

Facility Name & ID Number Ninth Street Place

0038505 Report Period Beginning: 7/1/02 Ending: 6/30/03

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 16

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</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	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>5,660</u>			<u>5,660</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,660</u>			<u>5,660</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.92%

D. How many bed-hold days during this year were paid by Public Aid? 180 (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)

No _____

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 2/5/93

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/5/93 NO

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

Medicare Intermediary no

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/03 Fiscal Year: 6/30/03

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

STATE OF ILLINOIS

Facility Name & ID Number Ninth Street Place # 0038505 Report Period Beginning: 7/1/02 Ending: 6/30/03

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	20,487	636	1,165	22,288		22,288		22,288		1
2	Food Purchase		27,312		27,312	(3,468)	23,844	53	23,897		2
3	Housekeeping		2,625		2,625		2,625	19	2,644		3
4	Laundry										4
5	Heat and Other Utilities			11,132	11,132		11,132	323	11,455		5
6	Maintenance	7,895	7,971	906	16,772		16,772	461	17,233		6
7	Other (specify):*										7
8	TOTAL General Services	28,382	38,544	13,203	80,129	(3,468)	76,661	856	77,517		8
	B. Health Care and Programs										
9	Medical Director			2,720	2,720		2,720		2,720		9
10	Nursing and Medical Records	250,945	5,005	318	256,268		256,268		256,268		10
10a	Therapy										10a
11	Activities		2,586		2,586		2,586		2,586		11
12	Social Services	16,300			16,300		16,300		16,300		12
13	Nurse Aide Training	3,050	114		3,164		3,164		3,164		13
14	Program Transportation		3,550		3,550		3,550		3,550		14
15	Other (specify):*		973		973		973		973		15
16	TOTAL Health Care and Programs	270,295	12,228	3,038	285,561		285,561		285,561		16
	C. General Administration										
17	Administrative	49,673			49,673		49,673	33,063	82,736		17
18	Directors Fees										18
19	Professional Services			880	880		880	2,879	3,759		19
20	Dues, Fees, Subscriptions & Promotions			2,011	2,011		2,011	1,919	3,930		20
21	Clerical & General Office Expenses	4,547	834	2,183	7,564		7,564	690	8,254		21
22	Employee Benefits & Payroll Taxes			81,991	81,991	3,468	85,459	8,099	93,558		22
23	Inservice Training & Education							186	186		23
24	Travel and Seminar			201	201		201	67	268		24
25	Other Admin. Staff Transportation		749		749		749	393	1,142		25
26	Insurance-Prop.Liab.Malpractice			7,224	7,224		7,224	486	7,710		26
27	Other (specify):*										27
28	TOTAL General Administration	54,220	1,583	94,490	150,293	3,468	153,761	47,782	201,543		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	352,897	52,355	110,731	515,983		515,983	48,638	564,621		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.

Facility Name & ID Number Ninth Street Place

#0038505

Report Period Beginning:

7/1/02

Ending:

6/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			20,133	20,133	20,133	1,740	21,873				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						436	436				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			20,133	20,133	20,133	2,176	22,309				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			37,428	37,428	37,428		37,428				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			37,428	37,428	37,428		37,428				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	352,897	52,355	168,292	573,544	573,544	50,814	624,358				45

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

Facility Name & ID Number Ninth Street Place

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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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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)	50,814		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 50,814		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 50,814		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Ninth Street Place

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Ending: 6/30/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/02

Ending:

6/30/03

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	53	0	0	0	0	0	0	0	0	0	53	2
3	Housekeeping	0	19	0	0	0	0	0	0	0	0	0	19	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	323	0	0	0	0	0	0	0	0	0	323	5
6	Maintenance	0	461	0	0	0	0	0	0	0	0	0	461	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	856	0	0	0	0	0	0	0	0	0	856	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	33,063	0	0	0	0	0	0	0	0	0	33,063	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,879	0	0	0	0	0	0	0	0	0	2,879	19
20	Fees, Subscriptions & Promotions	0	1,919	0	0	0	0	0	0	0	0	0	1,919	20
21	Clerical & General Office Expenses	0	690	0	0	0	0	0	0	0	0	0	690	21
22	Employee Benefits & Payroll Taxes	0	8,099	0	0	0	0	0	0	0	0	0	8,099	22
23	Inservice Training & Education	0	186	0	0	0	0	0	0	0	0	0	186	23
24	Travel and Seminar	0	0	67	0	0	0	0	0	0	0	0	67	24
25	Other Admin. Staff Transportation	0	0	393	0	0	0	0	0	0	0	0	393	25
26	Insurance-Prop.Liab.Malpractice	0	0	486	0	0	0	0	0	0	0	0	486	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	46,836	946	0	0	0	0	0	0	0	0	47,782	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	47,692	946	0	0	0	0	0	0	0	0	48,638	29

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/02

Ending:

6/30/03

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
none						

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	2 Food and Beverage	\$	ARC/RIC	100.00%	\$ 53	\$ 53 1
2	V	3 Housekeeping		ARC/RIC	100.00%	19	19 2
3	V	5 Utilities		ARC/RIC	100.00%	323	323 3
4	V	6 Maintenance		ARC/RIC	100.00%	461	461 4
5	V	19 Accountant/Consultant		ARC/RIC	100.00%	2,064	2,064 5
6	V	19 Legal Fees		ARC/RIC	100.00%	815	815 6
7	V	17 Administration Salaries		ARC/RIC	100.00%	33,063	33,063 7
8	V	20 Sub/Promotion/Printing		ARC/RIC	100.00%	1,919	1,919 8
9	V	21 Office Supplies		ARC/RIC	100.00%	489	489 9
10	V	21 Telephone		ARC/RIC	100.00%	201	201 10
11	V	22 Employee Benefits		ARC/RIC	100.00%	8,099	8,099 11
12	V	10 Medical/Hygiene Supplies		ARC/RIC	100.00%		
13	V	23 Staff Training		ARC/RIC	100.00%	186	186 13
14	Total		\$			\$ 47,692	\$ * 47,692 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	24 Travel Seminar	\$	ARC/RIC	100.00%	\$ 67	\$ 67
16	V	25 Other Administration, Staff Transportation		ARC/RIC	100.00%	393	393
17	V	26 Insurance/Prof/Liability		ARC/RIC	100.00%	486	486
18	V	32 Interest Mortgage		ARC/RIC	100.00%	436	436
19	V	30 Depreciation		ARC/RIC	100.00%	1,740	1,740
20	V						
21	V						
22	V						
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		\$			\$ 3,122	\$ * 3,122

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

Facility Name & ID Number Ninth Street Place # 0038505 Report Period Beginning: 7/1/02 Ending: 6/30/03

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	None								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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

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		None						\$	\$			\$	1						
2													2						
3													3						
4													4						
5													5						
		Working Capital																	
6													6						
7													7						
8													8						
9		TOTAL Facility Related						\$	\$			\$	9						
		B. Non-Facility Related*																	
10													10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$	14						
15		TOTALS (line 9+line14)						\$	\$			\$	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.)

Facility Name & ID Number **Ninth Street Place**# **0038505** Report Period Beginning: **7/1/02** Ending: **6/30/03****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.		\$	None	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.)		\$		2	
3.	Under or (over) accrual (line 2 minus line 1).		\$	#VALUE!	3	
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		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.		\$	#VALUE!	7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1998 _____	8	FOR OHF USE ONLY		
	1999 _____	9				
	2000 _____	10				
	2001 _____	11				
	2002 _____	12				
				13	FROM R. E. TAX STATEMENT FOR 2002 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

IMPORTANT NOTICE

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

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

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

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

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ninth Street Place COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0038505

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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. _____	_____	\$ _____	\$ _____
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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Ninth Street Place # 0038505 Report Period Beginning: 7/1/02 Ending: 6/30/03

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 Association for Retarded Citizens
 Street Address 4016 9th Street
 City / State / Zip Code Rock Island IL 61201
 Phone Number (309 786-6474
 Fax Number (309 786-9861

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	2	Food and Beverage	The percent of Budgeted	741,268	16 programs	\$ 819	\$ 47,812	\$ 53	1
2	3	Housekeeping	Administrative costs are	741,268	16 programs	301	47,812	19	2
3	5	Utilities	to be allocated based on	741,268	16 programs	5,014	47,812	323	3
4	6	Maintenance	percentage of salary	741,268	16 programs	7,142	47,812	461	4
5	19	Accountant/Consultant		741,268	16 programs	31,999	47,812	2,064	5
6	19	Legal Fees		741,268	16 programs	12,633	47,812	815	6
7	17	Administration Salaries		741,268	16 programs	512,600	512,600	33,063	7
8	20	Sub/Promotion/Printing		741,268	16 programs	29,745	47,812	1,919	8
9	21	Office Expense		741,268	16 programs	7,575	47,812	489	9
10	21	Telephone		741,268	16 programs	3,122	47,812	201	10
11	22	Employee Benefits		741,268	16 programs	125,566	47,812	8,099	11
12	10	Medical/Hygiene supplies		741,268	16 programs		47,812	0	12
13	23	Staff Training		741,268	16 programs	2,888	47,812	186	13
14	24	Travel Seminar		741,268	16 programs	1,034	47,812	67	14
15	25	Other Administration, Staff Transportation		741,268	16 programs	6,088	47,812	393	15
16	26	Insurance/Prof/Liability		741,268	16 programs	7,528	47,812	486	16
17	32	Interest Mortgage		741,268	16 programs	6,760	47,812	436	17
18	30	Depreciation		741,268	16 programs	26,982	47,812	1,740	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 787,796	\$ 512,600	\$ 50,814	25

Facility Name & ID Number Ninth Street Place# 0038505 Report Period Beginning:7/1/02 Ending:6/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,218 B. General Construction Type: Exterior Vinyl Siding Frame Wood Frame Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: None 2. Number of Years Over Which it is Being Amortized: _____

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>DD Facility</u>	<u>99,015</u>	<u>1997</u>	<u>\$ 25,115</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	99,015		\$ 25,115	3

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/02

Ending:

6/30/03

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	16	1997	1992	\$ 417,394	\$ 13,251	31.5	\$ 13,251	\$	\$ 72,880
5									
6									
7									
8									
Improvement Type**									
9	Insulation	1994		4,038		31.5			
10	Final Payment on Retainage Building Fee	1995		1,051		31.5			
11	Engineering and Architecture	1993		16,791		31.5			
12	Dumpster Enclosure	1994		550	17	31.5	17		164
13	Vinyl Floor	1995		875	28	31.5	28		209
14	Carpet/Gazebo	1997		5,126	163	31.5	163		1,060
15	Fence	1997		2,936	93	31.5	93		512
16	Carpet/Gazebo	1998		1,690	54	31.5	54		264
17	Wall Protection	1998		1,044	33	31.5	33		182
18	Paved Parking Lot	1998		1,600	51	31.5	51		280
19	Vinyl Floor	1999		3,330	106	31.5	106		318
20	Sidewalk Concrete	2000		3,000	95	31.5	95		334
21	Automatic Doors	2000		2,253	72	31.5	72		180
22	Sidewalk Handrails	2000		2,706	86	31.5	86		215
23	Toilet Toppers	2000		852	27	31.5	27		68
24	Interior Handrails	2001		596	19	31.5	19		28
25	Vinyl Floor/Tile in Tub Room	2001		1,024	33	31.5	33		49
26	Install Interior Handrails	2002		910	14	31.5	14		14
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 467,766	\$ 14,142		\$ 14,142	\$	\$ 76,757	70

**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	\$ 63,089	\$ 4,531	\$ 4,531		5	\$ 58,802	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Admin allocation page 8 c9line	8,750	1,750	1,750		5	1,750	74
75	TOTALS	\$ 71,839	\$ 6,281	\$ 6,281			\$ 60,552	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	Patient Care	2003 Chrysler Voyager	2002	\$ 14,500	\$ 1,450	\$ 1,450		5	\$ 1,450	76
77										77
78										78
79										79
80	TOTALS			\$ 14,500	\$ 1,450	\$ 1,450			\$ 1,450	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)	\$ 579,220	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,873	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,873	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 138,759	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: None
 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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></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 <u>80</u></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		114		114
3	Classroom Wages (a)	440			440
4	Clinical Wages (b)	880			880
5	In-House Trainer Wages (c)	1,730			1,730
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 3,164	\$	\$	\$ 3,164
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,164			

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
2. From other facilities (f)	
TOTAL TRAINED	2

- (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	None	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 Ninth Street Place

0038505

Report Period Beginning: 7/1/02

Ending:

6/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/03

(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	\$ 88,155	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	188,083		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments	13,090		5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	3,560		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 292,888	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	25,115		13
14 Buildings, at Historical Cost	467,766		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	86,339		16
17 Accumulated Depreciation (book methods)	(138,759)		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):			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 440,461	\$	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 733,349	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 7,576	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	73,026		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 80,602	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	13,457		39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 13,457	\$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 94,059	\$	46
47 TOTAL EQUITY (page 18, line 24)	\$ 639,290	\$	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 733,349	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 580,549	1
2	Restatements (describe):		2
3	Reclassification of Fixed Assets	(4,279)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 576,270	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	63,020	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)	\$ 63,020	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)	\$ 639,290	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning: 7/1/02

Ending:

6/30/03

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	\$ 621,131	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 621,131	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	85	9
10	Other Government Grants	1,612	10
11	Nurses Aide Training Reimbursements	3,343	11
12	Gift and Coffee Shop	85	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,258	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	2,030	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,413	23
D. Non-Operating Revenue			
24	Contributions	5,437	24
25	Interest and Other Investment Income***	1,583	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,020	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)	\$ 636,564	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	80,129	31
32	Health Care	285,561	32
33	General Administration	150,293	33
B. Capital Expense			
34	Ownership	20,133	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	37,428	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 573,544	40
41	Income before Income Taxes (line 30 minus line 40)**	63,020	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 63,020	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

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

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning: 7/1/02

Ending:

6/30/03

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			\$	\$	1
2					2
3	624	733	10,745	14.66	3
4					4
5					5
6	310	344	3,050	8.87	6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14	1,792	1,861	20,487	11.01	14
15					15
16					16
17	926	975	7,895	8.10	17
18					18
19					19
20	889	936	18,973	20.27	20
21	1,973	2,077	30,700	14.78	21
22					22
23					23
24	455	527	4,547	8.63	24
25					25
26					26
27					27
28	1,040	1,195	16,300	13.64	28
29					29
30	22,706	24,068	240,200	9.98	30
31					31
32					32
33					33
34	30,715	32,716	\$ 352,897 *	\$ 10.79	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	35	\$ 1,165	L1c3	35
36	Annual	2,720	L9c3	36
37				37
38				38
39	Annual	120	L10c3	39
40	5	63	L10c3	40
41				41
42				42
43				43
44				44
45				45
46	5	135	L10c3	46
47				47
48				48
49	45	\$ 4,202		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$		53

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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line _____
- (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. \$ 37,428
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. \$ 3,468 Has any meal income been offset against related costs? No 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? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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? Yes
Firm Name: Crippen, Reid and Bowen L.L.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes 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.