

Facility Name & ID Number TWIN WILLOWS NURSING CENTER

0014753 Report Period Beginning: 1/1/04 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 _____

	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)	29	3,480	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	45	23,610	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	74	27,090	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	202	117	59	378	8
9	SNF/PED					9
10	ICF	13,875	3,680		17,555	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,077	3,797	59	17,933	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.20%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 01/01/73

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 29 and days of care provided 59

Medicare Intermediary ADMINASTAR FEDERAL KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 01/01/2004 Fiscal Year: 12/31/2004

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

STATE OF ILLINOIS

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1/1/04 Ending: 12/31/04

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	84,277	11,747	4,507	100,531		100,531		100,531		1
2	Food Purchase		110,897		110,897		110,897	(6,278)	104,619		2
3	Housekeeping	41,617	9,179		50,796		50,796		50,796		3
4	Laundry	18,497	6,589		25,086		25,086		25,086		4
5	Heat and Other Utilities			48,616	48,616		48,616	(2,329)	46,287		5
6	Maintenance	24,418	12,816	13,068	50,302		50,302		50,302		6
7	Other (specify):*										7
8	TOTAL General Services	168,809	151,228	66,191	386,228		386,228	(8,607)	377,621		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	518,516	40,484	4,835	563,835		563,835	(123)	563,712		10
10a	Therapy			6,259	6,259		6,259		6,259		10a
11	Activities	15,819	3,573		19,392		19,392		19,392		11
12	Social Services	12,701		2,191	14,892		14,892		14,892		12
13	Nurse Aide Training	2,591	1,966	4,557	9,114		9,114		9,114		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	549,627	46,023	19,042	614,692		614,692	(123)	614,569		16
	C. General Administration										
17	Administrative	45,000			45,000		45,000		45,000		17
18	Directors Fees										18
19	Professional Services			11,830	11,830		11,830		11,830		19
20	Dues, Fees, Subscriptions & Promotions			5,105	5,105		5,105		5,105		20
21	Clerical & General Office Expenses		8,419	4,780	13,199		13,199		13,199		21
22	Employee Benefits & Payroll Taxes			115,596	115,596		115,596		115,596		22
23	Inservice Training & Education										23
24	Travel and Seminar			259	259		259		259		24
25	Other Admin. Staff Transportation			988	988		988		988		25
26	Insurance-Prop.Liab.Malpractice			51,995	51,995		51,995		51,995		26
27	Other (specify):*										27
28	TOTAL General Administration	45,000	8,419	190,553	243,972		243,972		243,972		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	763,436	205,670	275,786	1,244,892		1,244,892	(8,730)	1,236,162		29

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

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

Facility Name & ID Number TWIN WILLOWS NURSING CENTER #0014753 Report Period Beginning: 1/1/04 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			34,818	34,818		34,818		34,818			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,462	27,462		27,462	(8,841)	18,621			32
33	Real Estate Taxes			23,884	23,884		23,884		23,884			33
34	Rent-Facility & Grounds			1,200	1,200		1,200		1,200			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			87,364	87,364		87,364	(8,841)	78,523			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			7,162	7,162		7,162		7,162			41
42	Provider Participation Fee			40,746	40,746		40,746		40,746			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		7,162	40,746	47,908		47,908		47,908			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	763,436	212,832	403,896	1,380,164		1,380,164	(17,571)	1,362,593			45

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

Facility Name & ID Number TWIN WILLOWS NURSING CENTER

0014753

Report Period Beginning: 1/1/04

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	(6,162)	2-7		4
5	Telephone, TV & Radio in Resident Rooms	(2,329)	5-7		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(123)	10-7		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,304)	32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(116)	2-7		13
14	Non-Care Related Interest	(2,537)	32-7		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,571)		\$	30

OHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (17,571)		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

TWIN WILLOWS NURSING CENTER

ID# 0014753

Report Period Beginning: 1/1/04

Ending: 12/31/04

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

Facility Name & ID Number **TWIN WILLOWS NURSING CENTER**

0014753

Report Period Beginning:

1/1/04

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
HELEN WOODRUFF	95	N/A	N/A	MOTEL DEVELOPM	SALEM	MOTEL
JEFFREY WOODRUFF	5	N/A	N/A	WOODRUFF SERVIC	CARBONDALE	AC/HEATING

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V	34 OFFICE STORAGE	1,200	MOTEL DEVELOPMENT	100.00%	1,200		3
4	V	32 INTEREST	21,549	TODD WOODRUFF	0.00%	21,549		4
5	V	30 AC PURCHASE	2,117	WOODRUFF SERVICES	100.00%	2,117		5
6	V	20 BACKGROUND CHECKS	300	WOODRUFF SERVICES	100.00%	300		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 25,166			\$ 25,166	\$ *	14

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

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1/1/04 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	TODD WOODRUFF	ADMINISTRATOR		0.00	N/A	60	100.00	INTEREST	\$ 21,549	32-3	1
2	TODD WOODRUFF	ADMINISTRATOR		0.00	N/A	60	100.00	WAGES	45,000	17-1	2
3	HELEN WOODRUFF	AUDIT ACCOUNTING		95.00	N/A	20	30.00	FEES	11,500	19-3	3
4	HUBERT WOODRUFF	ATTORNEY		0.00	N/A	5	10.00	FEES		20-3	4
5	JEFFREY WOODRUFF	WOODRUFF SERVICES		5.00	N/A	N/A	N/A	N/A	2,417	30-3	5
6								AC PURCHASE			6
7								BACKGROUND			7
8								CHECK FEES			8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 80,466		13

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

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

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1/1/04 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

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1/1/04 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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	BONDS		X	WORKING CAPITAL	N/A	11-2-72	\$ 8,000	\$ 8,000	12-31-84	10.0000	\$ 800	1
2	BONDS		X	PURCHASING FACILITY	N/A	11-2-72	36,450	5,150	12-31-84	10.0000	515	2
3	TODD WOODRUFF	X		WORKING CAPITAL	N/A	1-87	246,584	252,097	12/31/04	0.0875	21,549	3
4												4
5												5
	Working Capital											
6	FINANCING CHANGES		X	ACCOUNTS PAYABLE							554	6
7				INSURANCE							1,507	7
8												8
9	TOTAL Facility Related						\$ 291,034	\$ 265,247			\$ 24,925	9
	B. Non-Facility Related*											
10	MOTEL DEVELOPMENTS	X		PURCHASE OFFICE BUILDING		4-1-86	56,000	31,536	12/31/04	0.0875	2,537	10
11				216 S. BROADWAY								11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 56,000	\$ 31,536			\$ 2,537	14
15	TOTALS (line 9+line14)						\$ 347,034	\$ 296,783			\$ 27,462	15

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

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

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

Facility Name & ID Number **TWIN WILLOWS NURSING CENTER**

0014753 Report Period Beginning: **1/1/04** 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.		\$	26,356	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.)		\$	24,940	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	(1,416)	3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	25,300	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	23,884	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	23,673	8	
		2000	24,716	9	
		2001	24,406	10	
		2002	25,003	11	
		2003	24,940	12	
FOR OHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

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

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

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

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

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TWIN WILLOWS NURSING CENTER COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0014753

CONTACT PERSON REGARDING THIS REPORT TODD WOODRUFF

TELEPHONE (618) 548-0542 FAX #: (618) 548-5893

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>11-02-000-027</u>	<u>PT SE NE</u>	\$ <u>24,940.12</u>	\$ <u>24,940.12</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>24,940.12</u>	\$ <u>24,940.12</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number TWIN WILLOWS NURSING CENTER# 0014753 Report Period Beginning:1/1/04 Ending:12/31/04**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 16,205 B. General Construction Type: Exterior BRICK Frame FIREPROOF CONST Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>87,000</u>	<u>1973</u>	<u>\$ 28,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	87,000		\$ 28,000	3

Facility Name & ID Number TWIN WILLOWS NURSING CENTER

0014753

Report Period Beginning:

1/1/04

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	74	1973	1966	\$ 380,183	\$ 11,406	33 1/3	\$ 11,406	\$	\$ 364,992	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12	WATER HEATER		1977	1,024		10			1,024	12
13	FIRE EXIT LIGHTS		1978	695		5			695	13
14	EMERGENCY POWER		1978	1,695		5			1,695	14
15	EMERGENCY POWER		1979	1,359		5			1,359	15
16	COMPRESSOR		1979	372		5			372	16
17	BATTERY UNITS		1980	570		3			570	17
18	COMPRESSOR		1980	533		5			533	18
19	MIXING VALVE		1981	780		10			780	19
20	CENTRAL AIR		1981	771		10			771	20
21	DISPOSAL KITCHEN		1982	745		10			745	21
22	STORAGE SHED		1982	600		8			600	22
23	3 HEAT PUMPS		1983	2,245		10			2,245	23
24	PHONE SYSTEM		1985	3,318		20			3,318	24
25	2 HEAT PUMPS		1985	1,400		8			1,400	25
26	DRIVEWAY		1988	2,767		3			2,767	26
27	SEAL COAT-PATCH DRIVEWAY		1997	1,850		3			1,850	27
28	DOOR MONITOR SYSTEM		1999	7,590	759	10	759		3,985	28
29	3 CENTRAL AIR SYSTEMS-3T		1999	12,588	2,202	5	2,202		12,588	29
30	REPLACEMENT ROOF		1999	64,580	4,305	15	4,305		21,884	30
31	ASPHALT TOP COAT DRIVEWAY		1999	16,136	2,017	8	2,017		10,337	31
32	OUTSIDE WALK WAY LIGHTS		1999	600	65	5	65		600	32
33	REPLACE SOUTH WING SEWER LINE		2000	1,046	105	10	105		481	33
34	REPLACE THREE OUTSIDE HYDRANTS		2000	525	52	10	52		212	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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 503,972	\$ 20,911		\$ 20,911	\$	\$ 435,803		70

**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	\$ 111,105	\$ 11,550	\$ 11,550	\$		\$ 59,349	71
72	Current Year Purchases	8,265	614	614		6.75	614	72
73	Fully Depreciated Assets	110,114	933	933			110,114	73
74								74
75	TOTALS	\$ 229,484	\$ 13,097	\$ 13,097	\$		\$ 170,077	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		WAGON	1987	\$ 10,990	\$	\$	\$	4	\$ 10,990	76
77										77
78										78
79										79
80	TOTALS			\$ 10,990	\$	\$	\$		\$ 10,990	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)	\$ 772,446	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,008	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,008	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 616,870	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	ALUMINUM TRAILER	\$ 10,000	\$	\$ 10,000	86
87	216 S. BROADWAY	56,000		56,000	87
88	SCHEDULE	19,807	501	12,564	88
89	DRIVEWAY 216	6,119	285	3,036	89
90					90
91	TOTALS	\$ 91,926	\$ 786	\$ 81,600	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: MOTEL DEVELOPMENT INC. RENTS OFFICE SPACE STORAGE SPACE
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Office Storage Space				1,200			5
6								6
7	TOTAL				\$ 1,200			7

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

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

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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?</p> <p><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	\$	1,438	\$	\$ 1,438
2	Books and Supplies		328		328
3	Classroom Wages (a)		1,575		1,575
4	Clinical Wages (b)		1,016		1,016
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		200		200
9	TOTALS	\$	4,557	\$	\$ 4,557
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,557		

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$			\$			1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			12 HRS	778						778	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10A-3	hrs			77 HRS	5,481						5,481	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		89 HRS	6,259	\$		\$			6,259	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.

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 86,282	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	407,148	3
4	Supply Inventory (priced at)	12,600	4
5	Short-Term Investments	19,510	5
6	Prepaid Insurance	26,992	6
7	Other Prepaid Expenses	9,884	7
8	Accounts Receivable (owners or related parties)	11,573	8
9	Other(specify): 1120 TAX DEPOSITS	20,902	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 594,891	10
B. Long-Term Assets			
11	Long-Term Notes Receivable	139,451	11
12	Long-Term Investments		12
13	Land	32,000	13
14	Buildings, at Historical Cost	436,183	14
15	Leasehold Improvements, at Historical Cost	88,807	15
16	Equipment, at Historical Cost	311,693	16
17	Accumulated Depreciation (book methods)	(697,498)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 310,636	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 905,527	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 72,414	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	24,319	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,578	31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,884	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36			36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 125,195	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	430,913	39
40	Mortgage Payable		40
41	Bonds Payable	13,150	41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43	STOCK	3,500	43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 447,563	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 572,758	46
47	TOTAL EQUITY(page 18, line 24)	\$ 332,769	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 905,527	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 374,243	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 374,243	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(40,375)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) UNEXPLAINED	433	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (39,942)	17
	B. Transfers (Itemize):		
18	1120 TAX 2001 ADDITIONAL TAX PAID IN 2004 IL	(655)	18
19	1120 PENALTY TAX 2001 PAID IN 2004 IL	(877)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,532)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 332,769	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number TWIN WILLOWS NURSING CENTER

0014753

Report Period Beginning: 1/1/04

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	\$ 1,341,639	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,341,639	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	1,837	11
12	Gift and Coffee Shop	7,324	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,162	14
15	Telephone, Television and Radio	1,476	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	240	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)	\$ 17,039	23
D. Non-Operating Revenue			
24	Contributions	625	24
25	Interest and Other Investment Income***	5,291	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,916	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	216 RENTAL	7,200	28
28a	INS/WORKMEN COMP REFUNDS	6,278	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,478	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,378,072	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	377,621	31
32	Health Care	614,569	32
33	General Administration	243,972	33
B. Capital Expense			
34	Ownership	78,523	34
C. Ancillary Expense			
35	Special Cost Centers	7,162	35
36	Provider Participation Fee	40,746	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,362,593	40
41	Income before Income Taxes (line 30 minus line 40)**	15,479	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 15,479	43

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

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

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

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

Facility Name & ID Number **TWIN WILLOWS NURSING CENTER**

0014753

Report Period Beginning: **1/1/04**

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	1,990	2,250	\$ 49,448	\$ 21.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,150	7,359	118,177	16.06	3
4	Licensed Practical Nurses	6,854	7,098	105,182	14.82	4
5	Nurse Aides & Orderlies	33,714	34,259	232,753	6.79	5
6	Nurse Aide Trainees	422	422	2,591	6.14	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,351	1,405	9,497	6.76	9
10	Activity Assistants	1,059	1,059	6,322	5.97	10
11	Social Service Workers	1,734	1,876	12,701	6.77	11
12	Dietician					12
13	Food Service Supervisor	1,856	1,946	13,281	6.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,443	5,522	34,071	6.17	15
16	Dishwashers	5,862	6,182	36,925	5.97	16
17	Maintenance Workers	1,735	2,107	24,418	11.59	17
18	Housekeepers	6,435	6,844	41,617	6.08	18
19	Laundry	2,744	2,942	18,497	6.29	19
20	Administrator	2,912	3,014	45,000	14.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,775	1,872	12,956	6.92	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	83,036	86,157	\$ 763,436 *	\$ 8.86	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	96	\$ 4,507	1-3	35
36	Medical Director	12	1,200	9-3	36
37	Medical Records Consultant	4	100	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	45	1,500	10-3	39
40	Physical Therapy Consultant	40	3,235	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	41	2,191	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	238	\$ 12,733		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
TODD WOODRUFF	ADMINISTRATOR		\$ 45,000	Workers' Compensation Insurance	\$ 45,290	IDPH License Fee	\$ 750	
				Unemployment Compensation Insurance	7,764	Advertising: Employee Recruitment	483	
				FICA Taxes	58,403	Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed <u>48</u>)	663	
				Employee Meals		IHCA	2,800	
				Illinois Municipal Retirement Fund (IMRF)*		IL SECY STATE	100	
				X-MAS	2,220	MES	208	
				EMPLOYEE RECOGNITION	1,061	NFIB	101	
				BOTTLE WATER	858			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 45,000	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount
HELEN WOODRUFF	AUDIT ACCOUNTING	11,500					Out-of-State Travel	\$
H & R BLOCK	TAX RETURN	330						
							In-State Travel	30
							Seminar Expense	229
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 11,830	TOTAL		\$	TOTAL	\$ 259

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA TOTAL 4104 (2800 DUES)
- (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? YES If YES, what is the capacity? 74
- (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? 6.75
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,255 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. _____
- (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. \$ 40,746
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 6,162
- (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? < 10%
- d. Have vehicle usage logs been maintained? NO
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? _____
Attach invoices and a summary of services for all architect and appraisal fees.