

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER# 0043646 Report Period Beginning: 1/1/2003 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	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36135</u>	1
2	<u>0</u>	Skilled Pediatric (SNF/PED)	<u>0</u>	<u>0</u>	2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4	<u>0</u>	Intermediate/DD	<u>0</u>	<u>0</u>	4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6	<u>0</u>	ICF/DD 16 or Less	<u>0</u>	<u>0</u>	6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	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	<u>17924</u>	<u>5474</u>	<u>1164</u>	<u>24,562</u>	8
9	SNF/PED	<u>0</u>	<u>0</u>	<u>0</u>		9
10	ICF	<u>0</u>	<u>0</u>	<u>0</u>		10
11	ICF/DD	<u>0</u>	<u>0</u>	<u>0</u>		11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS	<u>0</u>	<u>0</u>	<u>0</u>		13
14	TOTALS	<u>17,924</u>	<u>5,474</u>	<u>1,164</u>	<u>24,562</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.97%D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - NoneF. Does the facility maintain a daily midnight census? YESG. 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 2/7/1998

J. Was the facility purchased or leased after January 1, 1978?

YES Date 2/7/1998 NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 8 and days of care provided 1,164Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCURAL 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 PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 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	133,321	6,700	5,640	145,661		145,661	1	145,662		1
2	Food Purchase		90,357		90,357		90,357	(535)	89,822		2
3	Housekeeping	64,842	9,801		74,643		74,643		74,643		3
4	Laundry	31,978	10,902		42,880		42,880	1	42,881		4
5	Heat and Other Utilities			69,669	69,669		69,669	(998)	68,671		5
6	Maintenance	26,360	6,331	23,530	56,221		56,221	1,724	57,945		6
7	Other (specify):* Waste Removal			3,487	3,487		3,487	4	3,491		7
8	TOTAL General Services	256,501	124,091	102,326	482,918		482,918	197	483,115		8
	B. Health Care and Programs										
9	Medical Director			1,750	1,750		1,750		1,750		9
10	Nursing and Medical Records	756,044	46,478	64,517	867,039		867,039		867,039		10
10a	Therapy		8,734	150,266	159,000		159,000		159,000		10a
11	Activities	35,417	1,153	3,056	39,626		39,626		39,626		11
12	Social Services	28,157		3,016	31,173		31,173		31,173		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	819,618	56,365	222,605	1,098,588		1,098,588		1,098,588		16
	C. General Administration										
17	Administrative			74,519	74,519		74,519	1,841	76,360		17
18	Directors Fees										18
19	Professional Services			20,494	20,494		20,494	54,358	74,852		19
20	Dues, Fees, Subscriptions & Promotions			7,931	7,931		7,931	482	8,413		20
21	Clerical & General Office Expenses	70,190	14,248	83,323	167,761		167,761	96,810	264,571		21
22	Employee Benefits & Payroll Taxes			170,308	170,308		170,308		170,308		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,151	8,151		8,151	10,261	18,412		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			72,140	72,140		72,140	218	72,358		26
27	Other (specify):*										27
28	TOTAL General Administration	70,190	14,248	436,866	521,304		521,304	163,970	685,274		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,146,309	194,704	761,797	2,102,810		2,102,810	164,167	2,266,977		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

PITTSFIELD HEALTH CARE CENTER

#0043646

Report Period Beginning:

1/1/2003

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			103,910	103,910		103,910	5,394	109,304			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			313,154	313,154		313,154	4,950	318,104			32
33	Real Estate Taxes			54,193	54,193		54,193	46	54,239			33
34	Rent-Facility & Grounds							2,931	2,931			34
35	Rent-Equipment & Vehicles			17,740	17,740		17,740	570	18,310			35
36	Other (specify):*											36
37	TOTAL Ownership			488,997	488,997		488,997	13,891	502,888			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,725	4,020	34,745		34,745		34,745			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,648	54,648		54,648		54,648			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		30,725	58,668	89,393		89,393		89,393			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,146,309	225,429	1,309,462	2,681,200		2,681,200	178,058	2,859,258			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 **PITTSFIELD HEALTH CARE CENTER**

0043646

Report Period Beginning: **1/1/2003**

Ending: **12/31/2003**

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	(237)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,223)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,216	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(242)	2		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	(45)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(90)	20		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 <u>Vending Revenue</u>	(897)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,482		\$	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)	176,576	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 176,576		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ 178,058		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			X		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

PITTSFIELD HEALTH CARE CENTER

ID# 0043646

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4	Non-Patient Meals	(237)	2 4
5	Telephone, TV & Radio in Resident Rooms	(1,223)	5 5
6			6
7			7
8			8
9	Non-Straightline Depreciation	4,216	30 9
10			10
11			11
12			12
13	Sales Tax	(242)	2 13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22	Special Legal Fees & Legal Retainers	(45)	19 22
23			23
24			24
25	Fund Raising, Advertising and Promotional	(90)	20 25
26			26
27			27
28			28
29			29
30			30
31			31
32	Vending revenue	(897)	21 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	1,482	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **PITTSFIELD HEALTH CARE CENTER**# **0043646** Report Period Beginning:

1/1/2003

Ending:

12/31/2003

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	1	0	0	0	0	0	0	0	0	0	1	1
2	Food Purchase	(479)	(56)	0	0	0	0	0	0	0	0	0	(535)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	(1,223)	225	0	0	0	0	0	0	0	0	0	(998)	5
6	Maintenance	0	1,724	0	0	0	0	0	0	0	0	0	1,724	6
7	Other (specify):*	0	4	0	0	0	0	0	0	0	0	0	4	7
8	TOTAL General Services	(1,702)	1,899	0	0	0	0	0	0	0	0	0	197	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	1,841	0	0	0	0	0	0	0	0	0	1,841	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(45)	54,403	0	0	0	0	0	0	0	0	0	54,358	19
20	Fees, Subscriptions & Promotions	(90)	572	0	0	0	0	0	0	0	0	0	482	20
21	Clerical & General Office Expenses	(897)	97,707	0	0	0	0	0	0	0	0	0	96,810	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	0	0	10,261	0	0	0	0	0	0	0	0	10,261	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	218	0	0	0	0	0	0	0	0	218	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,032)	154,523	10,479	0	163,970	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,734)	156,422	10,479	0	164,167	29							

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

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 Organizational Structure Description						

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	1 Dietary	\$	Senior Living Properties, LLC	100%	\$ 1	1
2	V	2 Food Purchase		Senior Living Properties, LLC	100%	(56)	(56) 2
3	V	3 Housekeeping		Senior Living Properties, LLC	100%	0	3
4	V	4 Laundry		Senior Living Properties, LLC	100%	1	1 4
5	V	5 Heat and Other Utilities		Senior Living Properties, LLC	100%	225	225 5
6	V	6 Maintenance		Senior Living Properties, LLC	100%	1,724	1,724 6
7	V	7 Waste Removal		Senior Living Properties, LLC	100%	4	4 7
8	V	10 Nursing & Medical Records		Senior Living Properties, LLC	100%	0	8
9	V	10a Therapy		Senior Living Properties, LLC	100%	0	9
10	V	17 Administrative		Senior Living Properties, LLC	100%	1,841	1,841 10
11	V	19 Professional Services		Senior Living Properties, LLC	100%	54,403	54,403 11
12	V	20 Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100%	572	572 12
13	V	21 Clerical & General Office Expenses		Senior Living Properties, LLC	100%	97,707	97,707 13
14	Total		\$			\$ 156,422	\$ * 156,422 14

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER

0043646

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

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	22 Employee Benefits & Payroll Taxes	\$	Senior Living Properties, LLC	100.00%	\$ 0	\$
16	V	24 Travel and Seminar		Senior Living Properties, LLC	100.00%	10,261	10,261
17	V	26 Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	218	218
18	V	30 Depreciation		Senior Living Properties, LLC	100.00%	1,178	1,178
19	V	32 Interest		Senior Living Properties, LLC	100.00%	4,950	4,950
20	V	33 Real Estate Taxes		Senior Living Properties, LLC	100.00%	46	46
21	V	34 Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	2,931	2,931
22	V	35 Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	570	570
23	V	36 Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	0	
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		\$			\$ 20,154	\$ * 20,154

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER

0043646

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER

0043646

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER

0043646

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER

0043646

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER

0043646

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER

0043646

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER

0043646

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER

0043646

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 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	N/A								\$	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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Senior Living Properties, LLC
 Street Address 12900 N. Meridian Street, Suite 180
 City / State / Zip Code Carmel, Indiana 46032
 Phone Number (317) 566-1586
 Fax Number (317) 581-9513

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	See attachment	See attachment	\$ 16	\$	See attachment	\$ 1	1
2	2	Food Purchase	See attachment	See attachment	(3,006)		See attachment	(56)	2
3	3	Housekeeping	See attachment	See attachment	0		See attachment	0	3
4	4	Laundry	See attachment	See attachment	77		See attachment	1	4
5	5	Heat and Other Utilities	See attachment	See attachment	12,972		See attachment	225	5
6	6	Maintenance	See attachment	See attachment	110,754		See attachment	1,724	6
7	7	Waste Removal	See attachment	See attachment	209		See attachment	4	7
8	10	Nursing & Medical Records	See attachment	See attachment	0		See attachment	0	8
9	10a	Therapy	See attachment	See attachment	0		See attachment	0	9
10	17	Administrative	See attachment	See attachment	99,532		See attachment	1,841	10
11	19	Professional Services	See attachment	See attachment	2,548,930		See attachment	54,403	11
12	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	47,181		See attachment	572	12
13	21	Clerical & General Office Expens	See attachment	See attachment	7,140,654		See attachment	97,707	13
14	22	Employee Benefits & Payroll Tax	See attachment	See attachment	359		See attachment	0	14
15	24	Travel and Seminar	See attachment	See attachment	1,289,367		See attachment	10,261	15
16	26	Insurance - Prop Liab Malpractic	See attachment	See attachment	11,789		See attachment	218	16
17	30	Depreciation	See attachment	See attachment	63,665		See attachment	1,178	17
18	32	Interest	See attachment	See attachment	212,923		See attachment	4,950	18
19	33	Real Estate Taxes	See attachment	See attachment	2,499		See attachment	46	19
20	34	Rent-Facility & Grounds	See attachment	See attachment	158,445		See attachment	2,931	20
21	35	Rent-Equipment & Vehicles	See attachment	See attachment	30,791		See attachment	570	21
22	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	0		See attachment	0	22
23									23
24									24
25	TOTALS				\$ 11,727,157	\$		\$ 176,576	25

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER # 0043646 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number **PITTSFIELD HEALTH CARE CENTER** # **0043646** Report Period Beginning: **1/1/2003** 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	2		3	4	5	6		7	8	9	10
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required				
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	GMAC Comm Mort Corp		X	Acquisition	\$ 32,620	2/6/1998	\$ 4,652,436	\$	2/1/2008	0.0681	\$ 313,154	1
2	Complete Care Services		X	Acquisition	\$ 1,201	2/6/1998	205,860		2/6/2008	N/A - None	N/A - None	2
3	Manager Note		X	Acquisition	\$ 1,201	2/6/1998	205,860		2/6/2008	N/A - None	N/A - None	3
4	Related Organization		X	Allocated - Schedule VII B							4,950	4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital	None	2/6/1998	Various		Demand	Prime + 2%		6
7												7
8												8
9	TOTAL Facility Related				\$35,022.00		\$ 5,064,156	\$			\$ 318,104	9
	B. Non-Facility Related*											
10	Nonallowable interest		X	See Schedule VI								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 5,064,156	\$			\$ 318,104	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 **PITTSFIELD HEALTH CARE CENTER**# **0043646** Report Period Beginning: **1/1/2003** Ending: **12/31/2003****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.			\$	50,230	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.)			\$	2,642	2																			
3.	Under or (over) accrual (line 2 minus line 1).			\$	(47,588)	3																			
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	101,781	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.			\$	54,193	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		1998	46,969	8	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2002	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		1999	48,545	9																					
		2000	(2,162)	10																					
		2001	52,872	11																					
		2002	56,531	12																					

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 PITTSFIELD HEALTH CARE CENTER COUNTY PIKE

FACILITY IDPH LICENSE NUMBER 0043646

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 566-1586 FAX #: (317) 581-9513

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>53-033-05</u>	<u>See Attached</u>	\$ <u>56,531.18</u>	\$ <u>56,531.18</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>56,531.18</u>	\$ <u>56,531.18</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PITTSFIELD HEALTH CARE CENTER COUNTY PIKE

FACILITY IDPH LICENSE NUMBER 0043646

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 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,894 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	242,194	1998	\$ 137,500	1
2					2
3	TOTALS	242,194		\$ 137,500	3

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	99	1998	1970	\$ 2,020,231	\$ 67,341	30	\$ 67,341	\$	\$ 398,434
5									
6									
7									
8									
Improvement Type**									
9	carpet	1998		764	127	5	127		764
10	replace sink	1998		5,913	296	20	296		1,503
11	signage	1998		464	46	10	46		259
12	seal, coat, patch parking lot	1998		6,338	792	8	792		4,094
13	replacement doors	1999		6,619	441	15	441		2,207
14	steel door	1999		566	38	15	38		188
15	carpet install	1999		2,000	400	5	400		2,000
16	generator	1999		1,031	52	20	52		250
17	met / glass door	1999		1,779	89	20	89		430
18	repairs to nurse call system	1999		817	82	10	82		388
19	install a/c	1998		1,746	175	10	175		931
20	install a/c unit	1998		5,200	520	10	520		2,687
21	boiler repair	1999		1,100	55	20	55		229
22	shower tile	1999		680	34	20	34		142
23	compressors (2)	1999		1,732	115	15	115		471
24	a/c unit / airhandler	2000		6,980	465	15	465		1,551
25	floor and piping repairs	2000		2,089	209	10	209		679
26	repair steam pipe	2002		787	31	25	31		58
27	10 gal. commercial water heater	2002		1,860	186	10	186		357
28									
29	roof repair & insulation replace	2001		12,881	1,840	7	1,840		3,680
30	roof	2001		80,692	3,228	25	3,228		6,455
31	carpet	2001		1,115	223	5	223		446
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

Facility Name & ID Number PITTSFIELD HEALTH CARE CENTER

0043646

Report Period Beginning:

1/1/2003

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	Locking door system	2003	\$ 8262	\$ 207	10	\$ 207	\$	\$ 207	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	(DON'T ENTER BELOW THIS LINE)								
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410		34

**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 12B, Carried Forward		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410		34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,171,646	\$ 76,992		\$ 76,992	\$	\$ 428,410	34

**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	\$ 223,812	\$ 26,918	\$ 31,134	\$ 4,216	Various	\$ 182,535	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 223,812	\$ 26,918	\$ 31,134	\$ 4,216		\$ 182,535	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,532,958	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 103,910	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 108,126	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,216	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 610,945	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: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
 If NO, see instructions.

		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:	<u>N/A</u>			\$			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: N/A *

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 18,310 Description: Central Supply 12,540, Dietary 588, Activity 21, Plant 208, Admin 4,383, Home Office 570
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a, 3	hrs	\$	1,763	\$ 64,456	\$ 8,734	1,763	\$ 73,190	1				
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		144	9,656	0	144	9,656	2				
3	Licensed Recreational Therapist		hrs		0	0	0			3				
4	Licensed Physical Therapist	10a, 3	hrs		1,724	69,093	0	1,724	69,093	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			\$	3,631	\$ 143,205	\$ 8,734	3,631	\$ 151,939	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 **PITTSFIELD HEALTH CARE CENTER**

STATE OF ILLINOIS

0043646

Report Period Beginning: **1/1/2003**

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	\$ 49,838	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	308,193		3
4	Supply Inventory (priced at)	4,847		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 362,878	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	137,500		13
14	Buildings, at Historical Cost	2,169,601		14
15	Leasehold Improvements, at Historical Cost	6,802		15
16	Equipment, at Historical Cost	219,055		16
17	Accumulated Depreciation (book methods)	(610,945)		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 (spe			22
23	Other(specify): Intercompany Rec / (Pay)	(3,676,925)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ (1,754,912)	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,392,034)	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,754		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,738		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,781		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Other accrued expenses	401		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 197,674	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 197,674	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,589,708)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,392,034)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,147,380)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,147,380)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(442,328)	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)	\$ (442,328)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,589,708)	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	\$ 3,097,755	1
2	Discounts and Allowances for all Levels	(1,289,652)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,808,103	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	272,916	6
7	Oxygen	31,344	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 304,260	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	559	13
14	Non-Patient Meals	237	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,296	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,546	19
20	Radiology and X-Ray	1,532	20
21	Other Medical Services	56,442	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 125,612	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)		26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	897	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 897	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,238,872	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	482,918	31
32	Health Care	1,098,588	32
33	General Administration	521,304	33
B. Capital Expense			
34	Ownership	488,997	34
C. Ancillary Expense			
35	Special Cost Centers	34,745	35
36	Provider Participation Fee	54,648	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,681,200	40
41	Income before Income Taxes (line 30 minus line 40)**	(442,328)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (442,328)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 **PITTSFIELD HEALTH CARE CENTER**

0043646

Report Period Beginning: 1/1/2003

Ending:

12/31/2003

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,698	1,770	\$ 23,693	\$ 13.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,512	5,867	93,668	15.97	3
4	Licensed Practical Nurses	13,264	14,581	182,160	12.49	4
5	Nurse Aides & Orderlies	45,474	48,866	447,823	9.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,906	2,066	19,692	9.53	9
10	Activity Assistants	2,015	2,191	15,725	7.18	10
11	Social Service Workers	2,708	2,973	28,157	9.47	11
12	Dietician	1,960	2,080	23,730	11.41	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,755	14,701	109,591	7.45	15
16	Dishwashers					16
17	Maintenance Workers	2,032	2,206	26,360	11.95	17
18	Housekeepers	8,442	8,982	64,842	7.22	18
19	Laundry	3,815	4,077	31,978	7.84	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,081	5,708	70,190	12.30	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	848	893	8,700	9.74	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Beautician</u>					33
34	TOTAL (lines 1 - 33)	108,510	116,961	\$ 1,146,309 *	\$ 9.80	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	141	\$ 5,640	1, 3	35
36	Medical Director	96	1,750	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	144	340	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	3,056	11, 3	44
45	Social Service Consultant	48	3,016	12, 3	45
46	Other(specify) <u>Administrator Consultant</u>	2,080	72,780	17, 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,557	\$ 86,582		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,080	\$ 51,978	10, 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,080	\$ 51,978		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,647 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES No 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54648
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 237
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.