

Facility Name & ID Number GROSSE POINTE MANOR

0045203 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	99	Skilled (SNF)	99	36,234	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	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Public Aid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	5,899	2,701	2,251	10,851	8
9	SNF/PED					9
10	ICF	16,346	1,303		17,649	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,245	4,004	2,251	28,500	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.66%

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)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/01

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

YES Date 01/01/01 NO

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

YES NO If YES, enter number of beds certified 47 and days of care provided 2,116

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 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				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	235,744	17,481	4,676	257,901		257,901		257,901		1
2	Food Purchase		203,428		203,428	(19,581)	183,847	(1,678)	182,169		2
3	Housekeeping	40,767	20,317		61,084		61,084		61,084		3
4	Laundry	62,966	9,470	1,842	74,278		74,278		74,278		4
5	Heat and Other Utilities			106,078	106,078		106,078	643	106,721		5
6	Maintenance	63,414	31,727	19,503	114,644		114,644	1,311	115,955		6
7	Other (specify):*			10,340	10,340		10,340		10,340		7
8	TOTAL General Services	402,891	282,423	142,439	827,753	(19,581)	808,172	276	808,448		8
	B. Health Care and Programs										
9	Medical Director			11,500	11,500		11,500		11,500		9
10	Nursing and Medical Records	1,291,621	60,638	34,934	1,387,193		1,387,193	(356)	1,386,837		10
10a	Therapy			957	957		957		957		10a
11	Activities	112,710	4,487	572	117,769		117,769		117,769		11
12	Social Services			540	540		540		540		12
13	Nurse Aide Training										13
14	Program Transportation			876	876		876		876		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,404,331	65,125	49,379	1,518,835		1,518,835	(356)	1,518,479		16
	C. General Administration										
17	Administrative	71,128			71,128		71,128	21,745	92,873		17
18	Directors Fees										18
19	Professional Services			25,238	25,238		25,238	3,117	28,355		19
20	Dues, Fees, Subscriptions & Promotions			48,573	48,573		48,573	(44,934)	3,639		20
21	Clerical & General Office Expenses	151,040	12,959	79,919	243,918		243,918	(110,235)	133,683		21
22	Employee Benefits & Payroll Taxes			432,578	432,578	19,581	452,159		452,159		22
23	Inservice Training & Education			295	295		295		295		23
24	Travel and Seminar							374	374		24
25	Other Admin. Staff Transportation			1,037	1,037		1,037		1,037		25
26	Insurance-Prop.Liab.Malpractice			92,111	92,111		92,111	1,168	93,279		26
27	Other (specify):*							7,967	7,967		27
28	TOTAL General Administration	222,168	12,959	679,751	914,878	19,581	934,459	(120,798)	813,661		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,029,390	360,507	871,569	3,261,466		3,261,466	(120,878)	3,140,588		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	3,840
	REPAIRS & MAINTENANCE	836
		0
		4,676
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,842
		0
		1,842
5	HEAT & OTHER UTILITIES	
	GAS HEAT	34,672
	ELECTRICITY	52,223
	WATER	18,011
	CABLE TV - LOBBY	1,172
		0
		106,078
6	MAINTENANCE	
	GROUNDS MAINTENANCE	11,004
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,318
	ELEVATOR MAINTENANCE & REPAIR	3,701
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,480
	FIRE SERVICE	0
		0
		0
		0
		19,503
7	OTHER	
	SCAVENGER	10,340
	SECURITY SERVICE	0
		10,340
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	11,500
		11,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	30,658
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	383
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,210
	PHARMACY CONSULTANT XVIII B 39-2	1,683
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		34,934
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	311
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	598
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	48
		957
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	572
		0
		572
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	540
		0
		540
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	876
		876
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
		0
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	3,927
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	21,311
		0
		25,238
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	45,248
	EMPLOYEE WANT ADS XIX F	198
	CONTRIBUTIONS VI 20 XIX F	50
	DUES & SUBSCRIPTIONS XIX F	184
	LICENSES & PERMITS XIX F	2,883
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	10
		48,573
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,466
	OUTSIDE CLERICAL SERVICES	48,000
	PENALTIES / OVERDRAFT CHARGES VI 18	13,156
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,297
	MESSENGER SERVICE	0
		0
		79,919

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	158,974
	UNEMPLOYMENT COMPENSATION XIX D	58,432
	WORKERS COMPENSATION INSURANC XIX D	46,292
	HOSPITALIZATION INSURANCE XIX D	165,004
	EMPLOYEE BENEFITS - OTHER XIX D	3,876
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		432,578
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	295
		295
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,037
		1,037
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	92,111
		92,111
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

871,569

GROSSE POINTE MANOR
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2004

TOTAL FOOD PURCHASE	203,428	PATIENT MEALS	85500
LESS SALES TAX	(794)	ADD EMPLOYEE MEALS	9150
	-----		-----
NET FOOD	202,634	TOTAL MEALS/YEAR	94650
TOTAL PATIENT CENSUS	28,500	NET FOOD	202634
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	94650

TOTAL PATIENT MEALS	85500	COST PER MEAL	2.14
		TIME EMPLOYEE MEALS	9150
ADD # EMPLOYEE MEALS/DAY	25		-----
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	19581
	-----		=====
TOTAL EMPLOYEE MEALS	9150		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			13,015	13,015		13,015	132,200	145,215			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,410	54,410		54,410	186,774	241,184			32
33	Real Estate Taxes			164,906	164,906		164,906	2,281	167,187			33
34	Rent-Facility & Grounds			296,400	296,400		296,400	(296,400)				34
35	Rent-Equipment & Vehicles			16,295	16,295		16,295	4,747	21,042			35
36	Other (specify):*											36
37	TOTAL Ownership			545,026	545,026		545,026	29,602	574,628			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		61,906	48,526	110,432		110,432	(131)	110,301			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		61,906	102,878	164,784		164,784	(131)	164,653			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,029,390	422,413	1,519,473	3,971,276		3,971,276	(91,407)	3,879,869			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	(50,697)	30		9
10	Interest and Other Investment Income	(9,953)	32		10
11	Discounts, Allowances, Rebates & Refunds	(884)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(794)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(13,156)	21		18
19	Entertainment		20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(177)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(45,248)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(80,793)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (201,752)		\$	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)	110,345		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 110,345		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (91,407)		37

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

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

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

GROSSE POINTE MANOR

ID# 0045203

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	DEFERRED MAINTENANCE	\$ 0	6	1
2	MARKETING SALARIES	(80,793)	21	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	(80,793)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GROSSE POINTE MANOR# 0045203

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,678)	0	0	0	0	0	0	0	0	0	0	(1,678)	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	643	0	0	0	0	0	0	0	0	643	5
6	Maintenance	0	0	1,311	0	0	0	0	0	0	0	0	1,311	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,678)	0	1,954	0	0	0	0	0	0	0	0	276	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	(356)	0	0	0	0	0	(356)	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	(356)	0	0	0	0	0	(356)	16
	C. General Administration													
17	Administrative	0	0	0	21,745	0	0	0	0	0	0	0	21,745	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(177)	2,000	1,294	0	0	0	0	0	0	0	0	3,117	19
20	Fees, Subscriptions & Promotions	(45,298)	0	364	0	0	0	0	0	0	0	0	(44,934)	20
21	Clerical & General Office Expenses	(93,949)	(48,000)	26,994	4,720	0	0	0	0	0	0	0	(110,235)	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	374	0	0	0	0	0	0	0	0	374	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	1,168	0	0	0	0	0	0	0	0	1,168	26
27	Other (specify):*	0	0	4,788	0	3,179	0	0	0	0	0	0	7,967	27
28	TOTAL General Administration	(139,424)	(46,000)	34,982	26,465	3,179	0	0	0	0	0	0	(120,798)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(141,102)	(46,000)	36,936	26,465	3,179	(356)	0	0	0	0	0	(120,878)	29

STATE OF ILLINOIS

Facility Name & ID Number GROSSE POINTE MANOR# 0045203

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	(50,697)	180,764	2,133	0	0	0	0	0	0	0	0	132,200	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,953)	194,886	1,841	0	0	0	0	0	0	0	0	186,774	32
33	Real Estate Taxes	0	0	2,281	0	0	0	0	0	0	0	0	2,281	33
34	Rent-Facility & Grounds	0	(296,400)	0	0	0	0	0	0	0	0	0	(296,400)	34
35	Rent-Equipment & Vehicles	0	0	4,747	0	0	0	0	0	0	0	0	4,747	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(60,650)	79,250	11,002	0	0	0	0	0	0	0	0	29,602	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	(131)	0	0	0	0	0	(131)	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	(131)	0	0	0	0	0	(131)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(201,752)	33,250	47,938	26,465	3,179	(487)	0	0	0	0	0	(91,407)	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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	21	BOOKKEEPING SERVICES	\$ 48,000	DYNAMIC HEALTHCARE CONSULTANTS		\$	\$ (48,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	296,400	GROSSE POINTE MANOR REALTY LLC			(296,400)	7
8	V	30	DEPRECIATION		" " "		180,764	180,764	8
9	V	32	INTEREST		" " "		194,886	194,886	9
10	V	19	PROFESSIONAL FEES		" " "		2,000	2,000	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 344,400				\$ 377,650	\$ * 33,250	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	5 UTILITIES	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 643	\$	643	15
16	V	6 REPAIR & MAINT.		" " "		1,311		1,311	16
17	V	19 PROFESSIONAL FEES		" " "		1,294		1,294	17
18	V	20 DUES & SUBSCRIPTIONS		" " "		364		364	18
19	V	21 CLERICAL & GENERAL		" " "		26,994		26,994	19
20	V	24 SEMINARS & TRAVEL		" " "		374		374	20
21	V	26 INSURANCE		" " "		1,168		1,168	21
22	V	27 EMP.BEN - GEN, ADMIN.		" " "		4,788		4,788	22
23	V	30 DEPRECIATION		" " "		2,133		2,133	23
24	V	32 INTEREST		" " "		1,841		1,841	24
25	V	33 REAL ESTATE TAXES		" " "		2,281		2,281	25
26	V	35 EQUIPMENT RENTAL		" " "		4,747		4,747	26
27	V			" " "					27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 47,938	\$ *	47,938	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 MAINT.CMP.- D.NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$		15
16	V	17 ADMIN.CMP.- M. MAUER		" "		11,475	11,475	16
17	V	17 ADMIN.CMP.- M. AARON		" "				17
18	V	17 ADMIN.CMP.- F. AARON		" "				18
19	V	17 ADMIN.CMP.- S. GOLDSTEIN		" "				19
20	V	17 ADMIN.CMP.- S. KOPLIN		" "				20
21	V	17 ADMIN.CMP.- D. MAGAFAS		" "				21
22	V	17 ADMIN.CMP.- S. LEVY		" "		10,270	10,270	22
23	V	17 ADMIN.CMP.- HOWARD ALTER		" "				23
24	V	17 ADMIN.CMP.- NON-OWNER		" "				24
25	V	21 CLERICAL CMP.- S.AARON		" "		4,720	4,720	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 26,465	\$ * 26,465	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	7 EMP.BEN. - D.NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$		15
16	V	27 EMP.BEN. - M. MAUER		" " "		930	930	16
17	V	27 EMP.BEN. - M. AARON		" " "				17
18	V	27 EMP.BEN. - F. AARON		" " "				18
19	V	27 EMP.BEN. - S. GOLDSTEIN		" " "				19
20	V	27 EMP.BEN. - S. KOPLIN		" " "				20
21	V	27 EMP.BEN. - D. MAGAFAS		" " "				21
22	V	27 EMP.BEN. - S. LEVY		" " "		1,436	1,436	22
23	V	27 EMP.BEN. - H. ALTER		" " "				23
24	V	27 EMP.BEN. - NON-OWNER		" " "				24
25	V	27 EMP.BEN. - S.AARON		" " "		813	813	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 3,179	\$ * 3,179	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A THERAPY	\$	DYNAMIC REHAB CONSULTANTS LLC		\$	\$	15
16	V	19 PROFESSIONAL FEES						16
17	V	22 EMPLOYEE BENEFITS						17
18	V	39 ANCILLARY SERVICES						18
19	V							19
20	V							20
21	V	10 MEDICAL SUPPLIES	1,889	LINCOLN MEDICAL SUPPLIES, INC		1,533	(356)	21
22	V	39 ANCILLARY EXPENSE	697			566	(131)	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 2,586			\$ 2,099	\$ * (487)	39

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

Facility Name & ID Number

GROSSE POINTE MANOR

0045203

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	SHERRY MAUER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	\$ 71,128	17-1	1
2	SHERRY MAUER		NURSING					SALARY	21,592	10-1	2
3	MARSHALL MAUER		ADMINISTRATIVE					SALARY	11,475	17-7	3
4	SHARON AARON		CLERICAL					SALARY	4,720	21-7	4
5	DOVIE MAUER		FILE CLERK					SALARY	46,912	21-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 155,827		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 GROSSE POINTE MANOR

0045203

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 DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W.MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	5	UTILITIES	TOTAL PATIENT DAYS	427,864	12	\$ 9,658	\$ 28,500	\$ 643	1
2	6	REPAIR & MAINT.	" "	427,864	12	19,683	28,500	1,311	2
3	19	PROFESSIONAL FEES	" "	427,864	12	19,431	28,500	1,294	3
4	20	DUES AND SUBSCRIPTION	" "	427,864	12	5,469	28,500	364	4
5	21	CLERICAL & GENERAL	" "	427,864	12	405,253	290,672	26,994	5
6	24	SEMINARS AND TRAVEL	" "	427,864	12	5,616	28,500	374	6
7	26	INSURANCE	" "	427,864	12	17,537	28,500	1,168	7
8	27	EMP. BEN. - GEN, ADMIN.	" "	427,864	12	71,885	28,500	4,788	8
9	30	DEPRECIATION	" "	427,864	12	32,025	28,500	2,133	9
10	32	INTEREST	" "	427,864	12	27,646	28,500	1,841	10
11	33	REAL ESTATE TAXES	" "	427,864	12	34,248	28,500	2,281	11
12	35	EQUIPMENT RENTAL	" "	427,864	12	71,259	28,500	4,747	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					\$ 719,710	\$ 290,672	\$ 47,938	25

Facility Name & ID Number GROSSE POINTE MANOR

0045203

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 DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W.MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	6	MAINT.CMP.- D.NEHMER	WGHTD AVG.HOURS	40	9	\$ 65,436	\$ 65,436		1
2	17	ADMIN.CMP.- M. MAUER	" "	40	11	170,000	170,000	3	11,475
3	17	ADMIN.CMP.- M. AARON	" "	40	9	170,000	170,000		
4	17	ADMIN.CMP.- F. AARON	" "	47	6	119,100	119,100		
5	17	ADMIN.CMP.- S. GOLDSTEIN	" "	45	3	24,000	24,000		
6	17	ADMIN.CMP.- S. KOPLIN	" "	40	7	72,815	72,815		
7	17	ADMIN.CMP.- D. MAGAFAS	" "	45	9	80,395	80,395		
8	17	ADMIN.CMP.- S. LEVY	" "	45	11	152,350	152,350	3	10,270
9	17	ADMIN.CMP.- H. ALTER	" "	40	1	12,000	12,000		
10	17	ADMIN.CMP.- NON-OWNER	" "	45	9	164,490	164,490		
11	21	CLERICAL CMP.- S.AARON	" "	40	11	69,932	69,932	3	4,720
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					\$ 1,100,518	\$ 1,100,518		\$ 26,465

Facility Name & ID Number GROSSE POINTE MANOR

0045203

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 DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W.MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	7	EMP.BEN. - D.NEHMER	WGHTD AVG.HOURS	40	9	\$ 5,508		\$	1
2	27	EMP.BEN. - M. MAUER	" "	40	11	13,783	3	930	2
3	27	EMP.BEN. - M. AARON	" "	40	9	18,779			3
4	27	EMP.BEN. - F. AARON	" "	47	6	34,154			4
5	27	EMP.BEN. - S. GOLDSTEIN	" "	45	3	25,404			5
6	27	EMP.BEN. - S. KOPLIN	" "	40	7	21,655			6
7	27	EMP.BEN. - D. MAGAFAS	" "	45	9	7,575			7
8	27	EMP.BEN. - S. LEVY	" "	45	11	21,295	3	1,436	8
9	27	EMP.BEN. - H. ALTER	" "	40	1	1,244			9
10	27	EMP.BEN. - NON-OWNER	" "	45	9	24,475			10
11	27	EMP.BEN. - S.AARON	" "	40	11	12,038	3	813	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					\$ 185,910	\$	\$ 3,179	25

Facility Name & ID Number GROSSE POINTE MANOR

0045203

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 DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W.MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	<u>DYNAMIC REHAB CONSULTANTS</u>				\$	\$		\$	1
2	<u>10A THERAPY</u>	<u>DIRECT ALLOCATION</u>							2
3	<u>19 PROFESSIONAL FEES</u>	" "							3
4	<u>22 EMPLOYEE BENEFITS</u>	" "							4
5	<u>39 ANCILLARY SERVICES</u>	" "							5
6									6
7									7
8	<u>LINCOLN MEDICAL SUPPLIES</u>								8
9	<u>10 MEDICAL SUPPLIES</u>	<u>DIRECT ALLOCATION</u>						1,533	9
10	<u>39 ANCILLARY EXPENSES</u>	" "						566	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				\$	\$		\$ 2,099	25

Facility Name & ID Number

GROSSE POINTE MANOR

0045203

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	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	MB FINANCIAL		X	MORTGAGE			\$	\$ 4,741,709		\$ 194,886	1									
2											2									
3											3									
4											4									
5	REALTED PARTY	X								1,841	5									
Working Capital																				
6	MB FINANCIAL		X	WORKING CAPITAL				1,250,000		49,014	6									
7			X	INSURANCE FINANCING						2,133	7									
8	RELATED PARTY	X		LINE OF CREDIT				287,500		3,263	8									
9	TOTAL Facility Related						\$	\$ 6,279,209		\$ 251,137	9									
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES							10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$	\$ 6,279,209		\$ 251,137	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.		\$	108,000	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.)		\$	132,906	2
3. Under or (over) accrual (line 2 minus line 1).		\$	24,906	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	140,000	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.		\$	164,906	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1999	_____	8	
	2000	_____	9	
	2001	_____	10	
	2002	105,501	11	
	2003	132,906	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.				
	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.

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning:

01/01/2004 Ending:

12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>2001</u>	\$ <u>573,648</u>	1
2					2
3	TOTALS			\$ 573,648	3

Facility Name & ID Number GROSSE POINTE MANOR

0045203

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	99	2001		\$ 3,862,200	\$ 180,764	27.5	\$ 134,598	\$ (46,166)	\$ 538,392	4
5										5
6										6
7										7
8				39,548	758		844	86	9,568	8
	Improvement Type**									
9	ICE MACHINE DRAIN/COOLING PUMP/WATER PUMP	2001		6,224	226	27.5	226		898	9
10	ROOFING	2001		34,800	1,266	27.5	1,265	(1)	4,228	10
11	SURVEILLANCE EQUIP/ANTENNA	2001		2,250	82	27.5	82		304	11
12	TELEPHONE / SPLITTERS	2001		609		7	87	87		12
13	DINING CAR/ROOM SIGNS	2001		8,744	318	27.5	318		1,013	13
14	MONITOR / CAMERA	2002		5,303	193	27.5	193		534	14
15	MEZUZAHs	2002		2,240	81	27.5	81		228	15
16	WIRING / WATER VALVE / PUMP / VENTILATOR	2002		7,756	282	27.5	282		717	16
17	COMPRESSOR	2003		1,364	50	27.5	50		73	17
18	SATELLITE DISH SYSTEM	2003		1,054	38	27.5	38		56	18
19	WALK IN COOLER	2003		3,920	143	27.5	143		208	19
20	DRAIN	2003		923	34	27.5	34		49	20
21	SMOKE DETECTORS	2003		1,761	64	27.5	64		93	21
22	VIDEO CAMERA	2003		896	32	27.5	33	1	48	22
23	FIRE SUPPRESSION SYSTEM	2004		4,315	72	27.5	72		72	23
24	TOWER PUMP	2004		4,328	72	27.5	72		72	24
25	A/C CHILLER	2004		1,458	24	27.5	24		24	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,989,693	\$ 184,499		\$ 138,506	\$ (45,993)	\$ 556,577	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	\$ 50,204	\$ 7,457	\$ 5,020	\$ (2,437)	10	\$ 11,299	71
72	Current Year Purchases	4,301	2,581	215	(2,366)	10	215	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	18,747	947	1,399	452		13,754	74
75	TOTALS	\$ 73,252	\$ 10,985	\$ 6,634	\$ (4,351)		\$ 25,268	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	RELATED PARTY			\$ 3,750	\$ 428	\$ 75	\$ (353)		\$ 3,750	76
77										77
78										78
79										79
80	TOTALS			\$ 3,750	\$ 428	\$ 75	\$ (353)		\$ 3,750	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)	\$ 4,640,343	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 195,912	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 145,215	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (50,697)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 585,595	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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: \$ 10,734 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		<u>NISSAN</u>	\$ <u>463.45</u>	\$ <u>5,561</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>463.45</u>	\$ <u>5,561</u>	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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></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	39-3	hrs	\$		\$ 25,163	\$		\$ 25,163	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,008			1,008	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			22,355			22,355	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				52,859		52,859	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, RADIOLOGY, LAB, RENT & OTHER Other (specify):	39-2					9,047		9,047	13
14	TOTAL			\$		\$ 48,526	\$ 61,906		\$ 110,432	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 **GROSSE POINTE MANOR**# **0045203**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
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	858,885		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,342		6
7	Other Prepaid Expenses	6,525		7
8	Accounts Receivable (owners or related parties)	50,873		8
9	Other(specify): RE TAX ESCROW	2,094		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 940,719	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	87,945		15
16	Equipment, at Historical Cost	54,504		16
17	Accumulated Depreciation (book methods)	(50,105)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 92,344	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,033,063	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 467,923	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,250,000		29
30	Accrued Salaries Payable	116,487		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,102		31
32	Accrued Real Estate Taxes(Sch.IX-B)	140,000		32
33	Accrued Interest Payable	3,570		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,993,082	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	287,500		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)	\$ 287,500	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,280,582	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,247,519)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,033,063	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,063,999)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,063,999)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(183,520)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (183,520)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,247,519)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **GROSSE POINTE MANOR**# **0045203**Report Period Beginning: **01/01/2004**Ending: **12/31/2004**

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	\$ 3,731,533	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,731,533	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	45,141	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 45,141	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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,953	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,953	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	884	28
28a	VENDING - NET OF COST	245	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,129	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,787,756	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	827,753	31
32	Health Care	1,518,835	32
33	General Administration	914,878	33
B. Capital Expense			
34	Ownership	545,026	34
C. Ancillary Expense			
35	Special Cost Centers	110,432	35
36	Provider Participation Fee	54,352	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,971,276	40
41	Income before Income Taxes (line 30 minus line 40)**	(183,520)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (183,520)	43

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

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

*** 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 **GROSSE POINTE MANOR**

0045203

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	2,180	2,362	\$ 74,713	\$ 31.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,628	4,718	127,969	27.12	3
4	Licensed Practical Nurses	13,995	15,142	377,712	24.94	4
5	Nurse Aides & Orderlies	58,472	61,138	710,627	11.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,049	2,092	30,816	14.73	9
10	Activity Assistants	5,948	6,302	81,894	12.99	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,981	2,135	30,023	14.06	13
14	Head Cook	3,909	4,076	54,272	13.32	14
15	Cook Helpers/Assistants	11,613	12,513	110,170	8.80	15
16	Dishwashers	4,830	5,058	41,279	8.16	16
17	Maintenance Workers	4,094	4,337	63,414	14.62	17
18	Housekeepers	3,988	4,196	40,767	9.72	18
19	Laundry	6,465	6,855	62,966	9.19	19
20	Administrator	2,091	2,033	71,128	34.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,982	8,395	151,040	17.99	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) PLCMT COORD	21	40	600	15.00	33
34	TOTAL (lines 1 - 33)	134,246	141,392	\$ 2,029,390 *	\$ 14.35	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		\$ 3,840	1-3	35
36	Medical Director		11,500	9-3	36
37	Medical Records Consultant		2,210	10-3	37
38	Nurse Consultant		383	10-3	38
39	Pharmacist Consultant		1,683	10-3	39
40	Physical Therapy Consultant		311	10a-3	40
41	Occupational Therapy Consultant		598	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		48	10a-3	43
44	Activity Consultant		572	11-3	44
45	Social Service Consultant		540	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,685		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	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	
SHERRY MAUER	ADMIN	22.3	\$ 71,128	Workers' Compensation Insurance	\$ 46,292	IDPH License Fee	\$ 200	
				Unemployment Compensation Insurance	58,432	Advertising: Employee Recruitment	198	
				FICA Taxes	158,974	Health Care Worker Background Check	10	
				Employee Health Insurance	165,004	(Indicate # of checks performed <u>1</u>)		
				Employee Meals	19,581	MARKETING/ADV/PROMO	45,248	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	50	
				EMPLOYEE BENEFITS - OTHER	3,876	LICENSES & PERMITS	2,683	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	184	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	364	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(50)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(45,248)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,128	TOTAL (agree to Schedule V, line 22, col.8)	\$ 452,159	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,639	
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
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							Seminar Expense	
								0
							MGMT CO ALLOCATION	374
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 0	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 374
C. Professional Services								
Vendor/Payee	Type		Amount					
KRUPNICK, BOKOR	ACCOUNTING		\$ 14,750					
FROST RUTTENBERG	ACCOUNTING		3,340					
MAX ABRAHMS	LEGAL		150					
MYERS MILLER KRAUSKOPF	LEGAL		1,046					
SACHNOFF & WEAVER	LEGAL		128					
IL ASSOC OF HEALTH CARE	LEGAL		495					
ASKOUNIS & BORST	LEGAL		27					
HEALTH DATA SYSTEM	DATA PROCESSING		3,927					
PERSONELL PLANNERS	UC CONSULTING		1,375					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 25,238					

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$ 0		\$ 0	\$ 0	\$ 0	\$ 0	\$	\$	\$	\$	\$												
2																									
3																									
4																									
5																									
6																									
7																									
8																									
9																									
10																									
11																									
12																									
13																									
14																									
15																									
16																									
17																									
18																									
19																									
20	TOTALS		\$	\$	\$	\$	\$ 0	\$	\$	\$	\$	\$	\$												

Facility Name & ID Number GROSSE POINTE MANOR

0045203

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,528 Line 10-2
- (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. \$ 54,352
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. \$ 19,581 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? 5%
d. Have vehicle usage logs been maintained? NO
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.