

Facility Name & ID Number AVISTON TERRACE# 0036749 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,305			5,305	13
14	TOTALS	5,305			5,305	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.59%

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

292 (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)

NONEF. 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 01/01/91

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

YES Date 01/01/91 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 0 and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/04 Fiscal Year: 06/30/04

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

STATE OF ILLINOIS

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Facility Name & ID Number

AVISTON TERRACE

0036749

Report Period Beginning:

07/01/2003

Ending:

06/30/2004

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	19,779	1,638	1,807	23,224		23,224	500	23,724		1
2	Food Purchase		21,108		21,108		21,108		21,108		2
3	Housekeeping		2,187	261	2,448		2,448		2,448		3
4	Laundry		856		856		856		856		4
5	Heat and Other Utilities			10,710	10,710		10,710	(345)	10,365		5
6	Maintenance	8,483		3,459	11,942		11,942	221	12,163		6
7	Other (specify):*										7
8	TOTAL General Services	28,262	25,789	16,237	70,288		70,288	376	70,664		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	165,768	3,316	4,833	173,917		173,917	2,113	176,030		10
10a	Therapy			746	746		746		746		10a
11	Activities	41	796		837		837		837		11
12	Social Services			1,779	1,779		1,779		1,779		12
13	Nurse Aide Training										13
14	Program Transportation			1,013	1,013		1,013		1,013		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	165,809	4,112	9,571	179,492		179,492	2,113	181,605		16
	C. General Administration										
17	Administrative	9,142		54,335	63,477		63,477	(20,416)	43,061		17
18	Directors Fees			2,993	2,993		2,993	1,241	4,234		18
19	Professional Services			7,400	7,400		7,400	1,481	8,881		19
20	Dues, Fees, Subscriptions & Promotions			2,520	2,520		2,520	321	2,841		20
21	Clerical & General Office Expenses		2,627	7,659	10,286		10,286		10,286		21
22	Employee Benefits & Payroll Taxes			64,545	64,545		64,545	6,859	71,404		22
23	Inservice Training & Education			3,326	3,326		3,326	1,763	5,089		23
24	Travel and Seminar			26	26		26	147	173		24
25	Other Admin. Staff Transportation			799	799		799	31	830		25
26	Insurance-Prop.Liab.Malpractice			4,110	4,110		4,110	233	4,343		26
27	Other (specify):*										27
28	TOTAL General Administration	9,142	2,627	147,713	159,482		159,482	(8,340)	151,142		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	203,213	32,528	173,521	409,262		409,262	(5,851)	403,411		29

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

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

Facility Name & ID Number

AVISTON TERRACE

#0036749

Report Period Beginning:

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Ending:

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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			17,001	17,001		17,001	777	17,778		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			64,837	64,837		64,837	(2,490)	62,347		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds							1,307	1,307		34
35	Rent-Equipment & Vehicles							50	50		35
36	Other (specify):*										36
37	TOTAL Ownership			81,838	81,838		81,838	(356)	81,482		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			36,440	36,440		36,440		36,440		42
43	Other (specify):*			189,518	189,518		189,518	(189,518)			43
44	TOTAL Special Cost Centers			225,958	225,958		225,958	(189,518)	36,440		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	203,213	32,528	481,317	717,058		717,058	(195,725)	521,333		45

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

Facility Name & ID Number AVISTON TERRACE

0036749

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

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	(189,506)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(587)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(974)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(47)	32		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	(414)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (191,528)		\$	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)	(4,197)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,197)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (195,725)		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

AVISTON TERRACE

Report Period Beginning: 07/01/2003
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Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	N/A	\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AVISTON TERRACE

0036749

Report Period Beginning:

07/01/2003

Ending:

06/30/2004

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	500	0	0	0	0	0	0	0	0	500	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(587)	0	242	0	0	0	0	0	0	0	0	(345)	5
6	Maintenance	0	0	221	0	0	0	0	0	0	0	0	221	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(587)	0	963	0	0	0	0	0	0	0	0	376	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	2,113	0	0	0	0	0	0	0	0	2,113	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	2,113	0	0	0	0	0	0	0	0	2,113	16
	C. General Administration													
17	Administrative	0	0	(20,416)	0	0	0	0	0	0	0	0	(20,416)	17
18	Directors Fees	0	0	1,241	0	0	0	0	0	0	0	0	1,241	18
19	Professional Services	0	0	1,481	0	0	0	0	0	0	0	0	1,481	19
20	Fees, Subscriptions & Promotions	0	1	320	0	0	0	0	0	0	0	0	321	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	6,859	0	0	0	0	0	0	0	0	6,859	22
23	Inservice Training & Education	0	0	1,763	0	0	0	0	0	0	0	0	1,763	23
24	Travel and Seminar	0	0	147	0	0	0	0	0	0	0	0	147	24
25	Other Admin. Staff Transportation	0	0	31	0	0	0	0	0	0	0	0	31	25
26	Insurance-Prop.Liab.Malpractice	0	0	233	0	0	0	0	0	0	0	0	233	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	1	(8,341)	0	0	0	0	0	0	0	0	(8,340)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(587)	1	(5,265)	0	0	0	0	0	0	0	0	(5,851)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AVISTON TERRACE# 0036749

Report Period Beginning:

07/01/2003

Ending:

06/30/2004

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	0	0	777	0	0	0	0	0	0	0	0	777 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,021)	(918)	(551)	0	0	0	0	0	0	0	0	(2,490) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	1,307	0	0	0	0	0	0	0	0	1,307 34
35	Rent-Equipment & Vehicles	0	0	50	0	0	0	0	0	0	0	0	50 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(1,021)	(918)	1,583	0	(356) 37							
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(189,920)	0	402	0	0	0	0	0	0	0	0	(189,518) 43
44	TOTAL Special Cost Centers	(189,920)	0	402	0	(189,518) 44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(191,528)	(917)	(3,280)	0	(195,725) 45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PROGRESSIVE HOUSING, INC.	100	SEE ATTACHED RELATED PARTY SCHEDULE		SEE ATTACHED RELATED PARTY SCHEDULE		
SEE ATTACHED SCHEDULE 7A						

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	18 BOARD FEES	\$ 2,993	PROGRESSIVE HOUSING, INC.	100.00%	\$ 2,993		1	
2	V	19 PROFESSIONAL FEES	7,042	PROGRESSIVE HOUSING, INC.	100.00%	7,042		2	
3	V	20 LICENSE, DUES	2	PROGRESSIVE HOUSING, INC.	100.00%	3	1	3	
4	V	21 GENERAL OFFICE	3,141	PROGRESSIVE HOUSING, INC.	100.00%	3,141		4	
5	V	22 EMPLOYEE BENEFITS	33	PROGRESSIVE HOUSING, INC.	100.00%	33		5	
6	V	23 INSERVICE TRAVEL	228	PROGRESSIVE HOUSING, INC.	100.00%	228		6	
7	V	24 SEMINARS	26	PROGRESSIVE HOUSING, INC.	100.00%	26		7	
8	V	32 INTEREST	4,840	PROGRESSIVE HOUSING, INC.	100.00%	4,840		8	
9	V	5 UTILITIES	32	PROGRESSIVE HOUSING, INC.	100.00%	32		9	
10	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%	(588)	(588)	10	
11	V	43 NONALLOWABLE	12	PROGRESSIVE HOUSING, INC.	100.00%	12		11	
12	V	32 MISCELLANEOUS INCOME		PROGRESSIVE HOUSING, INC.	100.00%	(330)	(330)	12	
13	V							13	
14	Total		\$ 18,349			\$ 17,432	\$ *	(917)	14

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

Facility Name & ID Number AVISTON TERRACE# 0036749Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE COST	\$ 54,335	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 33,919	\$ (20,416)
16	V	18 DIRECTORS FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,241	1,241
17	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,481	1,481
18	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	320	320
19	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	6,859	6,859
20	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,763	1,763
21	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	147	147
22	V	25 OTHER STAFF TRANSPORTATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	31	31
23	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	233	233
24	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	777	777
25	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	84	84
26	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,307	1,307
27	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	50	50
28	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	242	242
29	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	221	221
30	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	402	402
31	V	32 INTEREST INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(68)	(68)
32	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(567)	(567)
33	V	1 DIETARY		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	500	500
34	V	10 NURSING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,113	2,113
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 54,335			\$ 51,055	\$ * (3,280)

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

Facility Name & ID Number AVISTON TERRACE # 0036749 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

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	SHAWN JEFFERS	CHAIRMAN	BOARD MEMBE	NONE	14,732	3HRS/MTG	2.00	DIR. FEES	\$ 468	L18,C3	1
2	EDWARD CHILDERS	VICE CHAIRMAN	BOARD MEMBE	NONE	15,439	3HRS/MTG	2.00	DIR. FEES	561	L18,C3	2
3	RONALD SCHROEDER	SECRETARY	BOARD MEMBE	NONE	15,437	3HRS/MTG	2.00	DIR. FEES	561	L18,C3	3
4	ORLAND BAUER	TREASURER	BOARD MEMBE	NONE	10,639	3HRS/MTG	2.00	DIR. FEES	561	L18,C3	4
5	CORA FLOTA	BOARD MEMBER	BOARD MEMBE	NONE	4,239	3HRS/MTG	2.00	DIR. FEES	561	L18,C3	5
6	KAY SCHUMAN JOHNSON	BOARD MEMBER	BOARD MEMBE	NONE	2,119	3HRS/MTG	2.00	DIR. FEES	281	L18,C3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,993		13

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

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

Facility Name & ID Number AVISTON TERRACE # 0036749 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

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 PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61614
 Phone Number (309)685-0595
 Fax Number (309)685-8463

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	18	BOARD FEES	BEDS	136	14	\$ 25,600	\$ 16	\$ 2,993	1
2	19	PROFESSIONAL FEES	BEDS	136	14	60,522	16	7,042	2
3	20	LICENSE, DUES	BEDS	136	14	10,080	16	3	3
4	21	GENERAL OFFICE	BEDS	136	14	27,022	16	3,141	4
5	22	EMPLOYEE BENEFITS	BEDS	136	14	275	16	33	5
6	23	INSERVICE TRAVEL	BEDS	136	14	1,947	16	228	6
7	24	SEMINARS	BEDS	136	14	222	16	26	7
8	32	INTEREST	BEDS	136	14	41,543	16	4,840	8
9	5	UTILITIES	BEDS	136	14	275	16	32	9
10	32	INTEREST INCOME	BEDS	136	14	(2,804)	16	(588)	10
11	43	NONALLOWABLE	BEDS	136	14	100	16	12	11
12	32	MISCELLANEOUS INCOME	BEDS	136	14	(4,999)	16	(330)	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					\$ 159,783	\$	\$ 17,432	25

Facility Name & ID Number AVISTON TERRACE # 0036749 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

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 CENTER FOR RESIDENTIAL MANAGEMENT
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 616147
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6		
1	17	ADMINISTRATIVE COST	BEDS	330	18	\$ 699,564	\$ 574,950	16	\$ 33,919	1
2	18	DIRECTORS FEES	BEDS	330	18	25,600		16	1,241	2
3	19	PROFESSIONAL FEES	BEDS	330	18	30,555		16	1,481	3
4	20	DUES, FEES	BEDS	330	18	6,605		16	320	4
5	22	EMPLOYEE BENEFITS	BEDS	330	18	137,341		16	6,659	5
6	23	INSERVICE EDUCATION	BEDS	330	18	36,366		16	1,763	6
7	24	TRAVEL SEMINAR	BEDS	330	18	3,032		16	147	7
8	25	OTHER STAFF TRANSPORTATION	BEDS	330	18	631		16	31	8
9	26	INSURANCE	BEDS	330	18	4,797		16	233	9
10	30	DEPRECIATION	BEDS	330	18	16,031		16	777	10
11	32	INTEREST	BEDS	330	18	1,737		16	84	11
12	34	RENT	BEDS	330	18	26,963		16	1,307	12
13	35	EQUIPMENT RENTAL	BEDS	330	18	1,020		16	50	13
14	5	UTILITIES	BEDS	330	18	5,000		16	242	14
15	6	MAINTENANCE	BEDS	330	18	4,559		16	221	15
16	43	NONALLOWABLE	BEDS	330	18	8,286		16	402	16
17	32	INTEREST INCOME	BEDS	330	18	(1,401)		16	(68)	17
18	32	MISC INCOME	BEDS	330	18	(11,699)		16	(567)	18
19										19
20	1	DIETARY	DIRECT							20
21	10	NURSING	DIRECT				500		500	21
22	22	EMPLOYEE BENEFITS	DIRECT				2,113		2,113	22
23									200	23
24										24
25	TOTALS					\$ 994,987	\$ 577,563		\$ 51,055	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6		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	IL. HEALTH FAC AUTH. BOND	X	ACQUISITION OF FACILITY	VARIES	03/01/93	\$ 4,527,000	\$ 605,030	08/15/16	VARIES	\$ 57,313	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	HEALTH CARE BUSINESS CREDIT	X	WORKING CAPITAL		05/12/03	286,000	40,504		8.2500	7,524	6							
7			OFFSET INTERST INCOME/ NONALLOWABLE INT.							(2,574)	7							
8			MISC./PARENT ALLOCATION							84	8							
9	TOTAL Facility Related					\$ 4,813,000	\$ 645,534			\$ 62,347	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$ 4,813,000	\$ 645,534			\$ 62,347	15							

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

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

** 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 **AVISTON TERRACE**# **0036749** Report Period Beginning: **07/01/2003** Ending: **06/30/2004****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 2003 report.	\$	N/A		1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3.	Under or (over) accrual (line 2 minus line 1).	\$	#VALUE!		3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	#VALUE!		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	N/A	8	
		2000		9	
		2001		10	
		2002		11	
		2003		12	
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2003	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AVISTON TERRACE COUNTY CLINTON

FACILITY IDPH LICENSE NUMBER 0036749

CONTACT PERSON REGARDING THIS REPORT ROB KEIME

TELEPHONE 309-685-0595 EXT. 304 FAX #: 309-685-8463

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(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>N/A</u>	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number AVISTON TERRACE# 0036749 Report Period Beginning:07/01/2003 Ending:06/30/2004**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 3,900 B. General Construction Type: Exterior BRICK AND SIDING Frame WOOD Number of Stories ONEC. 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RESIDENT CARE</u>	<u>26,400</u>	<u>1991</u>	<u>\$ 20,000</u>	1
2					2
3	TOTALS	26,400		\$ 20,000	3

Facility Name & ID Number AVISTON TERRACE

0036749

Report Period Beginning:

07/01/2003

Ending:

06/30/2004

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1991	1986	\$ 432,500	\$ 10,813	40	\$ 10,813	\$	\$ 145,971
5									
6									
7									
8									
Improvement Type**									
9	EXPAND BEDROOM	1991		1,790	41	15	41		1,279
10	SPRINKLER SYSTEM	1993		603	119	15	119		540
11	SPRINKLER SYSTEM	1996		936	63	15	63		469
12	SPRINKLER SYSTEM	1998		1,274	85	15	85		467
13	ALLOCATED FROM COMPANY			5		15			
14	BATHROOM TOILETS	2001		1,349	90	15	90		315
15	BATHROOM TILES	2001		2,720	181	15	181		634
16	BATHROOM TILES AND DRYWALL	2001		2,540	169	15	169		494
17	SPRINKLER SYSTEM	2004		4,614	179	15	179		179
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 448,331	\$ 11,740		\$ 11,740	\$	\$ 150,348		70

**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	\$ 22,765	\$ 2,461	\$ 2,461	\$	5-10 YRS	\$ 13,429	71
72	Current Year Purchases	2,887	79	79		5-10 YRS	79	72
73	Fully Depreciated Assets	29,590					29,590	73
74	ALLOCATED FROM PARENT		777	777				74
75	TOTALS	\$ 55,242	\$ 3,317	\$ 3,317	\$		\$ 43,098	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	FACILITY USE	96 BUICK CENTURY	2002	\$ 4,500	\$ 900	\$ 900	\$		\$ 2,250	76
77	FACILITY USE	97 CHEVY ASTRO VAN	2002	8,000	1,600	1,600			4,000	77
78	FACILITY USE	REPAIR TO VAN	2003	1,328	221	221			221	78
79										79
80	TOTALS			\$ 13,828	\$ 2,721	\$ 2,721	\$		\$ 6,471	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)	\$ 537,401	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,778	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,778	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 199,917	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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			3
4	Additions				\$ _____			4
5					\$ _____			5
6					\$ _____			6
7	TOTAL				\$ _____			7

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

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</u>	\$ _____

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

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

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

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

16. Rental Amount for movable equipment: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$ N/A		\$	\$		\$	#VALUE!	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):										13
14	TOTAL			\$		\$	\$		\$	#VALUE!	14

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

Facility Name & ID Number AVISTON TERRACE

0036749

Report Period Beginning: 07/01/2003

Ending:

06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2004

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,647	1
2	Cash-Patient Deposits	11,791	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (3,525))	117,799	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	2,841	6
7	Other Prepaid Expenses	41,527	7
8	Accounts Receivable (owners or related parties)	930,722	8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,106,327	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	20,000	13
14	Buildings, at Historical Cost	448,331	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	69,070	16
17	Accumulated Depreciation (book methods)	(199,917)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify): LOAN COST	43,185	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 380,669	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,486,996	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 67,782	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	11,791	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	17,528	30
31	Accrued Taxes Payable (excluding real estate taxes)	37	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable	18,123	33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36			36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 115,261	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable	605,030	41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 605,030	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 720,291	46
47	TOTAL EQUITY(page 18, line 24)	\$ 766,705	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,486,996	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 665,171	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 665,171	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	101,534	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 101,534	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)	\$ 766,705	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 628,112	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 628,112	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	189,506	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 189,506	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	974	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 974	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 818,592	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	70,288	31
32	Health Care	170,698	32
33	General Administration	168,276	33
B. Capital Expense			
34	Ownership	81,838	34
C. Ancillary Expense			
35	Special Cost Centers	189,518	35
36	Provider Participation Fee	36,440	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 717,058	40
41	Income before Income Taxes (line 30 minus line 40)**	101,534	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 101,534	43

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

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

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

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

Facility Name & ID Number **AVISTON TERRACE**

0036749

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1			\$	\$	1
2					2
3	480	511	10,124	19.81	3
4					4
5					5
6					6
7					7
8					8
9	5	5	41	8.20	9
10					10
11					11
12					12
13					13
14					14
15	2,117	2,308	19,779	8.57	15
16					16
17	932	961	8,483	8.83	17
18					18
19					19
20	520	520	9,142	17.58	20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29	1,384	1,592	27,979	17.57	29
30	13,559	14,694	127,665	8.69	30
31					31
32					32
33					33
34	18,997	20,591	\$ 203,213 *	\$ 9.87	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	24	\$ 1,609	L1, C3	35
36	MONTHLY	1,200	L9, C3	36
37				37
38				38
39	MONTHLY	600	L10, C3	39
40	5	409	L10A, C3	40
41				41
42				42
43	5	337	L10A, C3	43
44				44
45	28	1,779	L12, C3	45
46				46
47	MONTHLY	2,503	L10, C3	47
48				48
49	62	\$ 8,437		49

C. CONTRACT NURSES

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

Facility Name & ID Number AVISTON TERRACE

0036749

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS HEALTH CARE ASSOC. \$864
- (3) Did the nursing home make political contributions or payments to a political action organization? N/A If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 14
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29 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? N/A
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.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 36,440
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? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,865 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 86%
- d. Have vehicle usage logs been maintained? ADEQUATE RECORDS ARE MAINTAINED
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: HEINOLD - BANWART, LTD. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.