,439	19.79	4
5	Nurse Aides & Orderlies	107,435	114,538	1,128,499	9.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,247	10,461	149,112	14.25	8
9	Activity Director					9
10	Activity Assistants	5,047	5,287	61,934	11.71	10
11	Social Service Workers	9,165	9,944	97,268	9.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,653	29,737	237,119	7.97	15
16	Dishwashers					16
17	Maintenance Workers	4,160	4,912	67,017	13.64	17
18	Housekeepers	14,703	15,511	135,794	8.75	18
19	Laundry	13,073	14,301	99,075	6.93	19
20	Administrator	2,080	2,336	51,154	21.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,529	9,181	164,561	17.92	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	242,639	263,902	\$ 3,219,172 *	\$ 12.20	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	287	\$ 11,493	1-3	35
36	Medical Director	60	15,000	9-3	36
37	Medical Records Consultant	175	4,392	10-3	37
38	Nurse Consultant	290	14,514	10-3	38
39	Pharmacist Consultant	10	2,788	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	10	1,000	11-3	44
45	Social Service Consultant	190	4,760	12-3	45
46	Other(specify) <u>REHABILITATION</u>	404	16,169	10a-3	46
47	<u>PSYCHIATRIC</u>	80	6,000	10-3	47
48	<u>DENTAL</u>	40	2,400	10-3	48
49	TOTAL (lines 35 - 48)	1,546	\$ 78,516		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2000	FY2001	FY2002	FY2003
1	PAINT / DECORATING	6/00	\$ 7,831	3 YRS	\$ 1,305	\$ 2,610	\$ 2,610	\$ 1,306	\$	\$	\$	\$								
2	PAINT / DECORATING	2001	833	3 YRS		139	278	278	138											
3	PAINT / DECORATING	2002	1,356	3 YRS			226	452	452	226										
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 10,020		\$ 1,305	\$ 2,749	\$ 3,114	\$ 2,036	\$ 590	\$ 226	\$	\$								

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER

0028480

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

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 ON LONG TERM \$5685
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 76,650
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees