

Facility Name & ID Number Eunice Smith Home# 0008409 Report Period Beginning: 01/01/04 Ending: 12/31/04

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 04-01-04

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>64</u>	Skilled (SNF)	<u>62</u>	<u>22,874</u>	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	<u>64</u>	TOTALS	<u>62</u>	<u>22,874</u>	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>1,727</u>	<u>19,700</u>	<u>477</u>	<u>21,904</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,727</u>	<u>19,700</u>	<u>477</u>	<u>21,904</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.76%D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES NO H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO I. On what date did you start providing long term care at this location?
Date started 12/30/66J. 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 7 and days of care provided 477Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31 Fiscal Year: 12/31

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

STATE OF ILLINOIS

Facility Name & ID Number Eunice Smith Home # 0008409 Report Period Beginning: 01/01/04 Ending: 12/31/04

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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		166,069	54,815	220,884		220,884	279,194	500,078		1
2	Food Purchase										2
3	Housekeeping	90,538	11,412	5,624	107,574		107,574		107,574		3
4	Laundry	16,855	5,977	46,157	68,989		68,989		68,989		4
5	Heat and Other Utilities			61,682	61,682		61,682		61,682		5
6	Maintenance	38,434	5	28,470	66,909		66,909		66,909		6
7	Other (specify):* Cafeteria							18,558	18,558		7
8	TOTAL General Services	145,827	183,463	196,748	526,038		526,038	297,752	823,790		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,388,353	102,585	8,832	1,499,770		1,499,770	12,465	1,512,235		10
10a	Therapy	32,570	807	244	33,621		33,621		33,621		10a
11	Activities										11
12	Social Services	71,392	3,450	6,244	81,086		81,086		81,086		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,492,315	106,842	15,320	1,614,477		1,614,477	12,465	1,626,942		16
	C. General Administration										
17	Administrative	147,155	7,770	184,616	339,541		339,541	30,882	370,423		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			6,493	6,493		6,493	(3,217)	3,276		20
21	Clerical & General Office Expenses							13,623	13,623		21
22	Employee Benefits & Payroll Taxes			446,573	446,573		446,573		446,573		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,407	8,407		8,407		8,407		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			28,237	28,237		28,237		28,237		26
27	Other (specify):*										27
28	TOTAL General Administration	147,155	7,770	674,326	829,251		829,251	41,288	870,539		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,785,297	298,075	886,394	2,969,766		2,969,766	351,505	3,321,271		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

Eunice Smith Home

#0008409

Report Period Beginning:

01/01/04

Ending:

12/31/04

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			120,172	120,172		120,172		120,172			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			15,402	15,402		15,402		15,402			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			135,574	135,574		135,574		135,574			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	3,560	26,545		30,105		30,105		30,105			39
40	Barber and Beauty Shops			8,733	8,733		8,733		8,733			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							35,040	35,040			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	3,560	26,545	8,733	38,838		38,838	35,040	73,878			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,788,857	324,620	1,030,701	3,144,178		3,144,178	386,545	3,530,723			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 Eu nice Smith Home

0008409

Report Period Beginning: 01/01/04

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VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,591)	17		24
25	Fund Raising, Advertising and Promotional	(3,217)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Provider Participation Fee</u>	35,040	42		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 21,232		\$	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))	\$ 21,232		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

Eunice Smith Home

ID# 0008409

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning:

01/01/04

Ending:

12/31/04

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	279,194	0	0	0	0	0	0	0	0	0	279,194	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	18,558	0	0	0	0	0	0	0	0	0	18,558	7
8	TOTAL General Services	0	297,752	0	0	0	0	0	0	0	0	0	297,752	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	12,465	0	0	0	0	0	0	0	0	0	12,465	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	12,465	0	0	0	0	0	0	0	0	0	12,465	16
	C. General Administration													
17	Administrative	(10,591)	41,473	0	0	0	0	0	0	0	0	0	30,882	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,217)	0	0	0	0	0	0	0	0	0	0	(3,217)	20
21	Clerical & General Office Expenses	0	13,623	0	0	0	0	0	0	0	0	0	13,623	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(13,808)	55,096	0	0	0	0	0	0	0	0	0	41,288	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,808)	365,313	0	0	0	0	0	0	0	0	0	351,505	29

Facility Name & ID Number Eunice Smith Home

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Report Period Beginning:

01/01/04

Ending:

12/31/04

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
Alton Memorial Hospital	100					
BJC Health System	100					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$ 220,884	Alton Memorial Hospital	100.00%	\$ 500,078	\$ 279,194
2	V	7 Cafeteria		Alton Memorial Hospital	100.00%	18,558	18,558
3	V	10 Medical Records		Alton Memorial Hospital	100.00%	12,465	12,465
4	V	21 Administrative & General		Alton Memorial Hospital	100.00%	13,623	13,623
5	V	17 Home Office Costs	119,491	BJC Home Office	100.00%	160,964	41,473
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 340,375			\$ 705,688	\$ * 365,313

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

Facility Name & ID Number Eunice Smith Home # 0008409 Report Period Beginning: 01/01/04 Ending: 12/31/04

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									\$	1	
2										2	
3		There were no payments								3	
4										4	
5										5	
6										6	
7										7	
8										8	
9										9	
10										10	
11										11	
12										12	
13									TOTAL	\$	13

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

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

Facility Name & ID Number Eunice Smith Home # 0008409 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Meals Served	204,360	5	\$ 1,727,333	\$	59,164	\$ 500,078	1
2	7 Cafeteria	FTE"s	55,911	31	185,220		5,602	18,558	2
3	10 Medical Records	Gross Revenue	245,963,111	25	971,661		3,155,303	12,465	3
4	21 Finance	Gross Revenue	246,037,578	27	930,318		3,155,303	11,931	4
5	21 Purchasing	Supplies	8,184,955	42	264,901		52,269	1,692	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				\$ 4,079,433	\$		\$ 544,724	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		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1						\$	\$			\$	1									
2			NA								2									
3											3									
4											4									
5											5									
	Working Capital																			
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$	9									
	B. Non-Facility Related*																			
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$			\$	15									

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

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

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

Facility Name & ID Number **Eunice Smith Home**# **0008409** Report Period Beginning: **01/01/04** Ending: **12/31/04****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.			\$	11,606	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.)			\$	14,224	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	2,618	3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	12,784	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.			\$	15,402	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1999	_____	8		
		2000	_____	9		
		2001	_____	10		
		2002	13,596	11		
		2003	14,224	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 Eunice Smith Home COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0008409

CONTACT PERSON REGARDING THIS REPORT Paul Bradshaw

TELEPHONE 314-653-5366 FAX #: ()

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>23-1-07-12-12-201-009</u>	<u>PT SE NE PART SW NE</u>	\$ <u>14,224.00</u>	\$ <u>14,224.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>14,224.00</u>	\$ <u>14,224.00</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 Eunice Smith Home# 0008409 Report Period Beginning:01/01/04 Ending:12/31/04**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 32,604 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1937	\$ 21,169	1
2					2
3	TOTALS			\$ 21,169	3

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning:

01/01/04

Ending:

12/31/04

XL 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	62	1966	1966	\$ 433,793	\$ 10,485	40	\$ 10,485	\$	\$ 417,169	4
5		1968	1968	1,770		Various			1,770	5
6		1968	1968	762		Various			762	6
7		1973	1973	1,000	30	33	30		949	7
8		1980	1980	1,178		Various			1,178	8
Improvement Type**										
9	A/C Units		1995	222		5			222	9
10	7 1/2 Ton		1981	6,888		20			6,888	10
11	Water Heater		1981	16,430		15			16,430	11
12	Sprinkler		1981	1,980		25			1,980	12
13	Painting		1985	13,850		Various			13,850	13
14	Misc Renovation		1988	75,082		15			75,082	14
15	Misc Renovation		1992	4,155	208	20	208		3,120	15
16	A/C Units		1989	16,438	546	15	546		16,438	16
17	Misc Renovation		1990	53,990		Various			53,990	17
18	Plumbing		1966	521,325		Various			521,325	18
19	Incinerator Upgrade		1973	695		5			695	19
20	Misc		1968	790		Various			790	20
21	Misc		1970	190		10			190	21
22	Incinerator Upgrade		1967	3,825		20			3,825	22
23	Parking/Wheelchair		1983	40,133		12			40,133	23
24	Driveway		1989	4,900		10			4,900	24
25	Driveway		1995	8,972	598	15	598		5,980	25
26	Fence Extension		1990	698	47	15	47		681	26
27	Parkin/Walk/Curbs		1966	47,660		Various			47,660	27
28	Misc Landscaping		1968	330		Various			330	28
29	Misc Landscaping		1970	600		Various			600	29
30	Oil & Chip Roadway		1981	3,805		5			3,805	30
31	Wall Construction		1991	5,509	275	20	275		3,713	31
32	Door Frame		1991	1,770		10			1,770	32
33	Concrete		1992	726	48	15	48		480	33
34	Patch & Seal Parking		1994	7,435	620	12	620		6,510	34
35	Door Frame		1995	1,449	72	10	72		1,449	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning:

01/01/04

Ending:

12/31/04

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	Install Water Softener	1995	\$ 14,149	\$ 1,415	10	\$ 1,415	\$	\$ 13,442		37
38	Window Treatment Lobby	1995	2,138	214	10	214		2,033		38
39	East Dining Room Carpet	1995	2,844		5			2,844		39
40	East Dining Room Alum Door	1995	1,449	72	20	72		684		40
41	East Dining Room Wall Covering	1995	2,845		5			2,845		41
42	Landscape	1995	42,800	2,853	15	2,853		27,104		42
43	Conference Room Renovation	1996	7,916	792	10	792		6,140		43
44	Replace Secondary Signage	1997	9,471	947	10	947		7,576		44
45	Install Vinyl Flooring Rest Rooms	1997	32,700	3,270	10	3,270		26,160		45
46	Elevator Door Protection	1997	1,656	166	10	166		1,328		46
47	Flat Roof Replacement	1997	82,637	8,264	10	8,264		58,537		47
48	Cabinetry	1997	5,816	291	20	291		2,075		48
49	Corridor Painting	1997	5,771		5			5,771		49
50	Door Frame Protectors	1997	2,426	244	10	244		1,738		50
51	Interior & Exterior Lighting	1997	20,084	2,014	10	2,014		14,373		51
52	Install Vinyl Flooring Rest Rooms	1997	29,773	2,986	10	2,986		18,329		52
53	Replace Carpet East Dining Room	1998	7,927		5			7,927		53
54	Install New Transformer	1998	28,092	1,405	20	1,405		9,132		54
55	Storm Drain Back Parking Lot	1999	8,413	467	18	467		2,569		55
56	Install 4 Smoke Dampers in Basement	1999	6,248	417	15	417		2,293		56
57	Install Wandeguard Locking System	1999	2,162	309	7	309		1,802		57
58	Wall Covering & Paint	2001	8,106	1,621	5	1,621		5,674		58
59	Fire Sprinkler System	2001	193,922	7,757	25	7,757		28,442		59
60	Roof Replacement	2003	31,668	3,167	10	3,167		6,336		60
61	Air Conditioning System	2003	75,514	15,103	5	15,103		30,206		61
62	Security Camera Upgrade	2003	4,737	947	5	947		1,894		62
63	Wandeguard Door Alarm	2003	28,750	2,875	10	2,875		3,594		63
64	Air Conditioning System	2003	54,665	10,933	5	10,933		12,755		64
65	Wood Fencing Courtyard	2004	21,760	907	8	907		907		65
66	Landscaping	2004	21,759	725	10	725		725		66
67	Carpentry Work Alzheimer's Unit	2004	44,130	2,697	15	2,697		2,697		67
68	Carpentry Work Tub Room Conversion	2004	11,500	319	15	319		319		68
69	Carpentry Work Screen Patio West Wing	2004	19,200	213	15	213		213		69
70	TOTAL (lines 4 thru 69)		\$ 2,111,378	\$ 86,319		\$ 86,319	\$	\$ 1,563,128		70

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

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,111,378	\$ 86,319		\$ 86,319	\$	\$ 1,563,128	1
2	Metal or Wood Cabinets	2004	26,500	736	15	736		736	2
3	Commercial Water Heater	2004	44,917	2,246	10	2,246		2,246	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,182,795	\$ 89,301		\$ 89,301	\$	\$ 1,566,110	34

**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	\$ 484,366	\$ 30,133	\$ 30,133	\$		\$ 432,903	71
72	Current Year Purchases	10,380	738	738			738	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 494,746	\$ 30,871	\$ 30,871	\$		\$ 433,641	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	Nursing Home Business	1992 Ford Savannah	1991	\$ 33,255	\$	\$	\$	4	\$ 33,255	76
77										77
78										78
79										79
80	TOTALS			\$ 33,255	\$	\$	\$		\$ 33,255	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 2,731,965	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 120,172	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 120,172	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)	\$ 2,033,006	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: Not Applicable
 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

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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	2		3		4		5		6	7	8
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
					Units	Cost							
1	Licensed Occupational Therapist		482 hrs	\$ 10,833							482	\$ 10,833	1
2	Licensed Speech and Language Development Therapist		93 hrs	2,242							93	2,242	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist		853 hrs	19,495				750			853	20,245	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy		# of prescripts										9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Exceptional Care Program												12
13	Other (specify):												13
14	TOTAL			\$ 32,570		\$		\$ 750			1,428	\$ 33,320	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 Eunice Smith Home

0008409

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(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	\$	\$ 32,258,123	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)		9,816,603	3
4 Supply Inventory (priced at)		431,517	4
5 Short-Term Investments			5
6 Prepaid Insurance		409,341	6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): Other Receivables		4,224,080	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 47,139,664	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments		525,000	12
13 Land		191,222	13
14 Buildings, at Historical Cost		64,214,704	14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost		35,343,538	16
17 Accumulated Depreciation (book methods)		(66,200,962)	17
18 Deferred Charges		2,786,401	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):		59,436,184	22
23 Other(specify):			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 96,296,087	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 143,435,751	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$	\$ 1,026,205	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable		1,415,000	29
30 Accrued Salaries Payable		4,189,248	30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable		135,851	33
34 Deferred Compensation		342,726	34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 Other Current Liabilities		7,605,806	36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 14,714,836	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable		18,425,000	39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 Self Insurance Liability		3,402,214	43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 21,827,214	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 36,542,050	46
47 TOTAL EQUITY(page 18, line 24)	\$ 106,893,701	\$ 106,893,701	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 106,893,701	\$ 143,435,751	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 86,597,372	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 86,597,372	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(132,216)	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) AMH Net Income	20,347,312	15
16	Other (describe) Adjustment	81,233	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 20,296,329	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)	\$ 106,893,701	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning: 01/01/04

Ending: 12/31/04

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,150,215	1
2	Discounts and Allowances for all Levels	(162,105)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,988,110	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,144	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	350	21
22	Laundry	5,836	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 17,330	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Non Operating Income	6,522	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,522	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,011,962	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	526,038	31
32	Health Care	1,614,477	32
33	General Administration	829,251	33
B. Capital Expense			
34	Ownership	135,574	34
C. Ancillary Expense			
35	Special Cost Centers	38,838	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,144,178	40
41	Income before Income Taxes (line 30 minus line 40)**	(132,216)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (132,216)	43

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

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

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

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

Facility Name & ID Number Eunice Smith Home

0008409

Report Period Beginning: 01/01/04

Ending:

12/31/04

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,857	2,091	\$ 54,400	\$ 26.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,744	15,142	429,110	28.34	3
4	Licensed Practical Nurses	11,000	12,597	231,454	18.37	4
5	Nurse Aides & Orderlies	51,760	59,183	673,389	11.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,307	1,428	32,570	22.81	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	5,810	6,409	71,392	11.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,062	2,322	38,434	16.55	17
18	Housekeepers	8,717	9,694	90,538	9.34	18
19	Laundry	1,750	1,963	16,855	8.59	19
20	Administrator	1,790	2,092	88,410	42.26	20
21	Assistant Administrator					21
22	Other Administrative	2,742	3,533	58,745	16.63	22
23	Office Manager					23
24	Clerical					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 C: Pharmacy	82	91	3,560	39.12	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	101,621	116,545	\$ 1,788,857 *	\$ 15.35	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Adinistrator			\$ 88,410	Workers' Compensation Insurance	\$ 50,080	IDPH License Fee	\$	
Clerical			58,745	Unemployment Compensation Insurance	2,574	Advertising: Employee Recruitment		
				FICA Taxes	129,490	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	244,584	Nursing Home Assoc Dues	2,695	
				Employee Meals		Other Dues	581	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	3,217	
				Life Insurance	1,652			
				Long Term Disability	1,909			
				Pension	14,089			
				Employee Tuition	20			
				Employee Activities	1,064	Less: Public Relations Expense	()	
				Employee Assistance	1,111	Non-allowable advertising	(3,217)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 147,155	TOTAL (agree to Schedule V, line 22, col.8)	\$ 446,573	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,276	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Corporate Fees			\$ 155,789			\$	Out-of-State Travel	\$
Bad Debt			10,591					
Office Equipment Rental			3,062				In-State Travel	3,552
Other See Attached			15,174					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 184,616				Seminar Expense	4,855
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	\$ 8,407
			\$				TOTAL	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eunice Smith Home# 0008409Report Period Beginning: 01/01/04Ending: 12/31/04**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. Life Services Network \$2,695
- (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? 8 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,922 Line 39
- (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. \$ 35,040
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? NA
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. See Cover Letter
- (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? NA
Attach invoices and a summary of services for all architect and appraisal fees.