

		FOR OHF USE				

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

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

<p>I. IDPH Facility ID Number: <u>0044289</u></p> <p>Facility Name: <u>Somerset Place</u></p> <p>Address: <u>5009 Sheridan Road</u> <u>Chicago</u> <u>60640</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 561-0700</u> Fax # <u>(773) 561-9843</u></p> <p>IDPA ID Number: <u>364269377001</u></p> <p>Date of Initial License for Current Owners: <u>02/01/99</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input 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>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Edward N. Slack, C.P.A.</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="center">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) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																															
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

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

None

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	450	Intermediate (ICF)	450	164,700	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	450	TOTALS	450	164,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	145,570	675		146,245	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	145,570	675		146,245	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.79%

D. How many bed-hold days during this year were paid by Public Aid?
2,252 (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 2/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/99 NO

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

Medicare Intermediary None

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/04 Fiscal Year: 12/31/04

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

STATE OF ILLINOIS

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	441,977	74,577	33,603	550,157		550,157	(6,766)	543,391		1
2	Food Purchase		455,956		455,956		455,956	(21)	455,935		2
3	Housekeeping	331,886	75,256		407,142		407,142	(9,440)	397,702		3
4	Laundry	16,982	3,077	94,138	114,197		114,197		114,197		4
5	Heat and Other Utilities			298,694	298,694		298,694	3,655	302,349		5
6	Maintenance	377,216		138,515	515,731		515,731	12,508	528,239		6
7	Other (specify):*							3,390	3,390		7
8	TOTAL General Services	1,168,061	608,866	564,950	2,341,877		2,341,877	3,326	2,345,203		8
B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,618,343	77,724	69,054	2,765,121		2,765,121	35,766	2,800,887		10
10a	Therapy	23,105			23,105		23,105		23,105		10a
11	Activities	303,729	23,720	196	327,645		327,645		327,645		11
12	Social Services	675,684	6,721	7,227	689,632		689,632	26,289	715,921		12
13	Nurse Aide Training			460	460		460		460		13
14	Program Transportation										14
15	Other (specify):*							10,605	10,605		15
16	TOTAL Health Care and Programs	3,620,861	108,165	88,937	3,817,963		3,817,963	72,660	3,890,623		16
C. General Administration											
17	Administrative	108,919		28,189	137,108		137,108	33,199	170,307		17
18	Directors Fees										18
19	Professional Services			651,673	651,673	(6,068)	645,605	(576,383)	69,222		19
20	Dues, Fees, Subscriptions & Promotions			92,469	92,469		92,469	(48,952)	43,517		20
21	Clerical & General Office Expenses	193,447	24,296	481,449	699,192		699,192	(28,846)	670,346		21
22	Employee Benefits & Payroll Taxes			852,387	852,387		852,387	(6,949)	845,438		22
23	Inservice Training & Education			200	200		200		200		23
24	Travel and Seminar			5,179	5,179		5,179	9,700	14,879		24
25	Other Admin. Staff Transportation			16,972	16,972		16,972	(10,140)	6,832		25
26	Insurance-Prop.Liab.Malpractice			259,792	259,792		259,792	2,378	262,170		26
27	Other (specify):*							56,959	56,959		27
28	TOTAL General Administration	302,366	24,296	2,388,310	2,714,972	(6,068)	2,708,904	(569,034)	2,139,870		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,091,288	741,327	3,042,197	8,874,812	(6,068)	8,868,744	(493,048)	8,375,696		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

#0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			74,574	74,574		74,574	581,158	655,732			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,220,214	1,220,214			32
33	Real Estate Taxes					6,068	6,068	476,345	482,413			33
34	Rent-Facility & Grounds			2,958,000	2,958,000		2,958,000	(2,946,603)	11,397			34
35	Rent-Equipment & Vehicles			13,618	13,618		13,618	4,383	18,001			35
36	Other (specify):*							134,400	134,400			36
37	TOTAL Ownership			3,046,192	3,046,192	6,068	3,052,260	(530,103)	2,522,157			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							108	108			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			247,050	247,050		247,050		247,050			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			247,050	247,050		247,050	108	247,158			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,091,288	741,327	6,335,439	12,168,054		12,168,054	(1,023,044)	11,145,010			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/04

Ending: 12/31/04

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	(61,763)	30		9
10	Interest and Other Investment Income	(387,992)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	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	(309)	21		18
19	Entertainment				19
20	Contributions	(1,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(101,616)	21		24
25	Fund Raising, Advertising and Promotional	(4,645)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,332)	20		28
29	Other-Attach Schedule	(311,987)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (871,165)		\$	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)	(151,878)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (151,878)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,023,044)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Somerset Place

ID# 0044289

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	\$	1
2	(1,441)	2
3	(230)	3
4	(130)	4
5	(121)	5
6	(7,221)	6
7	(700)	7
8	(5,562)	8
9	(1,252)	9
10	(283,811)	10
11	(8,400)	11
12		12
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97		97
98		98
99		99
100		100
101 Total	(311,987)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(27)	959		(7,698)					(6,766)	1
2	Food Purchase	(21)											(21)	2
3	Housekeeping				(9,440)								(9,440)	3
4	Laundry													4
5	Heat and Other Utilities					3,655							3,655	5
6	Maintenance	(4,353)			(62)	3,904		13,019					12,508	6
7	Other (specify):*						209	3,181					3,390	7
8	TOTAL General Services	(4,374)			(9,529)	8,518	209	8,502					3,326	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(238)			(9,496)			45,500					35,766	10
10a	Therapy													10a
11	Activities													11
12	Social Services							26,289					26,289	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						102	10,503					10,605	15
16	TOTAL Health Care and Programs	(238)			(9,496)		102	82,292					72,660	16
	C. General Administration													
17	Administrative							33,199					33,199	17
18	Directors Fees													18
19	Professional Services	(8,400)	8,400			(576,383)							(576,383)	19
20	Fees, Subscriptions & Promotions	(15,398)	700			(34,254)							(48,952)	20
21	Clerical & General Office Expenses	(387,438)				35,652		322,940					(28,846)	21
22	Employee Benefits & Payroll Taxes			(1,211)			(5,738)						(6,949)	22
23	Inservice Training & Education													23
24	Travel and Seminar					9,700							9,700	24
25	Other Admin. Staff Transportation					(10,140)							(10,140)	25
26	Insurance-Prop.Liab.Malpractice		400			1,978							2,378	26
27	Other (specify):*						5,286	51,673					56,959	27
28	TOTAL General Administration	(411,236)	9,500	(1,211)		(573,447)	(452)	407,812					(569,034)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(415,848)	9,500	(1,211)	(19,025)	(564,929)	(141)	498,606					(493,048)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Somerset Place# 0044289 Report Period Beginning:01/01/04 Ending:12/31/04

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

	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	(61,763)	606,681			36,240							581,158	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(387,992)	1,608,206										1,220,214	32
33	Real Estate Taxes		471,829			4,516							476,345	33
34	Rent-Facility & Grounds		(2,958,000)			11,397							(2,946,603)	34
35	Rent-Equipment & Vehicles					4,383							4,383	35
36	Other (specify):*	(5,562)	139,962										134,400	36
37	TOTAL Ownership	(455,317)	(131,322)			56,536							(530,103)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				108								108	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers				108								108	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(871,165)	(121,822)	(1,211)	(18,917)	(508,393)	(141)	498,606					(1,023,044)	45

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See 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:
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	34 Rental Income	\$ 2,958,000			\$	\$ (2,958,000) 1
2	V	32 Interest Income	4,246				(4,246) 2
3	V	32 Interest Expense Mortgage				1,612,452	1,612,452 3
4	V	19 Accounting Fees				8,400	8,400 4
5	V	20 License & Fees				700	700 5
6	V	36 MIP Insurance Expense				134,400	134,400 6
7	V	26 Hazard Insurance Expense				400	400 7
8	V	36 Amort. Closing Fees				5,562	5,562 8
9	V	30 Depreciation				606,681	606,681 9
10	V	33 Real Estate Tax				471,829	471,829 10
11	V						
12	V						
13	V						
14	Total		\$ 2,962,246			\$ 2,840,424	\$ * (121,822) 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 223,031	\$ 223,031	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	224,242	CCS EMPLOYEE BENEFIT GROUP	100.00%		(224,242)	19
20	V							20
21	V							21
22	V							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		\$ 224,242			\$ 223,031	\$ * (1,211)	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	01 DIETARY	\$ 182	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 155	\$ (27)
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%		
17	V	03 HOUSEKEEPING	63,628	XCEL MEDICAL SUPPLY, LLC	100.00%	54,188	(9,440)
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%		
19	V	06 REPAIRS & MAINTENANCE	418	XCEL MEDICAL SUPPLY, LLC	100.00%	356	(62)
20	V	10 NURSING	64,009	XCEL MEDICAL SUPPLY, LLC	100.00%	54,512	(9,496)
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%		
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%		
25	V	39 ANCILLARY	(727)	XCEL MEDICAL SUPPLY, LLC	100.00%	(619)	108
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 127,510			\$ 108,593	\$ * (18,917)

* 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	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 959	\$ 959
16	V	05 Utilities		Care Centers, Inc.	100.00%	3,655	3,655
17	V	06 Maintenance		Care Centers, Inc.	100.00%	3,904	3,904
18	V	10 Nursing		Care Centers, Inc.	100.00%		
19	V	11 Activities		Care Centers, Inc.	100.00%		
20	V	19 Professional Fees	596,063	Care Centers, Inc.	100.00%	19,680	(576,383)
21	V	20 Dues and Subscriptions	41,063	Care Centers, Inc.	100.00%	6,809	(34,254)
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	35,652	35,652
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	9,700	9,700
24	V	26 Insurance		Care Centers, Inc.	100.00%	1,978	1,978
25	V	30 Depreciation		Care Centers, Inc.	100.00%	36,240	36,240
26	V	32 Interest		Care Centers, Inc.	100.00%		
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	4,516	4,516
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	11,397	11,397
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	4,383	4,383
30	V	25 Bus Reimbursement	10,140	Care Centers, Inc.	100.00%		(10,140)
31	V	02 Food		Care Centers, Inc.	100.00%		
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 647,266			\$ 138,873	\$ * (508,393)

* 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	06 Maintenance Salary	\$ 1,431	Care Centers, Inc.	100.00%	\$ 1,431	\$
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	209	209
17	V	10 Nursing Salary	694	Care Centers, Inc.	100.00%	694	
18	V	10a Rehab Salary		Care Centers, Inc.	100.00%		
19	V	11 Activity Salary		Care Centers, Inc.	100.00%		
20	V	12 Social Service Salary		Care Centers, Inc.	100.00%		
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	102	102
22	V	17 Administration Salary		Care Centers, Inc.	100.00%		
23	V	21 Office Salary	36,129	Care Centers, Inc.	100.00%	36,129	
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	5,286	5,286
25	V	22 Employee Benefits	5,738	Care Centers, Inc.	100.00%		(5,738)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 43,992			\$ 43,851	\$ * (141)

* 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	01 Dietary Salary	\$ 16,425	Care Centers, Inc.	100.00%	\$ 8,727	\$ (7,698)
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%		
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	13,019	13,019
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	3,181	3,181
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	45,500	45,500
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%		
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	26,289	26,289
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	10,503	10,503
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	33,199	33,199
24	V	21 Office Salary		Care Centers, Inc.	100.00%	322,940	322,940
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	51,673	51,673
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 16,425			\$ 515,031	\$ * 498,606

* 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: 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		
15	V	01 Dietary	\$	Care Centers, Inc. - Health Systems Division	100.00%	\$	\$	15
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%			16
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%			17
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%			18
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%			19
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%			20
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%			21
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%			22
23	V	26 Insurance		Care Centers, Inc. - Health Systems Division	100.00%			23
24	V	32 Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%			24
25	V	34 Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%			25
26	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%			26
27	V	39 Ancillary Enteral Supplies		Care Centers, Inc. - Health Systems Division	100.00%			27
28	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%			28
29	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%			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		\$			\$	\$ *	39

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/04

Ending: 12/31/04

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: 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		
15	V	30 Depreciation	\$	Vent Lease, LLC.	100.00%	\$	\$	15
16	V	32 Interest		Vent Lease, LLC.	100.00%			16
17	V	39 Vent Reimbursement		Vent Lease, LLC.	100.00%			17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/04

Ending: 12/31/04

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/04

Ending: 12/31/04

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0%	See Attached	3.08	6.67%	Sal/Mgmt Fee	\$ 16,189	17-03	1
2	Adam Vales	Owner	Clerical	1.78%	See Attached	1.45	3.63%	Salary Alloc	1,504	22-7	2
3	Mark Steinberg	Relative	Administrative	0%	See Attached	3.00	5.45%	Salary Alloc	5,956	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 23,649		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CCS Employee Benefits Group, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 223,031	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 223,031	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Xcel Medical Supply, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation		\$	\$		155	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation					54,188	3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation					356	5
6	10	NURSING	Direct Allocation					54,512	6
7	10A	THERAPY	Direct Allocation						7
8	12	SOCIAL SERVICE	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	39	ANCILLARY	Direct Allocation					(619)	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				\$	\$		108,593	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary	Patient Days	42	\$ 9,730	\$	146,245	\$ 959	1
2	05	Utilities	Patient Days	42	37,103		146,245	3,655	2
3	06	Maintenance	Patient Days	42	39,622		146,245	3,904	3
4	10	Nursing	Patient Days	42			146,245		4
5	11	Activities	Patient Days	42			146,245		5
6	19	Professional Fees	Patient Days	42	199,755		146,245	19,680	6
7	20	Dues and Subscriptions	Patient Days	42	69,116		146,245	6,809	7
8	21	Office & Clerical	Patient Days	42	361,868		146,245	35,652	8
9	24	Travel and Seminar	Patient Days	42	98,454		146,245	9,700	9
10	26	Insurance	Patient Days	42	20,081		146,245	1,978	10
11	30	Depreciation	Patient Days	42	367,842		146,245	36,240	11
12	32	Interest	Patient Days	42			146,245		12
13	33	Real Estate Taxes	Patient Days	42	45,838		146,245	4,516	13
14	34	Rent - Building	Patient Days	42	115,677		146,245	11,397	14
15	35	Rent - Equipment & Auto	Patient Days	42	44,486		146,245	4,383	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,409,572	\$		\$ 138,873	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost		264,919	264,919		1,431	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost		38,757			209	2
3	10	Nursing Salary	Direct Cost		209,584	209,584		694	3
4	10a	Rehab Salary	Direct Cost		66,982	66,982			4
5	11	Activity Salary	Direct Cost						5
6	12	Social Service Salary	Direct Cost		66,710	66,710			6
7	15	Emp. Ben. - Healthcare	Direct Cost		50,220			102	7
8	17	Administration Salary	Direct Cost		38,431	38,431			8
9	21	Office Salary	Direct Cost		525,935	525,935		36,129	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost		82,566			5,286	10
11	22	Employee Benefits							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				\$ 1,344,103	\$ 1,172,560		\$ 43,851	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	146,245	\$ 8,727	1
2	03 Housekeeping Salary	Patient Days	1,484,397	42			146,245		2
3	06 Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	146,245	13,019	3
4	07 Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		146,245	3,181	4
5	10 Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	146,245	45,500	5
6	10a Rehab Salary	Patient Days	1,484,397	42			146,245		6
7	12 Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	146,245	26,289	7
8	15 Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		146,245	10,503	8
9	17 Administration Salary	Patient Days	1,484,397	42	336,976	336,976	146,245	33,199	9
10	21 Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	146,245	322,940	10
11	27 Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		146,245	51,673	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				\$ 5,227,610	\$ 4,564,232		\$ 515,031	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835	93,149			\$	1
2	02	Food	Billable Income	2,144,835	987,169				2
3	06	Maintenance	Billable Income	2,144,835	3,597				3
4	17	Administration	Billable Income	2,144,835	24,000				4
5	19	Professional Fees	Billable Income	2,144,835	2,500				5
6	20	Dues & Subscriptions	Billable Income	2,144,835	1,342				6
7	21	Office & Clerical	Billable Income	2,144,835	43,384				7
8	24	Travel & Seminar	Billable Income	2,144,835	10,755				8
9	26	Insurance	Billable Income	2,144,835	9,262				9
10	32	Interest Expense	Billable Income	2,144,835	1,371				10
11	34	Rent - Building	Billable Income	2,144,835	50,000				11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835	1,080				12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835	98,519				13
14	01	Dietary - Salary	Billable Income	2,144,835	335,801	335,801			14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835	49,127				15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,711,055	\$ 335,801		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Vent Lease, LLC
 Street Address 4101 W. Main Street
 City / State / Zip Code Skokie, Illinois 60076
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	620,670	29	\$ 300,000	\$		1
2	32	Interest	Direct Billing	620,670	29	33,493			2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 333,493	\$	\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	HUD Loan/Building Co.		X	Mortgage			\$	\$ 28,411,135			\$ 1,612,452	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
	Working Capital																			
6												6								
7												7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related						\$	\$ 28,411,135			\$ 1,612,452	9								
	B. Non-Facility Related*																			
10	Interest Income		X								(387,992)	10								
11	Interest Income - Bldg Co.		X								(4,246)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			(392,238)	14								
15	TOTALS (line 9+line14)						\$	\$ 28,411,135			\$ 1,220,214	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 134,399 Line # 36

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

** 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 - SUPPLEMENTAL SCHEDULE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
A. Directly Facility Related																				
Long-Term																				
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
6											6									
7	TOTAL Long-Term										7									
Working Capital																				
8						\$	\$			\$	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15						\$	\$			\$	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

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

Facility Name & ID Number **Somerset Place**# **0044289** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2003 report.			\$	609,849	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.)			\$	532,163	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(77,686)	3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	554,030	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.)			\$	6,068	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.			\$	482,412	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1999	568,847	8	FOR OHF USE ONLY	
		2000	559,809	9		
		2001	574,368	10	13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
		2002	580,808	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2003	527,647	12	15	LESS REFUND FROM LINE 6 \$ 15
2004 Accrual: \$527,647 * 1.05 = 554030					16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Allocated From Care Centers: \$4516.03						

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Somerset Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044289

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-08-408-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>519,790.07</u>	\$ <u>519,790.07</u>
2. <u>14-08-408-031-0000</u>	<u>Long Term Care Property</u>	\$ <u>7,857.52</u>	\$ <u>7,857.52</u>
3. <u>Care Center Allocation</u>	<u>Home Office Allocation</u>	\$ <u>106,873.39</u>	\$ <u>4,516.03</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>634,520.98</u>	\$ <u>532,163.62</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 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 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Somerset Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044289

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Somerset Place# 0044289 Report Period Beginning:01/01/04 Ending:12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 184,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 9C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1999	\$ 1,100,000	1
2	Allocation Care Center Inc.			34,650	2
3	TOTALS			\$ 1,134,650	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1999		37,488		20	1,876	1,876	10,594	9
10	Various		2000		615,158		20	31,699	31,699	148,613	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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
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66										66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)			15,295,711	285,252		288,336	3,084	1,652,005	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			133,677	5,490		5,490		11,401	68
69	Financial Statement Depreciation				74,574			(74,574)		69
70	TOTAL (lines 4 thru 69)			\$ 16,082,034	\$ 365,315		\$ 327,401	\$ (37,915)	\$ 1,822,613	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 16,082,034	\$ 365,315		\$ 327,401	\$ (37,915)	\$ 1,822,613		1
2	Shelves	2001 990		20	50	50	199		2
3	Bathroom Renovation	2001 819		20	41	41	164		3
4	Electrical Repairs	2001 5,401		20	270	270	1,080		4
5	Blinds	2001 1,550		20	78	78	311		5
6	Alco Sales & Service	2001 741		20	37	37	145		6
7	Paint	2001 1,113		20	56	56	218		7
8	Ac Repair	2001 1,357		20	68	68	266		8
9	Bathrooms Renovation	2001 1,067		20	53	53	209		9
10	Tiling	2001 783		20	39	39	153		10
11	Tiling	2001 559		20	28	28	110		11
12	Nurse Call Station	2001 700		20	35	35	137		12
13	King Of Tile, Inc.	2001 942		20	47	47	180		13
14	Duraline Overhead	2001 3,028		20	151	151	580		14
15	Tiles	2001 3,838		20	192	192	736		15
16	Tiles	2001 500		20	25	25	96		16
17	Transformer For Heat	2001 445		20	22	22	85		17
18	Window Installation	2001 15,000		20	750	750	2,813		18
19	Cooler Repair	2001 751		20	38	38	142		19
20	Outside Lighting	2001 6,003		20	300	300	1,125		20
21	Landscaping	2001 590		20	30	30	112		21
22	Clean Up Sewer Lines	2001 2,539		20	127	127	466		22
23	Doors	2001 2,610		20	131	131	479		23
24	Fan Repair	2001 561		20	28	28	100		24
25	Boiler Repair	2001 3,247		20	162	162	582		25
26	Landscaping	2001 1,153		20	58	58	207		26
27	Install Emergency	2001 1,113		20	56	56	200		27
28	Sewer Pump	2001 879		20	44	44	158		28
29	Repair Ground Pump	2001 2,963		20	148	148	518		29
30	Install Emergency Li	2001 4,295		20	215	215	752		30
31	Showers Renovation	2001 758		20	38	38	133		31
32	Paint	2001 792		20	40	40	136		32
33	Paint	2001 1,749		20	87	87	298		33
34	TOTAL (lines 1 thru 33)	\$ 16,150,870	\$ 365,315		\$ 330,845	\$ (34,471)	\$ 1,835,503		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 16,150,870	\$ 365,315		\$ 330,845	\$ (34,471)	\$ 1,835,503	1
2	Cooler Repair	2001	1,221		20	61	61	208	2
3	Heating And Ac	2001	54,659		20	2,733	2,733	9,338	3
4	Self-Closing Door	2001	4,900		20	245	245	837	4
5	Doors	2001	800		20	40	40	133	5
6	Hand Rails	2001	2,500		20	125	125	417	6
7	Roof Repair	2001	2,150		20	108	108	359	7
8	Boiler Treatment	2001	997		20	50	50	163	8
9	Repair Motor Pump	2001	2,819		20	141	141	458	9
10	Exhaust Fan	2001	1,446		20	72	72	235	10
11	Pipe System Upgrade	2001	7,289		20	364	364	1,184	11
12	Sewer Line Repair	2001	2,563		20	128	128	416	12
13	Sewer Line Repair	2001	3,200		20	160	160	520	13
14	Window Shades	2001	1,072		20	54	54	170	14
15	Landscaping	2001	5,021		20	251	251	3,633	15
16	Hvac Replacement	2001	3,116		20	156	156	506	16
17	Paint	2001	890		20	45	45	149	17
18	Paint	2001	1,246		20	62	62	203	18
19	Glass For Metal Fram	2001	1,785		20	89	89	342	19
20	Glass For Windows	2001	935		20	47	47	164	20
21	Replace Motor Upgrad	2001	970		20	49	49	158	21
22	Nurse Call System	2002	17,000		20	1,133	1,133	3,400	22
23	Knob Lock	2002	840		20	84	84	252	23
24	Plumbing Supplies	2002	610		20	61	61	178	24
25	Door Curtains	2002	1,068		20	107	107	312	25
26	Sewer Lines	2002	5,237		20	524	524	1,527	26
27	Tuckpointing	2002	1,000		20	100	100	292	27
28	Plaster Caulking, Tuckpointing	2002	8,000		20	800	800	2,267	28
29	Canopy	2002	3,494		20	349	349	990	29
30	Window Shades	2002	723		20	72	72	205	30
31	Magnetic Door Repair	2002	680		20	68	68	193	31
32	Metal Door Installation	2002	670		20	67	67	190	32
33	Fire Alarm Repair	2002	1,530		20	219	219	619	33
34	TOTAL (lines 1 thru 33)		\$ 16,291,301	\$ 365,315		\$ 339,409	\$ (25,907)	\$ 1,865,521	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 16,291,301	\$ 365,315		\$ 339,409	\$ (25,907)	\$ 1,865,521		1
2	Paint	2002 1,032		20	103	103	284		2
3	Shower Faucet	2002 596		20	40	40	109		3
4	Boiler Repair	2002 1,535		20	128	128	352		4
5	Exhaust Motor Replacement	2002 2,950		20	295	295	787		5
6	Tamper Valve Replacement	2002 950		20	95	95	253		6
7	Adt Unimode Fire Alarm	2002 20,693		20	2,956	2,956	7,883		7
8	Canopy Rental	2002 1,648		20	165	165	439		8
9	Door	2002 1,775		20	178	178	473		9
10	Landscaping	2002 1,317		20	88	88	227		10
11	Ac Repair	2002 1,556		20	130	130	324		11
12	Electric Wiring	2002 1,750		20	175	175	438		12
13	Timeclocks Installation	2002 506		20	51	51	122		13
14	Fire System Repair	2002 1,352		20	193	193	467		14
15	Nurse Call System	2002 552		20	37	37	89		15
16	Nurse Call System	2002 586		20	39	39	94		16
17	Nurse Call System	2002 1,554		20	104	104	250		17
18	Boiler Repair	2002 15,665		20	1,305	1,305	3,046		18
19	Paint	2002 589		20	59	59	137		19
20	Tiles	2002 708		20	47	47	110		20
21	Fire Alarm Repair	2002 646		20	92	92	215		21
22	Roof Cement	2002 523		20	52	52	118		22
23	Boiler Repair	2002 2,849		20	237	237	534		23
24	Boiler Repair	2002 2,000		20	167	167	375		24
25	Reroofing	2002 3,500		20	350	350	788		25
26	New Front Door	2002 800		20	80	80	180		26
27	Structural Engineer Service	2002 750		20	75	75	169		27
28	Sewer Study	2002 600		20	60	60	135		28
29	Cast Iron Piping Repair	2002 6,110		20	611	611	1,324		29
30	Cast Iron Piping Repair	2002 560		20	56	56	121		30
31	New Front Door	2002 800		20	80	80	173		31
32	Nurse Call System	2002 2,392		20	159	159	346		32
33	Paint & Tile	2002 2,671		20			2,671		33
34	TOTAL (lines 1 thru 33)	\$ 16,372,816	\$ 365,315		\$ 347,616	\$ (17,700)	\$ 1,888,554		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 16,372,816	\$ 365,315		\$ 347,616	\$ (17,700)	\$ 1,888,554	1
2	Plumbing Work	2002	16,800		20	1,680	1,680	5,040	2
3	Paint	2003	1,079		20	108	108	216	3
4	Plumbing Supplies	2003	960		20	96	96	192	4
5	Plumbing Supplies	2003	509		20	51	51	102	5
6	Roof Ladder Installation	2003	1,500		20	150	150	300	6
7	Sewer Line Repair	2003	3,590		20	359	359	688	7
8	Sewer Line Repair	2003	3,800		20	190	190	364	8
9	Second Floor Doors	2003	1,870		20	187	187	343	9
10	Tuckpointing	2003	3,200		20	320	320	560	10
11	Doors Repair	2003	925		20	93	93	162	11
12	Doors Repair	2003	890		20	89	89	156	12
13	Elevator Repair	2003	3,858		20	193	193	338	13
14	Roof Fan	2003	4,924		20	492	492	821	14
15	Plumbing Work	2003	9,300		20	930	930	1,550	15
16	Leasehold Improvements	2003	3,346		20	335	335	530	16
17	Duct Work	2003	2,615		20	262	262	414	17
18	Landscaping	2003	1,317		20	132	132	209	18
19	Ac Repair	2003	4,047		20	337	337	478	19
20	Blinds For 9Th Floor	2003	1,470		20	147	147	196	20
21	Replacement For 2 Doors Nad Sidelights	2003	2,700		20	270	270	360	21
22	Paint	2003	969		20	48	48	61	22
23	Cabinet Doors, Shower Rods	2003	1,059		20	53	53	66	23
24	Boiler Repair	2003	15,987		20	1,332	1,332	1,554	24
25	4 Toilet Kits	2003	822		20	82	82	96	25
26	Heat/Cooling System	2003	661		20	55	55	110	26
27	Door Locks	2003	1,281		20	128	128	256	27
28	Motor Repair	2003	668		20	67	67	134	28
29	Gutters And Downspouts	2003	950		20	95	95	190	29
30	Repair Pump	2004	855		20	86	86	86	30
31	2 New Doors	2004	1,200		20	60	60	60	31
32	New Motor For Grundfos Pump	2004	2,860		20	286	286	286	32
33	Plumbing Work	2004	23,625		20	2,166	2,166	2,166	33
34	TOTAL (lines 1 thru 33)		\$ 16,492,453	\$ 365,315		\$ 358,495	\$ (6,821)	\$ 1,906,638	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 16,492,453	\$ 365,315		\$ 358,495	\$ (6,821)	\$ 1,906,638	1
2	Replace Valves	2004	1,948		20	179	179	179	2
3	Pressure Balanced Shower Valves	2004	1,564		20	143	143	143	3
4	Mechanical Burner	2004	21,947		20	1,829	1,829	1,829	4
5	Drywall, Metal Studs, Fan Lights	2004	1,022		20	85	85	85	5
6	Emergency Fixture	2004	1,298		20	108	108	108	6
7	New Compressor	2004	1,070		20	80	80	80	7
8	Lamp Parts	2004	526		20	35	35	35	8
9	Replace Plate Glass	2004	750		20	44	44	44	9
10	Remove Bricks	2004	2,400		20	140	140	140	10
11	Replace Grease Traps	2004	1,593		20	93	93	93	11
12	Rewire Emergency Circuits	2004	4,945		20	288	288	288	12
13	Doors	2004	1,300		20	76	76	76	13
14	Condenser Fan Motor	2004	972		20	57	57	57	14
15	Elevator Repair	2004	2,308		20	67	67	67	15
16	12 Light Covers	2004	734		20	37	37	37	16
17	Boiler Repair	2004	9,732		20	487	487	487	17
18	Boiler	2004	4,700		20	235	235	235	18
19	6 Condensing Units	2004	1,766		20	88	88	88	19
20	Various Plumbing Parts	2004	994		20	50	50	50	20
21	Repairing Fire Extinguisher	2004	553		20	28	28	28	21
22	Install 4 Glass Block Windows	2004	1,700		20	71	71	71	22
23	New Fire Hoses & Reels	2004	2,823		20	118	118	118	23
24	Various Plumbing Parts	2004	1,593		20	66	66	66	24
25	35 Cases Of Tiles	2004	837		20	35	35	35	25
26	Boiler Repairs	2004	2,293		20	96	96	96	26
27	Various Hardware Supplies	2004	718		20	30	30	30	27
28	Repair Walk In Freezer	2004	558		20	23	23	23	28
29	Water Heater Repairs	2004	580		20	24	24	24	29
30	Boiler Repairs	2004	1,234		20	51	51	51	30
31	Tiles	2004	1,075		20	36	36	36	31
32	Patch & Seal Parking Lot	2004	700		20	23	23	23	32
33	Locks	2004	668		20	22	22	22	33
34	TOTAL (lines 1 thru 33)		\$ 16,569,354	\$ 365,315		\$ 363,239	\$ (2,077)	\$ 1,911,382	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 16,569,354	\$ 365,315		\$ 363,239	\$ (2,077)	\$ 1,911,382	1
2	Various Hardware Supplies	2004	939		20	31	31	31	2
3	Various Hardware Supplies	2004	702		20	23	23	23	3
4	Elevator Repairs	2004	663		20	11	11	11	4
5	Elevator Repairs	2004	2,392		20	40	40	40	5
6	Intercom Parts	2004	1,022		20	34	34	34	6
7	Roof Top Unit	2004	1,819		20	61	61	61	7
8	Repair Fire Hose Racks	2004	524		20	17	17	17	8
9	Drywall, Metal Studs	2004	1,154		20	29	29	29	9
10	Balance Due On Parking Lot	2004	800		20	20	20	20	10
11	Repairs To Flot	2004	2,758		20	69	69	69	11
12	Boiler Treatment	2004	1,085		20	27	27	27	12
13	Repair Leak And Greasetrap	2004	780		20	20	20	20	13
14	Rod Out Main Sewer	2004	2,258		20	56	56	56	14
15	Repair Leak	2004	783		20	20	20	20	15
16	Ceiling Fans, Plumbing Parts	2004	784		20	20	20	20	16
17	Ballasts & Light Bulbs	2004	901		20	15	15	15	17
18	Light Fixtures, Plates Etc.	2004	530		20	9	9	9	18
19	Clark Devon Hardware	2004	511		20	9	9	9	19
20	Boiler Repair	2004	4,139		20	69	69	69	20
21	Elevator Repair	2004	808		20	13	13	13	21
22	Elevator Repair	2004	1,105		20	18	18	18	22
23	8 Insulated Glass Units	2004	1,353		20	11	11	11	23
24	Door Locks/ Hardware	2004	2,283		20	19	19	19	24
25	Electric Stike On New Door	2004	577		20	5	5	5	25
26	Plumbing/Sink	2004	591		20	20	20	20	26
27	Room Lighting	2004	813		20	37	37	37	27
28	Painting	2004	965		20	4	4	4	28
29	Tile	2004	570		20	28	28	28	29
30	Toilets	2004	579		20	29	29	29	30
31	Tile	2004	1,061		20	53	53	53	31
32	Elevator Repair	2004	884		20	44	44	44	32
33	Elevator Repair	2004	552		20	28	28	28	33
34	TOTAL (lines 1 thru 33)		\$ 16,606,039	\$ 365,315		\$ 364,128	\$ (1,187)	\$ 1,912,271	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 16,606,039	\$ 365,315		\$ 364,128	\$ (1,187)	\$ 1,912,271	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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20									20
21									21
22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,606,039	\$ 365,315		\$ 364,128	\$ (1,187)	\$ 1,912,271	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 16,606,039	\$ 365,315		\$ 364,128	\$ (1,187)	\$ 1,912,271	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,606,039	\$ 365,315		\$ 364,128	\$ (1,187)	\$ 1,912,271	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 16,606,039	\$ 365,315		\$ 364,128	\$ (1,187)	\$ 1,912,271		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 16,606,039	\$ 365,315		\$ 364,128	\$ (1,187)	\$ 1,912,271		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12J, Carried Forward	\$ 16,606,039	\$ 365,315		\$ 364,128	\$ (1,187)	\$ 1,912,271		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 16,606,039	\$ 365,315		\$ 364,128	\$ (1,187)	\$ 1,912,271		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	450	1999		\$ 14,605,934	\$ 253,846	39	\$ 253,846	\$	\$ 1,491,346	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Allocated Somerset Realty, LLC	1999		586,916	27,466	20	29,346	1,880	147,406	9
10	Allocated Somerset Realty, LLC	2000		13,789	1,379	20	690	(689)	6,261	10
11										11
12	Building Improvement	2004		724	21	20	36	(15)	36	12
13	Boiler	2004		810	23	20	41	17	41	13
14	Hot Water Heater Repair	2003		527	15	20	26	11	53	14
15	Nurse Call System	2003		2,392	69	20	120	51	239	15
16	Electrical System - 16 Outlets	2003		12,750	367	20	638	271	1,275	16
17	Plumbing Work	2003		3,395	98	20	170	72	340	17
18	Bathrooms Plumbing Repair	2003		1,707	49	20	85	36	171	18
19	Leaking Drain Repair	2003		1,010	29	20	51	21	101	19
20	Concrete Patching	2003		8,200	236	20	410	174	820	20
21	Exterior Repairs	2003		10,000	287	20	500	213	1,000	21
22	Smoke Detectors	2003		2,395	69	20	120	51	240	22
23	Electrical Wiring	2003		5,590	161	20	280	119	559	23
24	Tiles	2003		799	23	20	40	17	80	24
25	Fire Alarm	2003		3,345	96	20	167	71	335	25
26	2 New Doors	2004		1,200	34	20	60	26	60	26
27	1 New Panic Door	2004		839	24	20	42	18	42	27
28	Replace Tiles	2004		1,123	32	20	56	24	56	28
29	Boiler Repair	2004		770	22	20	39	16	39	29
30	Pyro Chem Suppresion System	2004		3,279	94	20	164	70	164	30
31	Doors & Hardware	2004		1,510	43	20	76	32	76	31
32	Tiles	2004		878	25	20	44	19	44	32
33	Door	2004		900	26	20	45	19	45	33
34	9 New Doors	2004		11,000	316	20	550	234	550	34
35	Floor Tiles	2004		827	24	20	41	18	41	35
36	Head Assembly - Boiler #2	2004		1,051	30	20	53	22	53	36

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Rewire Controls Boiler #1	2004	\$ 3,461	\$ 99	20	\$ 173	\$ 74	\$ 260	37
38	Doors	2004	3,000	86	20	150	64	88	38
39	Wiring	2004	5,590	161	20	280	119	186	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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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)		\$ 15,295,711	\$ 285,252		\$ 288,336	\$ 3,053	\$ 1,652,005	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	Allocated From 2201 Main	2002	2002	\$ 47,749	\$ 1,194	35	\$ 1,194	\$	\$ 2,984
5									
6									
7									
8									
Improvement Type**									
9	Allocated From 2201 Main		2002	39,444	1,972	20	1,972		4,931
10	Allocated From 2201 Main		2003	46,484	2,324	20	2,324		3,486
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
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27									
28									
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31									
32									
33									
34									
35									
36									

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		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
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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)		\$ 133,677	\$ 5,490		\$ 5,490	\$	\$ 11,401		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 2,596,628	\$ 332,899	\$ 257,025	\$ (75,874)	10	\$ 2,117,925	71
72	Current Year Purchases	159,057	14,232	28,663	14,431	10	28,663	72
73	Fully Depreciated Assets	15,989				10	15,989	73
74								74
75	TOTALS	\$ 2,771,674	\$ 347,131	\$ 285,688	\$ (61,443)		\$ 2,162,577	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		VAN	1999	\$ 5,000	\$	\$ 583	\$ 583	5	\$ 5,000	76
77		INSTALL SEATBELTS	2000	780		78	78	5	358	77
78		1995 CADILLAC SEDAN	2004	5,500		206	206	5	206	78
79		Care Centers Allocation	2003	68,321	5,048	5,048		5	56,824	79
80	TOTALS			\$ 79,601	\$ 5,048	\$ 5,915	\$ 867		\$ 62,388	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)	\$ 20,591,964	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 717,494	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 655,731	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (61,763)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,137,236	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:				\$			3
4	Additions							4
5								5
6	Allocated From Care Centers				11,397			6
7	TOTAL				\$ 11,397			7

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

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

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 18,001 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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 checked="" 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 checked="" type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 460	\$	\$ 460
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	\$	\$ 460	\$	\$ 460
10	SUM OF line 9, col. 1 and 2 (e)	\$	460		

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

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		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): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 5,386	\$ 46,504	1
2	Cash-Patient Deposits	110,467	110,467	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,056,834	2,056,834	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	315,278	475,210	6
7	Other Prepaid Expenses	10,937	10,937	7
8	Accounts Receivable (owners or related parties)	88,372	598,372	8
9	Other(specify): See Attached Schedule	5,220,878	7,316,683	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,808,152	\$ 10,615,007	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,100,000	13
14	Buildings, at Historical Cost		9,900,000	14
15	Leasehold Improvements, at Historical Cost	1,150,729	3,400,729	15
16	Equipment, at Historical Cost	282,649	972,426	16
17	Accumulated Depreciation (book methods)	(391,903)	(3,941,264)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		194,679	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(8,807)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		10,907,768	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,041,475	\$ 22,525,531	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,849,627	\$ 33,140,538	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,133,659	\$ 1,162,029	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	87,491	87,491	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	240,217	240,217	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,385	9,385	31
32	Accrued Real Estate Taxes(Sch.IX-B)		554,030	32
33	Accrued Interest Payable		133,769	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,470,752	\$ 2,186,921	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		28,411,135	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 28,411,135	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,470,752	\$ 30,598,056	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,378,875	\$ 2,542,482	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,849,627	\$ 33,140,538	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,854,269	1
2	Restatements (describe):		2
3	See Attached	158,440	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,012,709	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,161,166	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	(795,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,366,166	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)	\$ 7,378,875	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/04

Ending:

12/31/04

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,938,361	1
2	Discounts and Allowances for all Levels	(80)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,938,281	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	80	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)	\$ 80	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	387,992	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 387,992	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,867	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,867	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,329,220	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,341,877	31
32	Health Care	3,817,963	32
33	General Administration	2,714,972	33
B. Capital Expense			
34	Ownership	3,046,192	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	247,050	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,168,054	40
41	Income before Income Taxes (line 30 minus line 40)**	2,161,166	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,161,166	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/04

Ending:

12/31/04

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,869	2,101	\$ 71,317	\$ 33.94	1
2	Assistant Director of Nursing	4,086	4,698	119,229	25.38	2
3	Registered Nurses	5,674	6,216	140,014	22.52	3
4	Licensed Practical Nurses	36,604	42,989	873,358	20.32	4
5	Nurse Aides & Orderlies	106,880	116,727	1,356,132	11.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,980	2,130	23,105	10.85	8
9	Activity Director	1,859	2,141	41,201	19.24	9
10	Activity Assistants	28,729	31,711	262,528	8.28	10
11	Social Service Workers	42,029	47,079	675,684	14.35	11
12	Dietician	3,557	4,137	43,499	10.51	12
13	Food Service Supervisor	3,543	4,045	62,084	15.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	41,456	44,211	336,394	7.61	15
16	Dishwashers					16
17	Maintenance Workers	29,736	32,683	377,216	11.54	17
18	Housekeepers	40,074	43,992	331,886	7.54	18
19	Laundry	1,749	2,074	16,982	8.19	19
20	Administrator	986	1,379	54,448	39.48	20
21	Assistant Administrator	1,897	2,100	54,471	25.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,930	16,109	193,447	12.01	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	3,680	4,154	58,293	14.03	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	370,318	410,676	\$ 5,091,288 *	\$ 12.40	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	335	\$ 17,178	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	Monthly	1,472	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,913	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	196	11-03	44
45	Social Service Consultant	Per Consult	7,227	12-03	45
46	Other(specify)				46
47	CCI Consultants	See Attached	17,119		47
48					48
49	TOTAL (lines 35 - 48)	339	\$ 60,105		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	1,771	61,975	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,771	\$ 61,975		53

SEE ACCOUNTANTS' COMPILATION REPORT

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
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council On LTC - \$21,547.32
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 422 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 247,050
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ _____ Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? None
 - 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. \$ _____
- (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 services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.