

Facility Name & ID Number Somerset Place

0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	450	Intermediate (ICF)	450	164,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	450	TOTALS	450	164,250	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	150,265	793		151,058	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	150,265	793		151,058	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.97%

D. How many bed-hold days during this year were paid by Public Aid? 4,247 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
 Date started 02/01/99

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 02/01/99 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 _____

IV. ACCOUNTING BASIS
 ACCRUAL MODIFIED CASH* CASH*

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

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

STATE OF ILLINOIS

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	429,449	147,736	41,271	618,456		618,456	(11,751)	606,705		1
2	Food Purchase		359,541		359,541		359,541	(252)	359,289		2
3	Housekeeping	303,008	81,190		384,198		384,198	(7,410)	376,788		3
4	Laundry	17,699	4,643	93,951	116,293		116,293		116,293		4
5	Heat and Other Utilities			335,993	335,993		335,993	3,957	339,950		5
6	Maintenance	292,003		127,942	419,945		419,945	13,137	433,082		6
7	Other (specify):*							2,919	2,919		7
8	TOTAL General Services	1,042,159	593,110	599,157	2,234,426		2,234,426	600	2,235,026		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,529,410	78,153	59,720	2,667,283		2,667,283	19,914	2,687,197		10
10a	Therapy	23,863		5,654	29,517		29,517	1,339	30,856		10a
11	Activities	226,934	15,640	1,263	243,837		243,837	72	243,909		11
12	Social Services	762,057	2,701	2,310	767,068		767,068	399	767,467		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							3,917	3,917		15
16	TOTAL Health Care and Programs	3,542,264	96,494	80,947	3,719,705		3,719,705	25,641	3,745,346		16
	C. General Administration										
17	Administrative	436,358		312,000	748,358		748,358	28,848	777,206		17
18	Directors Fees										18
19	Professional Services			650,363	650,363	(3,500)	646,863	(576,775)	70,088		19
20	Dues, Fees, Subscriptions & Promotions			91,308	91,308		91,308	(53,123)	38,185		20
21	Clerical & General Office Expenses	154,373	24,043	170,137	348,553		348,553	246,580	595,133		21
22	Employee Benefits & Payroll Taxes			775,381	775,381		775,381	(6,388)	768,993		22
23	Inservice Training & Education			428	428		428		428		23
24	Travel and Seminar			3,213	3,213		3,213	1,903	5,116		24
25	Other Admin. Staff Transportation			15,653	15,653		15,653	(10,140)	5,513		25
26	Insurance-Prop.Liab.Malpractice			252,992	252,992		252,992	18,272	271,264		26
27	Other (specify):*							42,926	42,926		27
28	TOTAL General Administration	590,731	24,043	2,271,475	2,886,249	(3,500)	2,882,749	(307,897)	2,574,852		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,175,154	713,647	2,951,579	8,840,380	(3,500)	8,836,880	(281,655)	8,555,225		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

#0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			133,725	133,725		133,725	517,330	651,055			30
31	Amortization of Pre-Op. & Org.			1,319	1,319		1,319	(0)	1,319			31
32	Interest			7,268	7,268		7,268	1,805,223	1,812,491			32
33	Real Estate Taxes			602,858	602,858	3,500	606,358	5,878	612,236			33
34	Rent-Facility & Grounds			2,507,142	2,507,142		2,507,142	(2,497,412)	9,730			34
35	Rent-Equipment & Vehicles			13,679	13,679		13,679	4,603	18,282			35
36	Other (specify):*							165,939	165,939			36
37	TOTAL Ownership			3,265,991	3,265,991	3,500	3,269,491	1,561	3,271,052			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							4	4			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			247,050	247,050		247,050	(675)	246,375			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			247,050	247,050		247,050	(671)	246,379			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,175,154	713,647	6,464,620	12,353,421		12,353,421	(280,766)	12,072,655			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(107,862)	30		9
10	Interest and Other Investment Income	(272,977)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(19)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(72,000)	21		24
25	Fund Raising, Advertising and Promotional	(8,432)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(937)	20		28
29	Other-Attach Schedule	(264,598)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (726,825)		\$	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)	446,059		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 446,059		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (280,766)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Somerset Place

ID# 0044289

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Jury Duty	21
2	Collection Expense	21
3	Bank Charges	21
4	Theft Loss	21
5	Illinois Replacement Tax	21
6	Il. Council on LTC - COPE Dues	20
7	Audit Fee (Building Co)	21
8	Trial Fees (Building Co)	21
9	Miscellaneous Income	21
10	Amortization (Building Co)	31
11	Provider Participation Fee	42
12		12
13		13
14		14
15		15
16		16
17		17
18		18
19		19
20		20
21		21
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98		98
99		99
100		100
101	Total	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			131		(7,787)			(4,095)				(11,751)	1
2	Food Purchase	(19)		(233)									(252)	2
3	Housekeeping					2,480			(9,890)				(7,410)	3
4	Laundry													4
5	Heat and Other Utilities			3,957									3,957	5
6	Maintenance			4,130	9	9,080			(82)				13,137	6
7	Other (specify):*				414	2,505							2,919	7
8	TOTAL General Services	(19)		7,985	423	6,278			(14,067)				600	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			523		28,675			(9,284)				19,914	10
10a	Therapy					1,339							1,339	10a
11	Activities			72									72	11
12	Social Services					399							399	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				216	3,701							3,917	15
16	TOTAL Health Care and Programs			595	216	34,114			(9,284)				25,641	16
	C. General Administration													
17	Administrative					28,848							28,848	17
18	Directors Fees													18
19	Professional Services			(576,775)									(576,775)	19
20	Fees, Subscriptions & Promotions	(15,092)		(38,031)									(53,123)	20
21	Clerical & General Office Expenses	(89,145)	5,515	44,008		286,202							246,580	21
22	Employee Benefits & Payroll Taxes				(5,456)			(932)					(6,388)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,903									1,903	24
25	Other Admin. Staff Transportation			(10,140)									(10,140)	25
26	Insurance-Prop.Liab.Malpractice		15,000	3,272									18,272	26
27	Other (specify):*				3,998	38,928							42,926	27
28	TOTAL General Administration	(104,237)	20,515	(575,763)	(1,458)	353,978		(932)					(307,897)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(104,256)	20,515	(567,183)	(819)	394,370		(932)	(23,350)				(281,655)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Somerset Place# 0044289 Report Period Beginning:01/01/03 Ending: 12/31/03

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(107,862)	604,120	21,072									517,330	30
31	Amortization of Pre-Op. & Org.	(241,055)	241,055										(0)	31
32	Interest	(272,977)	2,036,729	41,471									1,805,223	32
33	Real Estate Taxes			5,878									5,878	33
34	Rent-Facility & Grounds		(2,507,142)	9,730									(2,497,412)	34
35	Rent-Equipment & Vehicles			4,603									4,603	35
36	Other (specify):*		165,939										165,939	36
37	TOTAL Ownership	(621,894)	540,701	82,754									1,561	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								4				4	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(675)											(675)	42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(675)							4				(671)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(726,825)	561,216	(484,429)	(819)	394,370		(932)	(23,347)				(280,766)	45

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

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

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

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

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

1	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	34 Rental Income	\$ 2,507,142	Somerset Real Estate LLC	100.00%	\$	\$ (2,507,142)
2	V	32 Interest Income	7,561	Somerset Real Estate LLC	100.00%		(7,561)
3	V	21 Audit Fee		Somerset Real Estate LLC	100.00%	5,315	5,315
4	V	21 Trust Fees		Somerset Real Estate LLC	100.00%	200	200
5	V	30 Depreciation Expense		Somerset Real Estate LLC	100.00%	604,120	604,120
6	V	31 Amortization Expense		Somerset Real Estate LLC	100.00%	241,055	241,055
7	V	36 Mortgage Insurance		Somerset Real Estate LLC	100.00%	165,939	165,939
8	V	26 Insurance		Somerset Real Estate LLC	100.00%	15,000	15,000
9	V	32 Interest Paid HUD Loan		Somerset Real Estate LLC	100.00%	2,044,290	2,044,290
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 2,514,703			\$ 3,075,919	\$ * 561,216

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 131	\$ 131
16	V	05 Utilities		Care Centers, Inc.	100.00%	3,957	3,957
17	V	06 Maintenance		Care Centers, Inc.	100.00%	4,130	4,130
18	V	10 Nursing	78	Care Centers, Inc.	100.00%	601	523
19	V	11 Activities		Care Centers, Inc.	100.00%	72	72
20	V	19 Professional Fees	596,878	Care Centers, Inc.	100.00%	20,103	(576,775)
21	V	20 Dues and Subscriptions	41,063	Care Centers, Inc.	100.00%	3,032	(38,031)
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	44,008	44,008
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	1,903	1,903
24	V	26 Insurance		Care Centers, Inc.	100.00%	3,272	3,272
25	V	30 Depreciation		Care Centers, Inc.	100.00%	21,072	21,072
26	V	32 Interest		Care Centers, Inc.	100.00%	41,471	41,471
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	5,878	5,878
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	9,730	9,730
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	4,603	4,603
30	V	25 Bus Reimbursement	10,140	Care Centers, Inc.	100.00%		(10,140)
31	V	02 Food	233	Care Centers, Inc.	100.00%		(233)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 648,392			\$ 163,963	\$ * (484,429)

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Maintenance Salary	\$ 3,276	Care Centers, Inc.	100.00%	\$ 3,285	\$ 9
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	414	414
17	V	10 Nursing Salary		Care Centers, Inc.	100.00%		
18	V	10a Rehab Salary		Care Centers, Inc.	100.00%		
19	V	11 Activity Salary	1,179	Care Centers, Inc.	100.00%	1,179	
20	V	12 Social Service Salary	386	Care Centers, Inc.	100.00%	386	
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	216	216
22	V	17 Administration Salary		Care Centers, Inc.	100.00%		
23	V	21 Office Salary	31,530	Care Centers, Inc.	100.00%	31,530	
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	3,998	3,998
25	V	22 Employee Benefits	5,456	Care Centers, Inc.	100.00%		(5,456)
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		\$ 41,827			\$ 41,008	\$ * (819)

* 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	01 Dietary Salary	\$ 16,425	Care Centers, Inc.	100.00%	\$ 8,638	\$ (7,787)
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%	2,480	2,480
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	9,080	9,080
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	2,505	2,505
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	28,675	28,675
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%	1,339	1,339
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	399	399
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	3,701	3,701
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	28,848	28,848
24	V	21 Office Salary		Care Centers, Inc.	100.00%	286,202	286,202
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	38,928	38,928
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		\$ 16,425			\$ 410,795	\$ * 394,370

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 220,942	\$ 220,942	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	221,874	CCS EMPLOYEE BENEFIT GROUP	100.00%		(221,874)	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		\$ 221,874			\$ 220,942	\$ * (932)	39

* 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	01 DIETARY	\$ 31,109	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 27,014	\$ (4,095)
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%		
17	V	03 HOUSEKEEPING	75,140	XCEL MEDICAL SUPPLY, LLC	100.00%	65,249	(9,890)
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%		
19	V	06 REPAIRS & MAINTENANCE	620	XCEL MEDICAL SUPPLY, LLC	100.00%	538	(82)
20	V	10 NURSING	70,530	XCEL MEDICAL SUPPLY, LLC	100.00%	61,247	(9,284)
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%		
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%		
25	V	39 ANCILLARY	(29)	XCEL MEDICAL SUPPLY, LLC	100.00%	(25)	4
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		\$ 177,369			\$ 154,023	\$ * (23,347)

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0%	See Attached	3.21	5.84%	Sal/Mgmt Fee	\$ 600,000	17-1,17-3	1
2	Adam Vales	Owner	Clerical	0.17%	See Attached	1.14	2.85%	Salary Alloc	884	22-7	2
3	Mark Steinberg	Relative	Administrative	0%	See Attached	3.50	6.93%	Salary Alloc	4,003	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 604,887		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01 Dietary	Patient Days	1,764,895	42	\$ 1,527	\$	151,058	\$ 131	1
2	05 Utilities	Patient Days	1,764,895	42	46,229		151,058	3,957	2
3	06 Maintenance	Patient Days	1,764,895	42	48,251		151,058	4,130	3
4	10 Nursing	Patient Days	1,764,895	42	7,018		151,058	601	4
5	11 Activities	Patient Days	1,764,895	42	838		151,058	72	5
6	19 Professional Fees	Patient Days	1,764,895	42	309,074		151,058	20,103	6
7	20 Dues and Subscriptions	Patient Days	1,764,895	42	35,428		151,058	3,032	7
8	21 Office & Clerical	Patient Days	1,764,895	42	523,091		151,058	44,008	8
9	24 Travel and Seminar	Patient Days	1,764,895	42	22,233		151,058	1,903	9
10	26 Insurance	Patient Days	1,764,895	42	38,230		151,058	3,272	10
11	30 Depreciation	Patient Days	1,764,895	42	246,194		151,058	21,072	11
12	32 Interest	Patient Days	1,764,895	42	484,531		151,058	41,471	12
13	33 Real Estate Taxes	Patient Days	1,764,895	42	68,681		151,058	5,878	13
14	34 Rent - Building	Patient Days	1,764,895	42	113,677		151,058	9,730	14
15	35 Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		151,058	4,603	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,998,780	\$		\$ 163,963	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	06	Maintenance Salary	Direct Cost		213,393	213,393		3,285	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost		26,918			414	2
3	10	Nursing Salary	Direct Cost		976,718	976,718			3
4	10a	Rehab Salary	Direct Cost		103,898	103,898			4
5	11	Activity Salary	Direct Cost		10,902	10,902		1,179	5
6	12	Social Service Salary	Direct Cost		306,863	306,863		386	6
7	15	Emp. Ben. - Healthcare	Direct Cost		174,348			216	7
8	17	Administration Salary	Direct Cost		1,191,200	1,191,200			8
9	21	Office Salary	Direct Cost		698,886	698,886		31,530	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost		238,998			3,998	10
11	22	Employee Benefits							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				\$ 3,942,124	\$ 3,501,860		\$ 41,008	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01 Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	151,058	8,638	1
2	03 Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	151,058	2,480	2
3	06 Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	151,058	9,080	3
4	07 Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		151,058	2,505	4
5	10 Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	151,058	28,675	5
6	10a Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	151,058	1,339	6
7	12 Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	151,058	399	7
8	15 Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		151,058	3,701	8
9	17 Administration Salary	Patient Days	1,764,895	42	337,043	337,043	151,058	28,848	9
10	21 Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	151,058	286,202	10
11	27 Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		151,058	38,928	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				\$ 4,799,547	\$ 4,272,235		\$ 410,795	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289 Report Period Beginning: 01/01/03

Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,073,579	138,556				1
2	02	Food	Billable Income	2,073,579	852,614				2
3	06	Maintenance	Billable Income	2,073,579	1,311				3
4	17	Administration	Billable Income	2,073,579	25,000				4
5	19	Professional Fees	Billable Income	2,073,579	8,170				5
6	20	Dues & Subscriptions	Billable Income	2,073,579	2,312				6
7	21	Office & Clerical	Billable Income	2,073,579	53,285				7
8	24	Travel & Seminar	Billable Income	2,073,579	68,680				8
9	32	Interest Expense	Billable Income	2,073,579	571				9
10	35	Rent - Equipment & Auto	Billable Income	2,073,579	13,336				10
11	39	Ancillary Enteral Supplies	Billable Income	2,073,579	114,955				11
12	01	Dietary - Salary	Billable Income	2,073,579	268,554	268,554			12
13	07	Emp. Ben. - Gen. Serv.	Billable Income	2,073,579	34,942				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				\$ 1,582,287	\$ 268,554		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 220,942	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				\$	\$		\$ 220,942	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization XCEL MEDICAL SUPPLY, LLC
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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	01	DIETARY	Direct Allocation		\$	\$		\$ 27,014	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation					65,249	3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation					538	5
6	10	NURSING	Direct Allocation					61,247	6
7	10A	THERAPY	Direct Allocation						7
8	12	SOCIAL SERVICE	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	39	ANCILLARY	Direct Allocation					(25)	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				\$	\$		\$ 154,023	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289 Report Period Beginning: 01/01/03

Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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		HUD Loan/Building Co		X	Mortgage			\$	\$ 28,687,262			\$	2,044,303	1					
2														2					
3														3					
4														4					
5		See Supplemental Schedule												5					
		Working Capital																	
6		Daiwa Loan		X									7,255	6					
7		Care Center Allocation		X									41,471	7					
8		See Supplemental Schedule												8					
9		TOTAL Facility Related					\$	\$ 28,687,262			\$	2,093,029	9						
		B. Non-Facility Related*																	
10														10					
11														11					
12														12					
13		See Supplemental Schedule											(280,538)	13					
14		TOTAL Non-Facility Related					\$	\$			\$	(280,538)	14						
15		TOTALS (line 9+line14)					\$	\$ 28,687,262			\$	1,812,491	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 165,939 Line # 36

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15	Interest Income						\$	\$			\$	(272,977) 15							
16	Interest Income (Bldg Co)											(7,561) 16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											(280,538) 20							

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

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

Facility Name & ID Number **Somerset Place**# **0044289** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2002 report.			\$	587,799	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.)			\$	586,686	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(1,113)	3
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	609,849	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.)			\$	3,500	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.			\$	612,236	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1998	572,691	8	FOR OHF USE ONLY	
		1999	568,847	9		
		2000	559,809	10	13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
		2001	574,368	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2002	580,808	12	15	LESS REFUND FROM LINE 6 \$ 15
2003 Accrual - \$580,808*1.03=\$609,848					16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Care Center Allocation - \$5,878						
Urban Real Estate - Appraisal Fee - \$3,500.00						

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

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

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

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

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

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Somerset Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044289

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-08-408-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>573,601.01</u>	\$ <u>573,601.01</u>
2. <u>14-08-408-031-0000</u>	<u>Long Term Care Property</u>	\$ <u>7,207.14</u>	\$ <u>7,207.14</u>
3. <u>Care Center Allocation</u>	<u>Home Office Allocation</u>	\$ <u>68,681.49</u>	\$ <u>1,674.37</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>649,489.64</u>	\$ <u>582,482.52</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

IMPORTANT NOTICE

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

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

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

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

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Somerset Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044289

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Somerset Place# 0044289 Report Period Beginning:01/01/03 Ending:12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 184,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 9C. 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: 1,319 2. Number of Years Over Which it is Being Amortized: _____3. Current Period Amortization: 1,319 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		1999	\$ 1,100,000	1
2	2201 Main LLC			43,514	2
3	TOTALS			\$ 1,143,514	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1999		37,488		20	1,876	1,876	8,719	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		15,206,639	282,691		312,893	30,202	1,349,558	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		164,594	5,503		5,503		5,859	68
69	Financial Statement Depreciation			133,725			(133,725)		69
70	TOTAL (lines 4 thru 69)	\$	15,408,721	\$ 421,919		\$ 320,272	\$ (101,647)	\$ 1,364,136	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 15,408,721	\$ 421,919		\$ 320,272	\$ (101,647)	\$ 1,364,136	1
2	Loose Sill Removal	2000	74,460		20	3,723	3,723	14,892	2
3	Sinks	2000	3,398		20	170	170	666	3
4	Exit Control Lock	2000	1,647		20	82	82	322	4
5	Generator	2000	1,414		20	71	71	277	5
6	Phone System Install	2000	26,841		20	1,342	1,342	5,256	6
7	Hot Water Heater Rep	2000	9,500		20	475	475	1,821	7
8	Paint	2000	1,939		20	97	97	372	8
9	Blinds	2000	6,223		20	311	311	1,192	9
10	Carpet Installation	2000	750		20	38	38	142	10
11	Gas Pump Repair	2000	1,235		20	62	62	233	11
12	Electric Wiring	2000	1,143		20	57	57	214	12
13	Paint	2000	3,809		20	190	190	698	13
14	Window Treatments	2000	6,562		20	328	328	1,203	14
15	Tiles	2000	2,377		20	119	119	436	15
16	Renovation Of 117 Ba	2000	22,815		20	1,141	1,141	4,184	16
17	Roof Leak Repair	2000	1,247		20	62	62	228	17
18	New Boiler	2000	784		20	39	39	143	18
19	Plumbing Work	2000	5,550		20	278	278	1,018	19
20	Exhaust System Repai	2000	66,798		20	3,340	3,340	12,247	20
21	Boiler Repair	2000	601		20	30	30	110	21
22	New Carpeting	2000	3,400		20	170	170	623	22
23	Paint	2000	559		20	28	28	100	23
24	Paint	2000	217		20	11	11	39	24
25	Paint	2000	564		20	28	28	100	25
26	Facade Project	2000	9,451		20	473	473	1,694	26
27	12 Knob Sets	2000	919		20	46	46	165	27
28	Sneeze Guard	2000	7,631		20	382	382	1,368	28
29	Fire Alarm System Re	2000	1,100		20	55	55	197	29
30	Exhaust Motor Repair	2000	3,730		20	187	187	669	30
31	Plumbing Repair	2000	9,974		20	499	499	1,787	31
32	Drywall	2000	502		20	25	25	90	32
33	Landscaping	2000	46,025		20	2,301	2,301	8,246	33
34	TOTAL (lines 1 thru 33)		\$ 15,731,886	\$ 421,919		\$ 336,432	\$ (85,487)	\$ 1,424,868	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 15,731,886	\$ 421,919		\$ 336,432	\$ (85,487)	\$ 1,424,868		1
2	Awning Frames & Fixt	2000 10,000		20	500	500	1,792		2
3	Tiles Installation	2000 10,558		20	528	528	1,892		3
4	New Carpeting	2000 10,000		20	500	500	1,792		4
5	Sewer Repair	2000 653		20	33	33	117		5
6	Light Fixtures	2000 1,642		20	82	82	294		6
7	Replace Thermostat	2000 1,719		20	86	86	308		7
8	Paint	2000 1,873		20	94	94	328		8
9	Aviary	2000 7,966		20	398	398	1,394		9
10	New Boiler Drain	2000 598		20	30	30	105		10
11	Light Fixtures,Lamps	2000 76,263		20	3,813	3,813	13,346		11
12	Drywall	2000 717		20	36	36	126		12
13	Electrical Supplies	2000 622		20	31	31	109		13
14	Life Safety Code Rev	2000 1,239		20	62	62	217		14
15	Fire Doors	2000 1,864		20	93	93	326		15
16	New Frame	2000 3,500		20	175	175	613		16
17	Painting Off All Res	2000 13,000		20	650	650	2,275		17
18	Elevator Repair \$2610	2000 1,305		20	65	65	223		18
19	Paint	2000 677		20	34	34	116		19
20	Paint	2000 683		20	34	34	116		20
21	Nurse Call Station	2000 807		20	40	40	138		21
22	Tiles	2000 598		20	30	30	103		22
23	Ac Repair	2000 652		20	33	33	112		23
24	Ac Repair	2000 1,729		20	86	86	295		24
25	Electric Wiring	2000 1,500		20	75	75	256		25
26	Hopkins Elevator	2000 1,301		20	65	65	217		26
27	Hi-Grade	2000 519		20	26	26	87		27
28	Sewer Repair	2000 760		20	38	38	127		28
29	Drywall	2000 1,483		20	74	74	247		29
30	Electrical Wiring	2000 900		20	45	45	150		30
31	Fire Alarm Panel Rep	2000 595		20	30	30	100		31
32	Fire Alarm Panel Rep	2000 505		20	25	25	84		32
33	Stove Repair	2000 2,899		20	145	145	471		33
34	TOTAL (lines 1 thru 33)	\$ 15,891,013	\$ 421,919		\$ 344,388	\$ (77,531)	\$ 1,452,744		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 15,891,013	\$ 421,919		\$ 344,388	\$ (77,531)	\$ 1,452,744	1
2	Painting	2000	19,800		20	990	990	3,218	2
3	Boiler Repair	2000	1,250		20	63	63	199	3
4	Light Fixtures,Lamps	2000	41,012		20	2,051	2,051	6,494	4
5	Upgrade From Lightin	2000	2,375		20	119	119	377	5
6	Replace Pump In Hot	2000	2,117		20	106	106	336	6
7	Glass Blocks	2000	500		20	25	25	77	7
8	Boiler Treatment	2000	997		20	50	50	154	8
9	Locker Room Air Hand	2000	606		20	30	30	94	9
10	Water Pump	2000	539		20	27	27	83	10
11	Sewer Lines Cleaning	2000	1,861		20	93	93	287	11
12	Replcing Drains 1	2000	475		20	24	24	74	12
13	Gas Piping Installat	2000	2,655		20	133	133	410	13
14	Tiling	2000	10,029		20	501	501	1,546	14
15	Landscaping	2000	48,650		20	2,433	2,433	2,433	15
16	Shelves	2001	990		20	50	50	149	16
17	Bathroom Renovation	2001	819		20	41	41	123	17
18	Electrical Repairs	2001	5,401		20	270	270	810	18
19	Blinds	2001	1,550		20	78	78	233	19
20	Alco Sales & Service	2001	741		20	37	37	108	20
21	Paint	2001	1,113		20	56	56	162	21
22	Ac Repair	2001	1,357		20	68	68	198	22
23	Bathrooms Renovation	2001	1,067		20	53	53	156	23
24	Tiling	2001	783		20	39	39	114	24
25	Tiling	2001	559		20	28	28	82	25
26	Nurse Call Station	2001	700		20	35	35	102	26
27	King Of Tile, Inc.	2001	942		20	47	47	133	27
28	Duraline Overhead	2001	3,028		20	151	151	429	28
29	Tiles	2001	3,838		20	192	192	544	29
30	Tiles	2001	500		20	25	25	71	30
31	Transformer For Heat	2001	445		20	22	22	63	31
32	Window Installation	2001	15,000		20	750	750	2,063	32
33	Cooler Repair	2001	751		20	38	38	104	33
34	TOTAL (lines 1 thru 33)		\$ 16,063,463	\$ 421,919		\$ 353,013	\$ (68,907)	\$ 1,474,170	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 16,063,463	\$ 421,919		\$ 353,013	\$ (68,907)	\$ 1,474,170	1
2	Steam Kettle Repair	2001			20				2
3	Outside Lighting	2001	6,003		20	300	300	825	3
4	Landscaping	2001	590		20	30	30	82	4
5	Clean Up Sewer Lines	2001	2,539		20	127	127	339	5
6	Doors	2001	2,610		20	131	131	348	6
7	Fan Repair	2001	561		20	28	28	72	7
8	Boiler Repair	2001	3,247		20	162	162	420	8
9	Landscaping	2001	1,153		20	58	58	149	9
10	Install Emergency Li	2001	1,113		20	56	56	144	10
11	Sewer Pump	2001	879		20	44	44	114	11
12	Repair Ground Pump	2001	2,963		20	148	148	370	12
13	Install Emergency Li	2001	4,295		20	215	215	538	13
14	Showers Renovation	2001	758		20	38	38	95	14
15	Paint	2001	792		20	40	40	96	15
16	Paint	2001	1,749		20	87	87	211	16
17	Cooler Repair	2001	1,221		20	61	61	147	17
18	Heating And Ac	2001	54,659		20	2,733	2,733	6,605	18
19	Self-Closing Door	2001	4,900		20	245	245	592	19
20	Doors	2001	800		20	40	40	93	20
21	Hand Rails	2001	2,500		20	125	125	292	21
22	Roof Repair	2001	2,150		20	108	108	251	22
23	Boiler Treatment	2001	997		20	50	50	113	23
24	Repair Motor Pump	2001	2,819		20	141	141	317	24
25	Exhaust Fan	2001	1,446		20	72	72	163	25
26	Pipe System Upgrade	2001	7,289		20	364	364	820	26
27	Sewer Line Repair	2001	2,563		20	128	128	288	27
28	Sewer Line Repair	2001	3,200		20	160	160	360	28
29	Window Shades	2001	1,072		20	54	54	116	29
30	Landscaping	2001	5,021		20	251	251	753	30
31	Hvac Replacement	2001	3,116		20	156	156	351	31
32	Paint	2001	890		20	45	45	104	32
33	Paint	2001	1,246		20	62	62	141	33
34	TOTAL (lines 1 thru 33)		\$ 16,188,604	\$ 421,919		\$ 359,272	\$ (62,648)	\$ 1,489,479	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 16,188,604	\$ 421,919		\$ 359,272	\$ (62,648)	\$ 1,489,479	1
2	Glass For Metal Fram	2001	1,785		20	89	89	253	2
3	Glass For Windows	2001	935		20	47	47	118	3
4	Replace Motor Upgrad	2001	970		20	49	49	109	4
5	Nurse Call System	2002	17,000		20	1,133	1,133	2,267	5
6	Knob Lock	2002	840		20	84	84	168	6
7	Plumbing Supplies	2002	610		20	61	61	117	7
8	Door Curtains	2002	1,068		20	107	107	205	8
9	Sewer Lines	2002	5,237		20	524	524	1,004	9
10	Tuckpointing	2002	1,000		20	100	100	192	10
11	Plaster Caulking, Tuckpointing	2002	8,000		20	800	800	1,467	11
12	Canopy	2002	3,494		20	349	349	641	12
13	Window Shades	2002	723		20	72	72	133	13
14	Magnetic Door Repair	2002	680		20	68	68	125	14
15	Metal Door Installation	2002	670		20	67	67	123	15
16	Fire Alarm Repair	2002	1,530		20	219	219	401	16
17	Paint	2002	1,032		20	103	103	181	17
18	Shower Faucet	2002	596		20	40	40	70	18
19	Boiler Repair	2002	1,535		20	128	128	224	19
20	Exhaust Motor Replacement	2002	2,950		20	295	295	492	20
21	Tamper Valve Replacement	2002	950		20	95	95	158	21
22	Adt Unimode Fire Alarm	2002	20,693		20	2,956	2,956	4,927	22
23	Canopy Rental	2002	1,648		20	165	165	275	23
24	Door	2002	1,775		20	178	178	296	24
25	Landscaping	2002	1,317		20	88	88	139	25
26	Ac Repair	2002	1,556		20	130	130	195	26
27	Electric Wiring	2002	1,750		20	175	175	263	27
28	Timeclocks Installation	2002	506		20	51	51	72	28
29	Fire System Repair	2002	1,352		20	193	193	274	29
30	Nurse Call System	2002	552		20	37	37	52	30
31	Nurse Call System	2002	586		20	39	39	55	31
32	Nurse Call System	2002	1,554		20	104	104	147	32
33	Boiler Repair	2002	15,665		20	1,305	1,305	1,741	33
34	TOTAL (lines 1 thru 33)		\$ 16,289,163	\$ 421,919		\$ 369,123	\$ (52,797)	\$ 1,506,363	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 16,289,163	\$ 421,919		\$ 369,123	\$ (52,797)	\$ 1,506,363	1
2	Paint	2002	589		20	59	59	79	2
3	Tiles	2002	708		20	47	47	63	3
4	Fire Alarm Repair	2002	646		20	92	92	123	4
5	Roof Cement	2002	523		20	52	52	65	5
6	Boiler Repair	2002	2,849		20	237	237	297	6
7	Boiler Repair	2002	2,000		20	167	167	208	7
8	Reroofing	2002	3,500		20	350	350	438	8
9	New Front Door	2002	800		20	80	80	100	9
10	Structural Engineer Service	2002	750		20	75	75	94	10
11	Sewer Study	2002	600		20	60	60	75	11
12	Cast Iron Piping Repair	2002	6,110		20	611	611	713	12
13	Cast Iron Piping Repair	2002	560		20	56	56	65	13
14	New Front Door	2002	800		20	80	80	93	14
15	Nurse Call System	2002	2,392		20	159	159	186	15
16	Paint & Tile	2002	2,671		20	2,448	2,448	2,671	16
17	Plumbing Work	2002	16,800		20	840	840	840	17
18	Hot Water Heater Repair	2003	527		20	44	44	44	18
19	Nurse Call System	2003	2,392		20	159	159	159	19
20	Paint	2003	1,079		20	108	108	108	20
21	Plumbing Supplies	2003	960		20	96	96	96	21
22	Plumbing Supplies	2003	509		20	51	51	51	22
23	Electrical System-16 Outlets	2003	12,750		20	1,275	1,275	1,275	23
24	Plumbing Work	2003	3,395		20	340	340	340	24
25	Bathrooms Plumbing Repair	2003	1,707		20	171	171	171	25
26	Leaking Drain Repair	2003	1,010		20	101	101	101	26
27	Concrete Patching	2003	8,200		20	820	820	820	27
28	Roof Ladder Installation	2003	1,500		20	150	150	150	28
29	Sewer Line Repair	2003	3,590		20	329	329	329	29
30	Sewer Line Repair	2003	3,800		20	174	174	174	30
31	Exterior Repairs	2003	10,000		20	833	833	833	31
32	Second Floor Doors	2003	1,870		20	156	156	156	32
33	Tuckpointing*	2003	3,200		20	240	240	240	33
34	TOTAL (lines 1 thru 33)		\$ 16,387,950	\$ 421,919		\$ 379,583	\$ (42,337)	\$ 1,517,520	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 16,387,950	\$ 421,919		\$ 379,583	\$ (42,337)	\$ 1,517,520	1
2	Smoke Detectors*	2003	2,395		20	257	257	257	2
3	Doors Repair*	2003	925		20	69	69	69	3
4	Doors Repair*	2003	890		20	67	67	67	4
5	Elevator Repair*	2003	3,858		20	145	145	145	5
6	Roof Fan*	2003	4,924		20	328	328	328	6
7	Plumbing Work*	2003	9,300		20	620	620	620	7
8	Leasehold Improvements*	2003	3,346		20	195	195	195	8
9	Electrical Wiring*	2003	5,590		20	326	326	326	9
10	Duct Work*	2003	2,615		20	153	153	153	10
11	Landscaping*	2003	1,317		20	77	77	77	11
12	Tiles*	2003	799		20	40	40	40	12
13	Ac Repair*	2003	4,047		20	141	141	141	13
14	Blinds For 9Th Floor*	2003	1,470		20	49	49	49	14
15	Replacement For 2 Doors Nad Sidelights*	2003	2,700		20	90	90	90	15
16	Paint	2003	969		20	12	12	12	16
17	Cabinet Doors, Shower Rods*	2003	1,059		20	13	13	13	17
18	Boiler Repair*	2003	15,987		20	222	222	222	18
19	4 Toilet Kits*	2003	822		20	14	14	14	19
20	Fire Alarm*	2003	3,345		20	80	80	80	20
21	Gutter And Down Spout Repair	2003	950		20	48	48	48	21
22	Heat/Cooling Svstem	2003	661		20	33	33	33	22
23	Door Locks	2003	1,281		20	64	64	64	23
24	Motor Repair	2003	668		20	33	33	33	24
25	*Added After 2003 Capital Projection				20				25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,457,868	\$ 421,919		\$ 382,659	\$ (39,261)	\$ 1,520,596	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 16,457,868	\$ 421,919		\$ 382,659	\$ (39,261)	\$ 1,520,596	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)		\$ 16,457,868	\$ 421,919		\$ 382,659	\$ (39,261)	\$ 1,520,596	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 16,457,868	\$ 421,919		\$ 382,659	\$ (39,261)	\$ 1,520,596	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,457,868	\$ 421,919		\$ 382,659	\$ (39,261)	\$ 1,520,596	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 16,457,868	\$ 421,919		\$ 382,659	\$ (39,261)	\$ 1,520,596	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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17									17
18									18
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,457,868	\$ 421,919		\$ 382,659	\$ (39,261)	\$ 1,520,596	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	450	1999		\$ 14,605,934	\$ 253,846		\$ 282,857	\$ 29,011	\$ 1,266,510	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Allocated - Sommerset Realty, LLC	1999		586,916	27,466	20	29,346	1,880	76,566	9
10	Allocated - Sommerset Realty, LLC	2000		13,789	1,379	20	690	(689)	6,482	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
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26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A-BLDG, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
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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)		\$ 15,206,639	\$ 282,691		\$ 312,893	\$ 30,202	\$ 1,349,558		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated - 2201 Main LLC		2002	2002	\$ 59,965	\$ 1,499	35	\$ 1,499	\$	\$ 1,624	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12	Allocated - 2201 Main LLC			2002	55,522	2,776	20	2,776		3,007	12
13	Allocated - 2201 Main LLC			2003	49,107	1,228	20	1,228		1,228	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	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)		\$ 164,594	\$ 5,503		\$ 5,503	\$	\$ 5,859	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,542,598	\$ 329,544	\$ 252,318	\$ (77,226)	10	\$ 1,266,687	71
72	Current Year Purchases	27,825	714	8,261	7,547	10	8,261	72
73	Fully Depreciated Assets	9,211				10	9,211	73
74								74
75	TOTALS	\$ 2,579,634	\$ 330,258	\$ 260,579	\$ (69,679)		\$ 1,284,159	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		VAN	1999	\$ 5,000	\$	\$ 1,000	\$ 1,000	5	\$ 4,417	76
77		INSTALL SEATBELTS	2000	780		78	78	5	280	77
78		Alloc-Care Centers	2003	62,354	6,740	6,740		5	49,066	78
79										79
80	TOTALS			\$ 68,134	\$ 6,740	\$ 7,818	\$ 1,078		\$ 53,763	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)	\$ 20,249,150	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 758,917	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 651,056	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (107,862)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,858,518	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Care Center Allocation				9,730			5
6								6
7	TOTAL				\$ 9,730			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2004 \$ _____
13. _____/2005 \$ _____
14. _____/2006 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 18,282 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	N/A	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 prescrpts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify): See Supplemental													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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 15,513	\$ 26,301	1
2 Cash-Patient Deposits	107,458	107,458	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	237,603	237,603	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	304,638	443,370	6
7 Other Prepaid Expenses	66,444	66,444	7
8 Accounts Receivable (owners or related parties)	89,048	89,048	8
9 Other(specify): See Attached Schedule	6,069,443	8,386,660	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,890,147	\$ 9,356,884	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		1,100,000	13
14 Buildings, at Historical Cost		9,900,000	14
15 Leasehold Improvements, at Historical Cost	1,054,523	1,655,228	15
16 Equipment, at Historical Cost	234,648	2,484,648	16
17 Accumulated Depreciation (book methods)	(306,820)	(3,249,500)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs		194,679	19
20 Accumulated Amortization - Organization & Pre-Operating Costs		(3,245)	20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): See Attached Schedule		10,907,768	23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 982,351	\$ 22,989,578	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,872,498	\$ 32,346,462	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 1,591,134	\$ 1,591,133	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	107,454	107,454	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	189,914	189,914	30
31 Accrued Taxes Payable (excluding real estate taxes)	4,381	4,381	31
32 Accrued Real Estate Taxes(Sch.IX-B)		609,849	32
33 Accrued Interest Payable		135,069	33
34 Deferred Compensation			34
35 Federal and State Income Taxes	675	675	35
Other Current Liabilities(specify):			
36 See Attached Schedule	124,671	124,671	36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,018,229	\$ 2,763,146	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable		28,687,262	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 See Attached Schedule			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 28,687,262	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,018,229	\$ 31,450,408	46
47 TOTAL EQUITY(page 18, line 24)	\$ 5,854,269	\$ 896,054	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,872,498	\$ 32,346,462	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,705,936	1
2	Restatements (describe):		2
3	Adjusting Journal - 12/31/02 - Depreciation Adjustment	30,049	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,735,985	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,678,284	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	(1,560,000)	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)	\$ 118,284	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)	\$ 5,854,269	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 13,758,166	1
2	Discounts and Allowances for all Levels	(126)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,758,040	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		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	126	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 126	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	272,977	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 272,977	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	562	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 562	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,031,705	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,234,426	31
32	Health Care	3,719,705	32
33	General Administration	2,886,249	33
B. Capital Expense			
34	Ownership	3,265,991	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	247,050	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,353,421	40
41	Income before Income Taxes (line 30 minus line 40)**	1,678,284	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,678,284	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

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

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/03

Ending:

12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,256	1,514	\$ 48,828	\$ 32.25	1
2	Assistant Director of Nursing	5,576	6,321	147,151	23.28	2
3	Registered Nurses	5,274	5,745	125,561	21.86	3
4	Licensed Practical Nurses	39,793	43,581	856,820	19.66	4
5	Nurse Aides & Orderlies	132,945	145,764	1,314,879	9.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,927	2,285	23,863	10.44	8
9	Activity Director	2,943	3,347	47,382	14.16	9
10	Activity Assistants	17,789	20,059	179,552	8.95	10
11	Social Service Workers	36,129	41,056	691,295	16.84	11
12	Dietician	3,655	4,132	42,389	10.26	12
13	Food Service Supervisor	3,144	3,536	56,708	16.04	13
14	Head Cook					14
15	Cook Helpers/Assistants	42,091	45,017	330,352	7.34	15
16	Dishwashers					16
17	Maintenance Workers	17,028	19,168	292,003	15.23	17
18	Housekeepers	37,182	41,311	303,008	7.33	18
19	Laundry	1,805	2,077	17,699	8.52	19
20	Administrator	1,838	2,127	86,188	40.52	20
21	Assistant Administrator	1,921	2,148	50,170	23.36	21
22	Other Administrative	2,080	2,080	300,000	144.23	22
23	Office Manager					23
24	Clerical	12,758	14,475	154,373	10.66	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	2,201	2,549	36,171	14.19	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	9,713	9,936	70,762	7.12	33
34	TOTAL (lines 1 - 33)	379,048	418,228	\$ 5,175,154 *	\$ 12.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly \$ 41,271	01-03	35	
36	Medical Director	Monthly 12,000	09-03	36	
37	Medical Records Consultant	Fee 368	10-03	37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	Monthly 3,600	10-03	39	
40	Physical Therapy Consultant	25 1,104	10a-03	40	
41	Occupational Therapy Consultant	101 4,550	10a-03	41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant	3 84	11-03	44	
45	Social Service Consultant	Per Consult 2,310	12-03	45	
46	Other(specify)			46	
47				47	
48	Activity Director -CCI Salary		1,179	11-03	48
49	TOTAL (lines 35 - 48)	129	\$ 66,466		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,593 \$ 55,752	10-03	50	
51	Licensed Practical Nurses			51	
52	Nurse Aides			52	
53	TOTAL (lines 50 - 52)	1,593	\$ 55,752		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Eric Rothner	Administrative	0	\$ 300,000	Workers' Compensation Insurance	\$ 83,699	IDPH License Fee	\$ 200		
Karen James	Administrator	0	86,188	Unemployment Compensation Insurance	47,039	Advertising: Employee Recruitment	5,359		
Blake Willey	Asst Administrator	0	50,170	FICA Taxes	371,876	Health Care Worker Background Check			
				Employee Health Insurance	201,959	(Indicate # of checks performed 192)	2,112		
				Employee Meals		Advertising & Promotion	49,495		
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Page Advertising	937		
				Pension Expense	38,513	Dues & Subscriptions	16,460		
				Chicago Head Tax	9,445	Licenses & Fees	11,022		
				Christmas Expense	3,150	Care Center Allocation	3,032		
				Misc Employee Welfare	13,313				
						Less: Public Relations Expense	()		
						Non-allowable advertising	(49,495)		
						Yellow page advertising	(937)		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 436,358	TOTAL (agree to Schedule V, line 22, col.8)	\$ 768,993	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 38,185		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount	
Eric Rothner-Management Fee			\$ 300,000				Out-of-State Travel	\$	
Nathan Langner - Management Fee			12,000				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 312,000				Seminar Expense	1,090	
(Attach a copy of any management service agreement)							Care Center Allocation	1,903	
C. Professional Services							Educational Expense	2,123	
Vendor/Payee	Type		Amount				Entertainment Expense	()	
Care Centers, Inc	Data Processing		\$ 16,257				(agree to Sch. V,		
ADP	Data Processing		14,144				line 24, col. 8)	\$ 5,116	
PayCor	Data Processing		1,455						
Keane Care	Data Processing		176						
Personnel Planners	Unemply Consulting		2,790						
Care Centers, Inc	Home Office		379,350						
Care Centers, Inc	Ancillary Fees		54,000						
Care Centers, Inc	Bookkeeping		91,800						
FR&R	Accounting		21,956						
Care Centers, Inc	Accounting		15,000						
Care Centers, Inc	Legal		40,471						
See Supplemental Schedule			12,964						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 650,363	TOTAL		\$			
(If total legal fees exceed \$2500 attach copy of invoices.)									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council LTC - \$21,546.00
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,769 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ 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. \$ 246,375
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. \$ _____ Has any meal income been offset against related costs? N/A 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? _____ 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? None
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT