

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0019364</u></p> <p>Facility Name: <u>Central Nursing</u></p> <p>Address: <u>2450 North Central Avenue</u> <u>Chicago</u> <u>60639</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 889-1333</u> Fax # <u>(773) 889-1516</u></p> <p>IDPA ID Number: <u>362801271001</u></p> <p>Date of Initial License for Current Owners: <u>01/01/1973</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Sanford B. Alper</u> Telephone Number: <u>(847) 580-4100</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2004</u> to <u>12/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) <u>Sanford B. Alper - Principal</u></td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Sanford B. Alper - Principal</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Kessler, Orlean, Silver & Company, P.C.</u> <u>1101 Lake Cook Road, Ste C, Deerfield, IL 60015-5233</u></td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Telephone) <u>(847) 580-4100</u> Fax # <u>(847) 580-4199</u></td> </tr> <tr> <td>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Sanford B. Alper - Principal</u>	(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Sanford B. Alper - Principal</u>	(Firm Name & Address) <u>Kessler, Orlean, Silver & Company, P.C.</u> <u>1101 Lake Cook Road, Ste C, Deerfield, IL 60015-5233</u>	Paid Preparer	(Telephone) <u>(847) 580-4100</u> Fax # <u>(847) 580-4199</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Central Nursing

0019364 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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	245	Skilled (SNF)	245	89,670	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,670	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	78,214	1,557	6,450	86,221	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	78,214	1,557	6,450	86,221	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.15%

D. How many bed-hold days during this year were paid by Public Aid? 336 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

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 01/01/1973

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 22 and days of care provided 2,482

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

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

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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

	Operating Expenses	Costs Per General Ledger				Reclassification	Reclassified Total	Adjustments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	167,941	28,484	29,773	226,198		226,198	38,000	264,198		1
2	Food Purchase		177,682		177,682	(25,791)	151,891		151,891		2
3	Housekeeping	189,217	9,036		198,253		198,253		198,253		3
4	Laundry		5,721		5,721		5,721		5,721		4
5	Heat and Other Utilities			155,552	155,552		155,552	3,401	158,953		5
6	Maintenance		15,687	29,104	44,791		44,791	30,221	75,012		6
7	Other (specify):*			10,178	10,178		10,178		10,178		7
8	TOTAL General Services	357,158	236,610	224,607	818,375	(25,791)	792,584	71,622	864,206		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,577,069	60,855	91,726	1,729,650		1,729,650		1,729,650		10
10a	Therapy			34,840	34,840		34,840		34,840		10a
11	Activities			16,267	16,267		16,267		16,267		11
12	Social Services	32,019		3,761	35,780		35,780		35,780		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Physician Care			690	690		690		690		15
16	TOTAL Health Care and Programs	1,609,088	60,855	147,284	1,817,227		1,817,227		1,817,227		16
	C. General Administration										
17	Administrative			486,041	486,041		486,041	(265,905)	220,136		17
18	Directors Fees										18
19	Professional Services			84,590	84,590		84,590	(1,011)	83,579		19
20	Dues, Fees, Subscriptions & Promotions			29,220	29,220		29,220	(6,402)	22,818		20
21	Clerical & General Office Expenses	153,599	7,364	6,920	167,883		167,883	162,563	330,446		21
22	Employee Benefits & Payroll Taxes			369,269	369,269	25,791	395,060	28,733	423,793		22
23	Inservice Training & Education					488	488		488		23
24	Travel and Seminar			2,963	2,963	(488)	2,475		2,475		24
25	Other Admin. Staff Transportation			1,337	1,337		1,337	187	1,524		25
26	Insurance-Prop.Liab.Malpractice			187,172	187,172		187,172		187,172		26
27	Other (specify):* Bad Debts			72,825	72,825		72,825	(71,589)	1,236		27
28	TOTAL General Administration	153,599	7,364	1,240,337	1,401,300	25,791	1,427,091	(153,424)	1,273,667		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,119,845	304,829	1,612,228	4,036,902		4,036,902	(81,802)	3,955,100		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 Central Nursing

#0019364

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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	
30	D. Ownership			22,458	22,458		22,458	28,474	50,932			30
31	Depreciation											31
32	Amortization of Pre-Op. & Org.											32
33	Interest											33
34	Real Estate Taxes					238,603	238,603		238,603			34
35	Rent-Facility & Grounds			1,445,841	1,445,841	(238,603)	1,207,238	(1,207,237)	1			35
36	Rent-Equipment & Vehicles			1,642	1,642		1,642	675	2,317			36
37	Other (specify):*											37
	TOTAL Ownership			1,469,941	1,469,941		1,469,941	(1,178,088)	291,853			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			102,109	102,109		102,109		102,109			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,506	134,506		134,506		134,506			42
43	Other (specify):* Internal Feeding			35,844	35,844		35,844		35,844			43
44	TOTAL Special Cost Centers			272,459	272,459		272,459		272,459			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,119,845	577,288	3,082,169	5,779,302		5,779,302	(1,259,890)	4,519,412			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	28,260	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(200)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,825)	27		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	(2,171)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (46,936)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (46,936)		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

Central Nursing

ID# 0019364

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Deductible Dues	\$ (4,446)	20	1
2	Franchise Tax	(100)	21	2
3	Franchise Tax - Management	(27)	21	3
4	Collection Fees	(1,146)	19	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
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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	(5,719)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nursing# 0019364

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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	38,000	0	0	0	0	0	0	0	0	38,000	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	0	3,401	0	0	0	0	0	0	0	0	0	3,401	5
6	Maintenance	0	921	29,300	0	0	0	0	0	0	0	0	30,221	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	4,322	67,300	0	0	0	0	0	0	0	0	71,622	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(486,041)	220,136	0	0	0	0	0	0	0	0	(265,905)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,146)	135	0	0	0	0	0	0	0	0	0	(1,011)	19
20	Fees, Subscriptions & Promotions	(6,617)	215	0	0	0	0	0	0	0	0	0	(6,402)	20
21	Clerical & General Office Expenses	(327)	547	162,343	0	0	0	0	0	0	0	0	162,563	21
22	Employee Benefits & Payroll Taxes	0	28,733	0	0	0	0	0	0	0	0	0	28,733	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	187	0	0	0	0	0	0	0	0	187	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(72,825)	1,236	0	0	0	0	0	0	0	0	0	(71,589)	27
28	TOTAL General Administration	(80,915)	(455,175)	382,666	0	0	0	0	0	0	0	0	(153,424)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(80,915)	(450,853)	449,966	0	0	0	0	0	0	0	0	(81,802)	29

STATE OF ILLINOIS

Facility Name & ID Number Central Nursing# 0019364

Report Period Beginning:

01/01/2004 Ending:

Summary B

12/31/2004

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	28,260	0	214	0	0	0	0	0	0	0	0	28,474	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,207,237)	0	0	0	0	0	0	0	0	0	(1,207,237)	34
35	Rent-Equipment & Vehicles	0	0	675	0	0	0	0	0	0	0	0	675	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	28,260	(1,207,237)	889	0	(1,178,088)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(52,655)	(1,658,090)	450,855	0	(1,259,890)	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
Marvin Mermelstein	50.00%	Winston Manor Nursing Home	Chicago	Nivram Mngmt, Inc.	Lincolnwood	Management
Joseph Mermelstein	50.00%	Balmoral Home, Inc.	Chicago			
		Sovereign Healthcare, LLC	Chicago			
		Chicago Ridge Nursing Center	Chicago Ridge			

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	17 Management Fees	\$ 486,041	Nivram Management, Inc.	50.00%	\$	(486,041)	1
2	V	21 Bank Charges		Nivram Management, Inc.	50.00%	29	29	2
3	V	21 Office Expenses		Nivram Management, Inc.	50.00%	518	518	3
4	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	215	215	4
5	V	27 Franchise Tax		Nivram Management, Inc.	50.00%	27	27	5
6	V	19 Accounting		Nivram Management, Inc.	50.00%	135	135	6
7	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	25,284	25,284	7
8	V	5 Utilities		Nivram Management, Inc.	50.00%	3,401	3,401	8
9	V	27 Insurance		Nivram Management, Inc.	50.00%	1,209	1,209	9
10	V	6 Repairs & Maintenance		Nivram Management, Inc.	50.00%	823	823	10
11	V	22 Health Insurance		Nivram Management, Inc.	50.00%	3,449	3,449	11
12	V	6 Scavenger		Nivram Management, Inc.	50.00%	98	98	12
13	V	34 Rent	1,207,237	Henry Mermelstein			(1,207,237)	13
14	Total		\$ 1,693,278			\$ 35,188	\$ * (1,658,090)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	35 Equipment Rental	\$	Nivram Management, Inc.	50.00%	\$ 675	\$	675	15
16	V	6 Building Expense		Nivram Management, Inc.	50.00%	398		398	16
17	V	25 Auto Expense		Nivram Management, Inc.	50.00%	187		187	17
18	V	21 Postage		Nivram Management, Inc.	50.00%	503		503	18
19	V	21 Mattress Expense		Nivram Management, Inc.	50.00%	256		256	19
20	V	30 Depreciation		Nivram Management, Inc.	50.00%	214		214	20
21	V	21 Data Processing		Nivram Management, Inc.	50.00%	508		508	21
22	V	21 Telephone		Nivram Management, Inc.	50.00%	1,389		1,389	22
23	V	6 Plant Salary		Nivram Management, Inc.	50.00%	28,902		28,902	23
24	V	17 Asst. Administrator		Nivram Management, Inc.	50.00%	43,352		43,352	24
25	V	21 Office Manager		Nivram Management, Inc.	50.00%	19,468		19,468	25
26	V	1 Dietary Supervisor		Nivram Management, Inc.	50.00%	38,000		38,000	26
27	V	17 Administrator		Nivram Management, Inc.	50.00%	150,000		150,000	27
28	V	17 Administrator		Nivram Management, Inc.	50.00%	26,784		26,784	28
29	V	21 Administrator		Nivram Management, Inc.	50.00%	67,476		67,476	29
30	V	21 Clerical		Nivram Management, Inc.	50.00%	72,743		72,743	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		\$			\$ 450,855	\$ *	450,855	39

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

Facility Name & ID Number

Central Nursing

0019364

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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	Henry Mermelstein	Administrator	Administrative	None	100,000	48	60.00	Salary	\$ 150,000	L 17, Col 7	1
2	Louise Mermelstein	Dietary Supervisor	Support	None	52,000	40	42.22	Salary	38,000	L 1, Col 7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	80,098	5	26.52	Salary	28,902	L 6, Col 7	3
4	Doreen Mermelstein	Office Manager	Administrative	None	84,652	7	18.70	Salary	19,468	L 21, Col 7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	120,148	7	26.51	Salary	43,352	L 17, Col 7	6
7	Joseph Mermelstein	Owner	Administrative	50.00	68,216	3	28.19	Salary	26,784	L 17, Col 7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 306,506		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 Central Nursing# 0019364

Report Period Beginning:

01/01/2004Ending: 2/31/2004

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

Nivram Management, Inc.

Street Address

6500 N. Hamlin Ave

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 679-7484

Fax Number

(847) 679-7494

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	21	Bank Charges	Resident Beds	924	5	\$ 110	\$ 245	\$ 29	1	
2	21	Office Expenses	Resident Beds	924	5	1,952	245	518	2	
3	20	Dues & Subscriptions	Resident Beds	924	5	810	245	215	3	
4	27	Franchise Tax	Resident Beds	924	5	100	245	27	4	
5	19	Accounting	Resident Beds	924	5	510	245	135	5	
6	22	Payroll Taxes	Resident Beds	924	5	95,359	245	25,285	6	
7	5	Utilities	Resident Beds	924	5	12,827	245	3,401	7	
8	27	Insurance	Resident Beds	924	5	4,558	245	1,209	8	
9	6	Repairs & Maintenance	Resident Beds	924	5	3,103	245	823	9	
10	22	Health Insurance	Resident Beds	924	5	13,008	245	3,449	10	
11	6	Scavenger	Resident Beds	924	5	370	245	98	11	
12	35	Equipment Rental	Resident Beds	924	5	2,544	245	675	12	
13	6	Building Expense	Resident Beds	924	5	1,500	245	398	13	
14	25	Auto Expense	Resident Beds	924	5	706	245	187	14	
15	21	Postage	Resident Beds	924	5	1,895	245	502	15	
16	21	Mattress Expense	Resident Beds	924	5	967	245	256	16	
17	30	Depreciation	Resident Beds	924	5	808	245	214	17	
18	21	Data Processing	Resident Beds	924	5	1,914	245	508	18	
19	21	Telephone	Resident Beds	924	5	5,238	245	1,389	19	
20	6	Plant Salary	Direct Cost	1	1	28,902	28,902	1	28,902	20
21	17	Asst. Administrator	Direct Cost	1	1	43,352	43,352	1	43,352	21
22	21	Office Manager	Direct Cost	1	1	19,468	19,468	1	19,468	22
23	1	Dietary Supervisor	Direct Cost	1	1	38,000	38,000	1	38,000	23
24	17	Administrative	Direct Cost	1	1	244,260	244,260	1	244,260	24
25	TOTALS					\$ 522,261	\$ 373,982	\$ 413,300	25	

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning:

01/01/2004

Ending: 2/31/2004

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

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

Name of Related Organization Nivram Management, Inc.
 Street Address 6500 N. Hamlin Ave
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-7484
 Fax Number (847) 679-7494

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	21	Clerical	Direct Cost	1	1	\$ 72,743	\$ 72,743	1	\$ 72,743	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					\$ 72,743	\$ 72,743		\$ 72,743	25

Facility Name & ID Number

Central Nursing

0019364

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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							\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$				\$						
	B. Non-Facility Related*																	
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$	\$				\$						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2003 report.		\$	209,600	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.)		\$	238,603	2
3. Under or (over) accrual (line 2 minus line 1).		\$	29,003	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	209,600	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.		\$	238,603	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	217,338	8
	2000	198,472	9
	2001	203,521	10
	2002	205,803	11
	2003	238,603	12

FOR OHF USE ONLY

2003 Tax bill = 238,603	13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
Leave estimate for 2004	14	PLUS APPEAL COST FROM LINE 5	\$	14
accrual constant at \$209,600	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 Central Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0019364

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-29-431-013-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>13,260.09</u>	\$ <u>13,260.09</u>
2. <u>13-29-431-014-0000</u>	<u>2451 N. Central Avenue</u>	\$ <u>32,768.29</u>	\$ <u>32,768.29</u>
3. <u>13-29-431-015-0000</u>	<u>2452 N. Central Avenue</u>	\$ <u>32,818.14</u>	\$ <u>32,818.14</u>
4. <u>13-29-431-016-0000</u>	<u>2453 N. Central Avenue</u>	\$ <u>32,818.14</u>	\$ <u>32,818.14</u>
5. <u>13-29-431-017-0000</u>	<u>2454 N. Central Avenue</u>	\$ <u>32,778.58</u>	\$ <u>32,778.58</u>
6. <u>13-29-431-018-0000</u>	<u>2455 N. Central Avenue</u>	\$ <u>32,700.23</u>	\$ <u>32,700.23</u>
7. <u>13-29-431-019-0000</u>	<u>2456 N. Central Avenue</u>	\$ <u>32,586.75</u>	\$ <u>32,586.75</u>
8. <u>13-29-431-020-0000</u>	<u>2457 N. Central Avenue</u>	\$ <u>25,981.09</u>	\$ <u>25,981.09</u>
9. <u>13-29-431-021-0000</u>	<u>2458 N. Central Avenue</u>	\$ <u>1,404.39</u>	\$ <u>1,404.39</u>
10. <u>13-29-431-022-0000</u>	<u>2459 N. Central Avenue</u>	\$ <u>1,487.44</u>	\$ <u>1,487.44</u>
TOTALS		\$ <u>238,603.14</u>	\$ <u>238,603.14</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 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 Central Nursing

0019364

Report Period Beginning:

01/01/2004 Ending:

12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>30,000</u>	<u>1973</u>	<u>\$ 158,977</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	30,000		\$ 158,977	3

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

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	245	1973	1973	\$ 1,729,156	\$	30	\$	\$	\$ 1,729,156	4
5				(95,563)						5
6										6
7										7
8										8
	Improvement Type**									
9	Sprinkler System		1976	8,246		20			8,246	9
10	Hot Water Heater		1983	2,156		10			2,156	10
11	Light Fixtures		1984	14,684		10			14,684	11
12	Roof		1984	20,000		20			19,417	12
13	Heating & Air Conditioning		1983	2,924		20			2,871	13
14	Painting & Decorating		1983	7,863		8			7,863	14
15	Doorways		1986	1,840		15			1,840	15
16	Elevator Upgrade		1986	1,080	57	20	54	(3)	960	16
17	Wall Corner Guard		1987	1,531		10			1,531	17
18	Resurface Parking Lot		1987	6,900		15			6,900	18
19	Additions		1988	1,200	38	20	60	22	926	19
20	Heater Foundation		1989	1,000	31	20	50	19	721	20
21	Roof		1990	7,916	251	20	396	145	5,484	21
22	Roof		1990	2,199		8			2,199	22
23	Various Improvements		1990	1,850		8			1,850	23
24	Cubicle Curtains		1992	11,273		10			11,273	24
25	HVAC Improvements		1993	8,907		10			8,907	25
26	Draperies		1993	2,700		10			2,700	26
27	Tiling		1995	6,600	170	10	660	490	5,890	27
28	Leasehold Improvements		1995	15,914		10	1,591	1,591	15,380	28
29	Generator		1996	17,527	449	10	1,753	1,304	13,888	29
30	Roof		1996	4,800	123	10	480	357	3,803	30
31	Doorways		1997	2,465	64	10	247	183	1,710	31
32	Wiring for Emergency System		1997	5,000	129	10	500	371	3,462	32
33	Phone System		1997	8,238		10	824	824	5,751	33
34	Architecture		1998	6,000	154	10	600	446	3,554	34
35	Boiler, A/C, Ductwork		1998	16,664	357	10	1,666	1,309	9,868	35
36										36

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

See Page 12A, Line 70 for total

**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	
37	Roofing	1998	\$ 54,000	\$ 1,385	10	\$ 5,400	\$ 4,015	\$ 31,985	37
38	Parking Lot Improvements	1998	8,000	800	10	800		4,533	38
39	Elevator Improvements	1998	4,450	68	10	445	377	2,145	39
40	HVAC Improvements	1998	2,820	72	10	282	210	1,388	40
41	Fire Alarm System Doors	1999	107,500	2,756	10	10,750	7,994	52,923	41
42	Extended Walls Through Ceiling	1999	3,000	77	10	300	223	1,477	42
43	Elevator Improvements	1999	2,650	68	10	265	197	1,309	43
44	HVAC Improvements	1999	20,388	522	10	2,039	1,517	10,033	44
45	Landscape Work	1999	4,100	105	10	410	305	2,018	45
46	Elevator Improvements	2000	89,750	2,301	10	8,975	6,674	35,210	46
47	HVAC Improvements	2000	23,639	606	10	2,364	1,758	9,274	47
48	Telephone System	2000	7,500	192	10	750	558	2,942	48
49	Air Conditioning System	2001	4,000	104	10	400	296	1,304	49
50	Air Conditioning System	2001	10,800	277	10	1,080	803	2,572	50
51	Air Conditioning System	2001	2,500	65	10	250	185	440	51
52	Air Conditioning Improvements	2003	5,800	74	10	580	506	3,002	52
53	Door	2004	1,742		10	15	15		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)		\$ 2,173,709	\$ 11,295		\$ 43,986	\$ 32,691	\$ 2,055,545	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	\$ 64,467	\$ 9,028	\$ 6,447	\$ (2,581)		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	392,583					392,583	73
74	Nivram Management Depr.		214	499	285			74
75	TOTALS	\$ 457,050	\$ 9,242	\$ 6,946	\$ (2,296)		\$ 392,583	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 Storage	Storage Trailer	1986	\$ 900	\$	\$	\$		\$	76
77	Administrative	1999 Oldsmobile	1999	22,218	2,135		(2,135)			77
78										78
79										79
80	TOTALS			\$ 23,118	\$ 2,135	\$	\$ (2,135)		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,812,854	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,672	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,932	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 28,260	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,448,128	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.

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

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:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 1,667 Description: Ice Makers \$900 Copier \$767

(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

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. _____ /2005 \$ _____

13. _____ /2006 \$ _____

14. _____ /2007 \$ _____

* 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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	15	12 visits	690				12	690	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				56,438		56,438	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Rentals Other (specify): <u>Internal Tube Feeding</u>	39-2 43-2					45,671 35,844		32,178 35,844	13
14	TOTAL			\$ 690		\$	\$ 137,953	12	\$ 125,150	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 Central Nursing

0019364

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004

(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	\$ 1,179,584	\$ 1,179,584	1
2	Cash-Patient Deposits	47,869	47,869	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,179,400	1,179,400	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,727	56,727	6
7	Other Prepaid Expenses	676	676	7
8	Accounts Receivable (owners or related parties)	1,338,708	1,338,708	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,802,964	\$ 3,802,964	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,977	13
14	Buildings, at Historical Cost		1,729,156	14
15	Leasehold Improvements, at Historical Cost	454,334	513,464	15
16	Equipment, at Historical Cost	329,417	530,429	16
17	Accumulated Depreciation (book methods)	(409,278)	(2,244,687)	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): <u>Deposits</u>	500,100	500,100	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 874,573	\$ 1,187,439	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,677,537	\$ 4,990,403	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,297	\$ 29,297	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,918	47,918	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,762	120,762	30
31	Accrued Taxes Payable (excluding real estate taxes)	46,552	46,552	31
32	Accrued Real Estate Taxes(Sch.IX-B)	209,600	209,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Rent</u>	1,104,069	1,104,069	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,558,198	\$ 1,558,198	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,558,198	\$ 1,558,198	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,119,339	\$ 3,432,205	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,677,537	\$ 4,990,403	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,835,145	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,835,145	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,099,194	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	(1,815,000)	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)	\$ 1,284,194	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)	\$ 3,119,339	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	\$ 8,694,315	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,694,315	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,473	6
7	Oxygen	102,350	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 112,823	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	95,029	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 95,029	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	18,160	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,160	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending</u>	5,500	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,500	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,925,827	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	818,375	31
32	Health Care	1,817,227	32
33	General Administration	1,401,300	33
B. Capital Expense			
34	Ownership	1,469,941	34
C. Ancillary Expense			
35	Special Cost Centers	137,953	35
36	Provider Participation Fee	134,506	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,779,302	40
41	Income before Income Taxes (line 30 minus line 40)**	3,146,525	41
42	Income Taxes	(47,331)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,099,194	43

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

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

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

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

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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	Director of Nursing	2,078	2,319	\$ 81,606	\$ 35.19	1
2	Assistant Director of Nursing	1,944	2,184	51,324	23.50	2
3	Registered Nurses	30,084	32,500	708,572	21.80	3
4	Licensed Practical Nurses	8,554	9,348	151,979	16.26	4
5	Nurse Aides & Orderlies	62,536	68,629	583,588	8.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,861	5,113	32,019	6.26	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,076	2,236	22,550	10.08	13
14	Head Cook	3,062	3,318	38,268	11.53	14
15	Cook Helpers/Assistants	14,346	16,074	107,123	6.66	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	19,407	21,295	189,217	8.89	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,347	11,711	153,599	13.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,295	174,727	\$ 2,119,845 *	\$ 12.13	34

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	M	\$ 11,828	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	702	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L	2,509	10a-3	40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F	725	10a-3	43
44	Activity Consultant	E			44
45	Social Service Consultant	E	3,761	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,525		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,715	\$ 61,302	10-3	50
51	Licensed Practical Nurses	1,858	29,722	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	5,573	\$ 91,024		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
_____	_____	_____	\$ _____	Workers' Compensation Insurance	\$ 60,215	IDPH License Fee	\$ _____	
_____	_____	_____	_____	Unemployment Compensation Insurance	15,566	Advertising: Employee Recruitment	10,197	
_____	_____	_____	_____	FICA Taxes	157,491	Health Care Worker Background Check (Indicate # of checks performed _____)	_____	
_____	_____	_____	_____	Employee Health Insurance	109,530	AARP Motoring Plan	44	
_____	_____	_____	_____	Employee Meals	25,791	IL Council on Long Term Care	13,267	
_____	_____	_____	_____	Illinois Municipal Retirement Fund (IMRF)*	_____	Less: Non Deductible Dues	(4,446)	
_____	_____	_____	_____	Union Pension	7,681	Advertising: Yellow Pages	2,171	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ _____	Profit Sharing Contribution	10,000	Schedule from Page 21a	3,541	
B. Administrative - Other				Other Employee Benefits	4,322	Allocation from Management	215	
Description			Amount	Chicago Head Tax	4,464	Less: Public Relations Expense	(_____)	
_____			\$ _____	Allocation from Management	28,733	Non-allowable advertising	(_____)	
_____			_____		_____	Yellow page advertising	(2,171)	
_____			_____		_____			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ _____	TOTAL (agree to Schedule V, line 22, col.8)		\$ 423,793	TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Kessler Orlean Silver</u>	<u>Accounting</u>		\$ 11,635	_____	_____	\$ _____	Out-of-State Travel	\$ _____
<u>ADP</u>	<u>Payroll Service</u>		2,721	_____	_____	_____	_____	_____
<u>Accu-Med Services, Inc.</u>	<u>Computer Support</u>		2,640	_____	_____	_____	In-State Travel	2,475
<u>Medi.Com</u>	<u>Computer Support</u>		248	_____	_____	_____	_____	_____
<u>Health Data Systems, Inc.</u>	<u>Computer Support</u>		3,944	_____	_____	_____	Seminar Expense	_____
<u>Medifax-EDI, Inc.</u>	<u>Computer Support</u>		582	_____	_____	_____	_____	_____
<u>Gary A. Weintraub, P.C.</u>	<u>Legal</u>		4,394	_____	_____	_____	Entertainment Expense	(_____)
<u>Howard Reich</u>	<u>Legal</u>		4,450	_____	_____	_____	(agree to Sch. V, line 24, col. 8)	
<u>Klafter & Burke</u>	<u>Legal</u>		25,090	_____	_____	_____	TOTAL	2,475
<u>Myers, Miller & Krauskoff</u>	<u>Legal</u>		730	_____	_____	_____		
<u>Fulgencio T. Duremdes</u>	<u>Legal</u>		4,530	_____	_____	_____		
<u>Schedule from Page 21a</u>			22,615	_____	_____	_____		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 83,579	TOTAL		\$ _____		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

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. Illinois Council on Long Term Care
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 134,506
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. \$ 25,791 Has any meal income been offset against related costs? No 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
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? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. _____
- (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