

		FOR OHF USE				

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

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

<p><b>I. IDPH Facility ID Number:</b> <u>0043646</u></p> <p><b>Facility Name:</b> <u>Pittsfield Healthcare Center</u></p> <p><b>Address:</b> <u>1400 East Washington Street</u> <u>Pittsfield</u> <u>62363</u>          Number City Zip Code</p> <p><b>County:</b> <u>Pike</u></p> <p><b>Telephone Number:</b> <u>(217) 285-4491</u> Fax # <u>(217) 285-4242</u></p> <p><b>IDPA ID Number:</b> <u>830320180022</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>2/7/1998</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>William H. Keys</u> <b>Telephone Number:</b> <u>(317)566-1586</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2004</u> to <u>12/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date) _____ (Type or Print Name) <u>William H. Keys</u></td> </tr> <tr> <td data-bbox="1155 820 1291 836"></td> <td data-bbox="1291 820 1950 836">(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td data-bbox="1155 836 1291 1031">Paid Preparer</td> <td data-bbox="1291 836 1950 1031">(Signed) _____ (Date) _____ (Print Name and Title) <u>Chris Murphy, CPA Partner</u> (Firm Name &amp; Address) <u>BKD, LLP 6120 S. Yale, Suite 1400</u> (Telephone) <u>(918) 584-2900</u> Fax # <u>(918) 584-2931</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE        ILLINOIS DEPARTMENT OF PUBLIC AID        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>William H. Keys</u>		(Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Chris Murphy, CPA Partner</u> (Firm Name & Address) <u>BKD, LLP 6120 S. Yale, Suite 1400</u> (Telephone) <u>(918) 584-2900</u> Fax # <u>(918) 584-2931</u>
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Facility Name & ID Number Pittsfield Healthcare Center# 0043646 Report Period Beginning: 1/1/2004 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Public Aid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF	16,219	5,578	
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,219	5,578	1,091	22,888	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.17%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)N/A - 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 2/7/1998J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 2/7/1998 NO K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 8 and days of care provided 1,091Medicare Intermediary Trailblazer Health Enterprises, L.L.C.

## 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 Pittsfield Healthcare Center # 0043646 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
<b>A. General Services</b>											
1	Dietary	109,502	7,471	4,760	121,733		121,733		121,733		1
2	Food Purchase		92,209		92,209		92,209	(266)	91,943		2
3	Housekeeping	66,907	11,653		78,560		78,560		78,560		3
4	Laundry	31,883	8,121	197	40,201		40,201	(257)	39,944		4
5	Heat and Other Utilities			66,392	66,392		66,392	(2,905)	63,487		5
6	Maintenance	23,876	6,000	18,254	48,130		48,130	1,608	49,738		6
7	Other (specify):* <b>Waste Removal</b>			4,279	4,279		4,279		4,279		7
8	<b>TOTAL General Services</b>	232,168	125,454	93,882	451,504		451,504	(1,820)	449,684		8
<b>B. Health Care and Programs</b>											
9	Medical Director			3,850	3,850		3,850		3,850		9
10	Nursing and Medical Records	686,180	63,769	72,190	822,139		822,139	5	822,144		10
10a	Therapy		926	106,805	107,731		107,731		107,731		10a
11	Activities	27,676	1,052	2,979	31,707		31,707		31,707		11
12	Social Services	20,419		2,879	23,298		23,298		23,298		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* <b>Non allow cost</b>										15
16	<b>TOTAL Health Care and Programs</b>	734,275	65,747	188,703	988,725		988,725	5	988,730		16
<b>C. General Administration</b>											
17	Administrative	5,782		60,012	65,794		65,794		65,794		17
18	Directors Fees										18
19	Professional Services			31,147	31,147		31,147	18,319	49,466		19
20	Dues, Fees, Subscriptions & Promotions			7,181	7,181		7,181	(4,206)	2,975		20
21	Clerical & General Office Expenses	29,820	8,851	12,624	51,295		51,295	219,751	271,046		21
22	Employee Benefits & Payroll Taxes			184,766	184,766		184,766		184,766		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,744	5,744		5,744	3,669	9,413		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,121	67,121		67,121	26	67,147		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	35,602	8,851	368,595	413,048		413,048	237,559	650,607		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,002,045	200,052	651,180	1,853,277		1,853,277	235,744	2,089,021		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 &amp; ID Number

Pittsfield Healthcare Center

#0043646

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			107,489	107,489		107,489	489	107,978			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							5	5			32
33	Real Estate Taxes			66,268	66,268		66,268	35	66,303			33
34	Rent-Facility & Grounds							1,926	1,926			34
35	Rent-Equipment & Vehicles			4,673	4,673		4,673	196	4,869			35
36	Other (specify):* <b>See Attached</b>			5	5		5		5			36
37	<b>TOTAL Ownership</b>			178,435	178,435		178,435	2,651	181,086			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,420	3,473	28,893		28,893		28,893			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):* <b>Lab &amp; Rad</b>											43
44	<b>TOTAL Special Cost Centers</b>		25,420	57,825	83,245		83,245		83,245			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,002,045	225,472	887,440	2,114,957		2,114,957	238,395	2,353,352			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	(2,905)	05		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	(266)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(360)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,393)	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 Vending Revenue	(661)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (8,585)		\$	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)	246,980	Var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 246,980		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 238,395		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		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Pittsfield Healthcare Center

ID# 0043646

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Other-Attach Schedule - Goodwill	\$ 0		1
2	Other-Attach Schedule - Other non allowable exp	0		2
3	Other-Attach Schedule - Vending revenue	(661)	21	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
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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	<b>Total</b>	(661)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pittsfield Healthcare Center# 0043646 Report Period Beginning:

1/1/2004

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(266)	0	0	0	0	0	0	0	0	0	0	(266)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(257)	0	0	0	0	0	0	0	0	0	(257)	4
5	Heat and Other Utilities	(2,905)	0	0	0	0	0	0	0	0	0	0	(2,905)	5
6	Maintenance	0	1,608	0	0	0	0	0	0	0	0	0	1,608	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(3,171)</b>	<b>1,351</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,820)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5	0	0	0	0	0	0	0	0	0	5	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(360)	18,679	0	0	0	0	0	0	0	0	0	18,319	19
20	Fees, Subscriptions & Promotions	(4,393)	187	0	0	0	0	0	0	0	0	0	(4,206)	20
21	Clerical & General Office Expenses	(661)	220,412	0	0	0	0	0	0	0	0	0	219,751	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	3,669	0	0	0	0	0	0	0	0	3,669	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	26	0	0	0	0	0	0	0	0	26	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(5,414)</b>	<b>239,278</b>	<b>3,695</b>	<b>0</b>	<b>237,559</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(8,585)</b>	<b>240,634</b>	<b>3,695</b>	<b>0</b>	<b>235,744</b>	<b>29</b>							



Facility Name & ID Number **Pittsfield Healthcare Center**

# **0043646**

Report Period Beginning: **1/1/2004**

Ending: **12/31/2004**

**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
<a href="#">See Attached Organizational Structure</a>						

**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	\$	Senior Living Properties, LLC	100.00%	\$ 0	\$
2	V	2 Food Purchase		Senior Living Properties, LLC	100.00%	0	
3	V	3 Housekeeping		Senior Living Properties, LLC	100.00%	0	
4	V	4 Laundry		Senior Living Properties, LLC	100.00%	(257)	(257)
5	V	5 Heat and Other Utilities		Senior Living Properties, LLC	100.00%	0	
6	V	6 Maintenance		Senior Living Properties, LLC	100.00%	1,608	1,608
7	V	7 Waste Removal		Senior Living Properties, LLC	100.00%	0	
8	V	10 Nursing & Medical Records		Senior Living Properties, LLC	100.00%	5	5
9	V	10a Therapy		Senior Living Properties, LLC	100.00%	0	
10	V	17 Administrative		Senior Living Properties, LLC	100.00%	0	
11	V	19 Professional Services		Senior Living Properties, LLC	100.00%	18,679	18,679
12	V	20 Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	187	187
13	V	21 Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	220,412	220,412
14	Total		\$			\$ 240,634	\$ * 240,634

\* 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	22 Employee Benefits & Payroll Taxes	\$	Senior Living Properties	100.00%	\$ 0	\$	15
16	V	24 Travel and Seminar		Senior Living Properties	100.00%	3,669		3,669 16
17	V	26 Insurance - Prop Liab Malpractice		Senior Living Properties	100.00%	26		26 17
18	V	30 Depreciation		Senior Living Properties	100.00%	489		489 18
19	V	32 Interest		Senior Living Properties	100.00%	5		5 19
20	V	33 Real Estate Taxes		Senior Living Properties	100.00%	35		35 20
21	V	34 Rent - Facility & Grounds		Senior Living Properties	100.00%	1,926		1,926 21
22	V	35 Rent - Equipment & Vehicles		Senior Living Properties	100.00%	196		196 22
23	V	36 Loss, Goodwill, & Depreciation		Senior Living Properties	100.00%	0		0 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		\$			\$ 6,346	\$ *	6,346 39

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

Facility Name & ID Number      Pittsfield Healthcare Center      #      0043646      Report Period Beginning:      1/1/2004      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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								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 Pittsfield Healthcare Center # 0043646 Report Period Beginning: 1/1/2004 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

Name of Related Organization Senior Living Properties, LLC  
 Street Address 12900 N. Meridian Street, Suite 180  
 City / State / Zip Code Carmel, Indiana 46032  
 Phone Number (317)566-1586  
 Fax Number (317) 581-9513

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	See Attachment	See Attachment	\$ 0	\$	See Attachment	0	1
2	2	Food Purchase	See Attachment	See Attachment	0		See Attachment	0	2
3	3	Housekeeping	See Attachment	See Attachment	0		See Attachment	0	3
4	4	Laundry	See Attachment	See Attachment	(14,096)		See Attachment	(257)	4
5	5	Heat and Other Utilities	See Attachment	See Attachment	0		See Attachment	0	5
6	6	Maintenance	See Attachment	See Attachment	95,381		See Attachment	1,608	6
7	7	Waste Removal	See Attachment	See Attachment	0		See Attachment	0	7
8	10	Nursing & Medical Records	See Attachment	See Attachment	267		See Attachment	5	8
9	10a	Therapy	See Attachment	See Attachment	0		See Attachment	0	9
10	17	Administrative	See Attachment	See Attachment	0		See Attachment	0	10
11	19	Professional Services	See Attachment	See Attachment	1,026,001		See Attachment	18,679	11
12	20	Dues, Fees, Subscriptions & Prom	See Attachment	See Attachment	10,855		See Attachment	187	12
13	21	Clerical & General Office Expense	See Attachment	See Attachment	12,021,375		See Attachment	220,412	13
14	22	Employee Benefits & Payroll Tax	See Attachment	See Attachment	0		See Attachment	0	14
15	24	Travel and Seminar	See Attachment	See Attachment	272,954		See Attachment	3,669	15
16	26	Insurance - Prop Liab Malpractice	See Attachment	See Attachment	1,435		See Attachment	26	16
17	30	Depreciation	See Attachment	See Attachment	26,841		See Attachment	489	17
18	32	Interest	See Attachment	See Attachment	249		See Attachment	5	18
19	33	Real Estate Taxes	See Attachment	See Attachment	1,914		See Attachment	35	19
20	34	Rent-Facility & Grounds	See Attachment	See Attachment	105,820		See Attachment	1,926	20
21	35	Rent-Equipment & Vehicles	See Attachment	See Attachment	10,725		See Attachment	196	21
22	36	Loss, Goodwill, & Depreciation	See Attachment	See Attachment	0		See Attachment	0	22
23									23
24									24
25	TOTALS				\$ 13,559,723	\$		\$ 246,980	25

Facility Name & ID Number **Pittsfield Healthcare Center** # **0043646** Report Period Beginning: **1/1/2004** Ending: **12/31/2004**

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	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.)

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

**B. Real Estate Taxes**

		<b>Important</b> , 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.		\$ 101,781	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.)		\$ 101,781	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 66,268	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 66,268	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	1999	48,545	8	
	2000	(2,162)	9	
	2001	52,872	10	
	2002	56,531	11	
	2003	64,652	12	
<b>FOR OHF USE ONLY</b>				
	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,

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Pittsfield Healthcare Center COUNTY Pike

FACILITY IDPH LICENSE NUMBER 0043646

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317)566-1586 FAX #: (317)581-9513

**A. Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

(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. 53-033-05	See Attached	\$ 64,652.34	\$ 64,652.34
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>64,652.34</u>	\$ <u>64,652.34</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (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 200 tax bill which is normally paid during 2004

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 30,894 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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 ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	242,194	1998	\$ 137,500	1
2					2
3	TOTALS	242,194		\$ 137,500	3

Facility Name & ID Number Pittsfield Healthcare Center# 0043646

Report Period Beginning:

1/1/2004Ending: 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	1998	1970	\$ 2,020,231	\$ 67,341	30	\$ 67,341	\$	\$ 465,775	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	carpet		1998	764		5			764	9
10	replace sink		1998	5,913	296	20	296		1,799	10
11	install a/c		1998	1,746	175	10	175		1,106	11
12	install a/c unit		1998	5,200	520	10	520		3,207	12
13	Gas Range,Lift Gate		1998	3,087	309	10	309		1,929	13
14	replacement doors		1999	6,619	441	15	441		2,648	14
15	steel door		1999	566	38	15	38		226	15
16	carpet install		1999	2,000		5			2,000	16
17	generator		1999	1,031	52	20	52		301	17
18	met / glass door		1999	1,779	89	20	89		519	18
19	repairs to nurse call system		1999	817	82	10	82		470	19
20	boiler repair		1999	1,100	55	20	55		284	20
21	shower tile		1999	680	34	20	34		176	21
22	compressors (2)		1999	1,732	116	15	116		587	22
23	a/c unit / airhandler		2000	6,980	465	15	465		2,017	23
24	floor and piping repairs		2000	2,089	209	10	209		888	24
25	roof repair & insulation replace		2001	12,881	1,840	7	1,840		7,207	25
26	roof		2001	80,692	3,228	25	3,228		11,835	26
27	carpet		2001	1,115	223	5	223		725	27
28	Locking Door System		2003	8,262	826	10	826		1,033	28
29	Relocate Smoke Detectors		2004	759	32	10	32		32	29
30	Wall Paper Project		2004	526	13	7	13		13	30
31	Carpet Purchase		2004	696		5				31
32	Photo Detectors		2002	1,670	167	10	167		404	32
33	Repair Steam Pipe		2002	787	31	25	31		89	33
34	Water Heater		2002	1,860	186	10	186		543	34
35	Seal, Coat, Patch Asphalt		1998	6,338	792	8	792		4,886	35
36	Signage		1998	464	46	10	46		305	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 Pittsfield Healthcare Center

# 0043646

Report Period Beginning:

1/1/2004

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	
	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	<b>TOTAL (lines 4 thru 69)</b>			\$ 2,178,384	\$ 77,606		\$ 77,606	\$	\$ 511,768	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	\$ 221,494	\$ 28,860	\$ 28,860	\$	Various	\$ 205,643	71
72	Current Year Purchases	28,698	1,023	1,023		Various	1,023	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 250,192	\$ 29,883	\$ 29,883	\$		\$ 206,666	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,566,076	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,489	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 107,489	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)	\$ 718,434	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?  YES  NO  
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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: N/A \*

**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: \$ 4,673 Description: Nursing - 51, Central Supply - 126, Dietary - 588, Laundry - 130, Administrative - 3778  
 (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>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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? <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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist	10a,3	hrs	\$	594	\$	26,413	\$	612	594	\$	27,025	1	
2	Licensed Speech and Language Development Therapist	10a,3	hrs		107		4,756		0	107		4,756	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10a,3	hrs		1,700		75,635		314	1,700		75,950	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	<b>TOTAL</b>			\$	2,401	\$	106,805	\$	926	2,401	\$	107,731	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.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number      Pittsfield Healthcare Center

#      0043646

Report Period Beginning:    1/1/2004

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 18,112	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	314,963		3
4	Supply Inventory (priced at )	4,847		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 337,922	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	137,500		13
14	Buildings, at Historical Cost	2,171,583		14
15	Leasehold Improvements, at Historical Cost	6,802		15
16	Equipment, at Historical Cost	250,191		16
17	Accumulated Depreciation (book methods)	(718,434)		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 <u>Intercompany</u> )			22
23	Other(specify): <u>Intercompany (Pay)/Rec</u>	(3,658,408)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ (1,810,766)	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (1,472,844)	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 22,422	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,750		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,681		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,268		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 143,121	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 143,121	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,615,965)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (1,472,844)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,589,708)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Accounting Adjustments</b>	<b>(52,695)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,642,403)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>26,438</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>26,438</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,615,965)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Pittsfield Healthcare Center

# 0043646

Report Period Beginning: 1/1/2004

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,664,230	1
2	Discounts and Allowances for all Levels	(1,867,113)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,797,117	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	160,893	6
7	Oxygen	41,946	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 202,839	8
<b>C. Other Operating Revenue</b>			
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	350	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	57,202	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,680	19
20	Radiology and X-Ray	98	20
21	Other Medical Services	68,642	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 138,972	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,804	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,804	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Vending	663	28
28a	Vending		28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 663	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,141,395	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	451,504	31
32	Health Care	988,725	32
33	General Administration	413,048	33
<b>B. Capital Expense</b>			
34	Ownership	178,435	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	28,893	35
36	Provider Participation Fee	54,352	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,114,957	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	26,438	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 26,438	43

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

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

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

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

Facility Name &amp; ID Number      Pittsfield Healthcare Center

# 0043646

Report Period Beginning: 1/1/2004

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	0	0	\$ 0	\$ 1
2	Assistant Director of Nursing	1,902	2,006	29,489	14.70
3	Registered Nurses	5,522	5,835	101,116	17.33
4	Licensed Practical Nurses	11,330	12,234	158,869	12.99
5	Nurse Aides & Orderlies	38,711	42,029	387,699	9.22
6	Nurse Aide Trainees	0	0	0	6
7	Licensed Therapist	0	0	0	7
8	Rehab/Therapy Aides	0	0	0	8
9	Activity Director	1,727	1,953	18,994	9.73
10	Activity Assistants	1,128	1,214	8,682	7.15
11	Social Service Workers	1,707	1,950	20,419	10.47
12	Dietician	1,946	2,238	24,464	10.93
13	Food Service Supervisor	0	0	0	13
14	Head Cook	0	0	0	14
15	Cook Helpers/Assistants	9,787	10,724	85,038	7.93
16	Dishwashers	0	0	0	16
17	Maintenance Workers	1,818	1,946	23,876	12.27
18	Housekeepers	7,324	8,457	66,907	7.91
19	Laundry	3,481	3,795	31,883	8.40
20	Administrator	372	376	5,782	15.38
21	Assistant Administrator	0	0	0	21
22	Other Administrative	0	0	0	22
23	Office Manager	0	0	0	23
24	Clerical	2,376	2,541	29,820	11.74
25	Vocational Instruction	0	0	0	25
26	Academic Instruction	0	0	0	26
27	Medical Director	0	0	0	27
28	Qualified MR Prof. (QMRP)	0	0	0	28
29	Resident Services Coordinator	0	0	0	29
30	Habilitation Aides (DD Homes)	0	0	0	30
31	Medical Records	611	865	9,007	10.41
32	Other Health Care(specify)	0	0	0	32
33	Other(specify)	0	0	0	33
34	TOTAL (lines 1 - 33)	89,742	98,163	\$ 1,002,045 *	\$ 10.21

\* 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	108	\$ 4,760	1, 3
36	Medical Director	30	3,850	9, 3
37	Medical Records Consultant	12	596	10, 3
38	Nurse Consultant			10, 3
39	Pharmacist Consultant	96	2,478	10, 3
40	Physical Therapy Consultant			10a, 3
41	Occupational Therapy Consultant			10a, 3
42	Respiratory Therapy Consultant			10a, 3
43	Speech Therapy Consultant			10a, 3
44	Activity Consultant	48	2,979	11, 3
45	Social Service Consultant	48	2,879	12, 3
46	Other(specify) <u>Administrative Consu</u>	2,080	58,962	17, 3
47				47
48				48
49	TOTAL (lines 35 - 48)	2,422	\$ 76,504	49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,080	\$ 55,755	10, 3
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	2,080	\$ 55,755	53





Facility Name & ID Number Pittsfield Healthcare Center# 0043646Report Period Beginning: 1/1/2004Ending: 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. 0 N/A
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,598 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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 service performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees