

Facility Name & ID Number GROSSE POINTE MANOR

0045203 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	8,426	3,363	2,238	14,027	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD	15,484	115		15,599	11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	23,910	3,478	2,238	29,626	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.99%

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

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

NONE

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 47 and days of care provided 1,911

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	237,491	23,253	4,201	264,945		264,945		264,945		1
2	Food Purchase		194,751		194,751	(18,068)	176,683	(1,672)	175,011		2
3	Housekeeping	42,822	22,687		65,509		65,509		65,509		3
4	Laundry	64,779	10,169	1,946	76,894		76,894		76,894		4
5	Heat and Other Utilities			121,275	121,275		121,275	790	122,065		5
6	Maintenance	62,970	34,789	15,513	113,272		113,272	2,249	115,521		6
7	Other (specify):*			8,936	8,936		8,936		8,936		7
8	TOTAL General Services	408,062	285,649	151,871	845,582	(18,068)	827,514	1,367	828,881		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,254,118	60,430	42,056	1,356,604		1,356,604	(107)	1,356,497		10
10a	Therapy			4,042	4,042		4,042		4,042		10a
11	Activities	113,416	4,932	576	118,924		118,924		118,924		11
12	Social Services			540	540		540		540		12
13	CNA Training										13
14	Program Transportation			2,325	2,325		2,325		2,325		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,367,534	65,362	61,539	1,494,435		1,494,435	(107)	1,494,328		16
	C. General Administration										
17	Administrative	79,195			79,195		79,195	23,550	102,745		17
18	Directors Fees										18
19	Professional Services			50,990	50,990		50,990	(750)	50,240		19
20	Dues, Fees, Subscriptions & Promotions			71,120	71,120		71,120	(59,709)	11,411		20
21	Clerical & General Office Expenses	175,119	12,591	82,320	270,030		270,030	(94,979)	175,051		21
22	Employee Benefits & Payroll Taxes			398,419	398,419	18,068	416,487		416,487		22
23	Inservice Training & Education			340	340		340		340		23
24	Travel and Seminar							66	66		24
25	Other Admin. Staff Transportation			2,078	2,078		2,078	1,052	3,130		25
26	Insurance-Prop.Liab.Malpractice			95,262	95,262		95,262	1,336	96,598		26
27	Other (specify):*			1,968	1,968		1,968	8,334	10,302		27
28	TOTAL General Administration	254,314	12,591	702,497	969,402	18,068	987,470	(121,100)	866,370		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,029,910	363,602	915,907	3,309,419		3,309,419	(119,840)	3,189,579		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	3,840
	REPAIRS & MAINTENANCE		361
			0
			4,201
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		1,946
			0
			1,946
5	HEAT & OTHER UTILITIES		
	GAS HEAT		51,748
	ELECTRICITY		52,517
	WATER		15,948
	CABLE TV - LOBBY		1,062
			0
			121,275
6	MAINTENANCE		
	GROUNDS MAINTENANCE		3,470
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		3,367
	ELEVATOR MAINTENANCE & REPAIR		5,196
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		3,480
	FIRE SERVICE		0
			0
			0
			15,513
7	OTHER		
	SCAVENGER		8,936
	SECURITY SERVICE		0
			8,936
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000
			12,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	39,028
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,340
	PHARMACY CONSULTANT	XVIII B 39-2	1,688
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			42,056
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		
	OCCUPATIONAL THERAPY SERVICES		
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	410
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,819
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	813
			4,042
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	576
			0
			576
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	540
			0
			540
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	2,325
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	3,762
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	47,228
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	50,990
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	60,212
	EMPLOYEE WANT ADS XIX F	6,617
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	130
	LICENSES & PERMITS XIX F	3,801
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	100
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	260
21	CLERICAL & GENERAL OFFICE EXPENSES	71,120
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	17,307
	EQUIPMENT REPAIR & MAINTENANCE	4,963
	OUTSIDE CLERICAL SERVICES	48,000
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,050
	MESSENGER SERVICE	0
		0
		82,320

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	155,749
	UNEMPLOYMENT COMPENSATION XIX D	49,272
	WORKERS COMPENSATION INSURANCE XIX D	46,578
	HOSPITALIZATION INSURANCE XIX D	139,540
	EMPLOYEE BENEFITS - OTHER XIX D	7,280
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		398,419
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	340
		340
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,078
		2,078
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	95,262
		95,262
27	OTHER	
	BAD DEBTS VI 24	1,968
		1,968

GRAND TOTAL COLUMN 3 OTHER 915,907

GROSSE POINTE MANOR
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	194,751	PATIENT MEALS	88878
LESS SALES TAX	(894)	ADD EMPLOYEE MEALS	9125
	-----		-----
NET FOOD	193,857	TOTAL MEALS/YEAR	98003
TOTAL PATIENT CENSUS	29,626	NET FOOD	193857
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	98003

TOTAL PATIENT MEALS	88878	COST PER MEAL	1.98
		TIME EMPLOYEE MEALS	9125
ADD # EMPLOYEE MEALS/DAY	25		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	18068
	-----		=====
TOTAL EMPLOYEE MEALS	9125		

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			10,824	10,824		10,824	182,450	193,274			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			85,637	85,637		85,637	1,976	87,613			32
33	Real Estate Taxes			137,619	137,619		137,619	2,116	139,735			33
34	Rent-Facility & Grounds			296,400	296,400		296,400	(296,400)				34
35	Rent-Equipment & Vehicles			12,405	12,405		12,405	3,531	15,936			35
36	Other (specify):*											36
37	TOTAL Ownership			542,885	542,885		542,885	(106,327)	436,558			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,013	148,902	227,915		227,915	(1,003)	226,912			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		79,013	203,105	282,118		282,118	(1,003)	281,115			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,029,910	442,615	1,661,897	4,134,422		4,134,422	(227,170)	3,907,252			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 **GROSSE POINTE MANOR**

0045203

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(82)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(778)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(894)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,394)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,968)	27		24
25	Fund Raising, Advertising and Promotional	(60,212)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(84,254)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (150,682)		\$	30

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)	(76,488)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (76,488)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (227,170)		37

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

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

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

OHF USE ONLY

48		49		50		51		52	
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GROSSE POINTE MANOR

ID# 0045203

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6 1
2	MARKETING SALARY	(84,254)	21 2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(84,254)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GROSSE POINTE MANOR# 0045203

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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)	
1	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,672)	0	0	0	0	0	0	0	0	0	0	(1,672)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	790	0	0	0	0	0	0	0	0	790	5
6	Maintenance	0	0	2,249	0	0	0	0	0	0	0	0	2,249	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,672)	0	3,039	0	0	0	0	0	0	0	0	1,367	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(107)	0	0	0	0	0	(107)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	(107)	0	0	0	0	0	(107)	16
	C. General Administration													
17	Administrative	0	0	0	23,550	0	0	0	0	0	0	0	23,550	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,394)	0	1,644	0	0	0	0	0	0	0	0	(750)	19
20	Fees, Subscriptions & Promotions	(60,312)	0	603	0	0	0	0	0	0	0	0	(59,709)	20
21	Clerical & General Office Expenses	(84,254)	(48,000)	32,003	5,272	0	0	0	0	0	0	0	(94,979)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	66	0	0	0	0	0	0	0	0	66	24
25	Other Admin. Staff Transportation	0	0	1,052	0	0	0	0	0	0	0	0	1,052	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,336	0	0	0	0	0	0	0	0	1,336	26
27	Other (specify):*	(1,968)	0	6,609	0	3,693	0	0	0	0	0	0	8,334	27
28	TOTAL General Administration	(148,928)	(48,000)	43,313	28,822	3,693	0	0	0	0	0	0	(121,100)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(150,600)	(48,000)	46,352	28,822	3,693	(107)	0	0	0	0	0	(119,840)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROSSE POINTE MANOR# 0045203

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(82)	180,764	1,768	0	0	0	0	0	0	0	0	182,450	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,976	0	0	0	0	0	0	0	0	1,976	32
33	Real Estate Taxes	0	0	2,116	0	0	0	0	0	0	0	0	2,116	33
34	Rent-Facility & Grounds	0	(296,400)	0	0	0	0	0	0	0	0	0	(296,400)	34
35	Rent-Equipment & Vehicles	0	0	3,531	0	0	0	0	0	0	0	0	3,531	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(82)	(115,636)	9,391	0	0	0	0	0	0	0	0	(106,327)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(1,003)	0	0	0	0	0	(1,003)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	(1,003)	0	0	0	0	0	(1,003)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(150,682)	(163,636)	55,743	28,822	3,693	(1,110)	0	0	0	0	0	(227,170)	45

Facility Name & ID Number

GROSSE POINTE MANOR

0045203

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTECHED		SCHEDULE ATTACHED		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21 BOOKKEEPING SERVICES	\$ 48,000	DYNAMIC HEALTHCARE CONSULTANTS		\$	\$ (48,000)	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	296,400	GROSSE POINTE MANOR REALTY LLC			(296,400)	7
8	V	30 DEPRECIATION		" " "		180,764	180,764	8
9	V	32 INTEREST		" " "				9
10	V	19 PROFESSIONAL FEES		" " "				10
11	V							11
12	V							12
13	V							13
14	Total		\$ 344,400			\$ 180,764	\$ * (163,636)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 790	\$	790	15
16	V	6 REPAIR & MAINT.		" "		2,249		2,249	16
17	V	19 PROFESSIONAL FEES		" "		1,644		1,644	17
18	V	20 DUES & SUBSCRIPTIONS		" "		603		603	18
19	V	21 CLERICAL & GENERAL		" "		32,003		32,003	19
20	V	24 SEMINARS & TRAVEL		" "		66		66	20
21	V	25 AUTO EXPENSE		" "		1,052		1,052	21
22	V	26 INSURANCE		" "		1,336		1,336	22
23	V	27 EMP.BEN - GEN, ADMIN.		" "		6,609		6,609	23
24	V	30 DEPRECIATION		" "		1,768		1,768	24
25	V	32 INTEREST		" "		1,976		1,976	25
26	V	33 REAL ESTATE TAXES		" "		2,116		2,116	26
27	V	35 EQUIPMENT RENTAL		" "		3,531		3,531	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		\$			\$ 55,743	\$ *	55,743	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	17 ADMIN.CMP.- M. MAUER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 12,198	\$	12,198	15
16	V	17 ADMIN.CMP.- S. LEVY		" " "		11,352		11,352	16
17	V	21 CLERICAL CMP.- SAARON		" " "		5,272		5,272	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		\$			\$ 28,822	\$ *	28,822	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	27 EMP.BEN. - M. MAUER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 835	\$	835	15
16	V	27 EMP.BEN. - S. LEVY		" " "		1,780		1,780	16
17	V	27 EMP.BEN. - S.AARON		" " "		1,078		1,078	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		\$			\$ 3,693	\$ *	3,693	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A THERAPY	\$	DYNAMIC REHAB CONSULTANTS LLC		\$	\$	15
16	V	19 PROFESSIONAL FEES						16
17	V	22 EMPLOYEE BENEFITS						17
18	V	39 ANCILLARY SERVICES						18
19	V							19
20	V							20
21	V	10 MEDICAL SUPPLIES	366	LINCOLN MEDICAL SUPPLIES, INC		259	(107)	21
22	V	39 ANCILLARY EXPENSE	3,439			2,436	(1,003)	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		\$ 3,805			\$ 2,695	\$ * (1,110)	39

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

Facility Name & ID Number

GROSSE POINTE MANOR

0045203

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHERRY MAUER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	\$ 79,192	17-1	1
2	SHERRY MAUER		NURSING					SALARY	14,000	10-1	2
3	MARSHALL MAUER		ADMINISTRATIVE					SALARY	12,198	17-7	3
4	SHARON AARON		CLERICAL					SALARY	4,865	21-1	4
5	DOVIE MAUER		FILE CLERK					SALARY	48,224	21-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 158,479		13

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

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

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	413,836	12	\$ 11,039	\$ 29,626	\$ 790	1
2	6	REPAIR & MAINT.	" "	413,836	12	31,419	29,626	2,249	2
3	19	PROFESSIONAL FEES	" "	413,836	12	22,969	29,626	1,644	3
4	20	DUES AND SUBSCRIPTION	" "	413,836	12	8,420	29,626	603	4
5	21	CLERICAL & GENERAL	" "	413,836	12	447,045	345,326	32,003	5
6	24	SEMINARS AND TRAVEL	" "	413,836	12	917	29,626	66	6
7	25	AUTO EXPENSE	" "	413,836	12	14,696	29,626	1,052	7
8	26	INSURANCE	" "	413,836	12	18,661	29,626	1,336	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	413,836	12	92,321	29,626	6,609	9
10	30	DEPRECIATION	" "	413,836	12	24,690	29,626	1,768	10
11	32	INTEREST	" "	413,836	12	27,602	29,626	1,976	11
12	33	REAL ESTATE TAXES	" "	413,836	12	29,555	29,626	2,116	12
13	35	EQUIPMENT RENTAL	" "	413,836		49,319	29,626	3,531	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					\$ 778,653	\$ 345,326	\$ 55,743	25

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINT.CMP.- D.NEHMER	WGHTD AVG.HOURS	40	12	\$ 55,120	\$ 55,120		1
2	17	ADMIN.CMP.- M. MAUER	" "	40	12	170,000	170,000	3	12,198
3	17	ADMIN.CMP.- M. AARON	" "	40	12	170,000	170,000		
4	17	ADMIN.CMP.- F. AARON	" "	47	12	88,500	88,500		
5	17	ADMIN.CMP.- S. GOLDSTEIN	" "	45	12	24,000	24,000		
6	17	ADMIN.CMP.- S. KOPLIN	" "	40	12	72,485	72,485		
7	17	ADMIN.CMP.- D. MAGAFAS	" "	45	12	104,642	104,642		
8	17	ADMIN.CMP.- S. LEVY	" "	45	12	158,233	158,233	3	11,358
9	17	ADMIN.CMP.- H. ALTER	" "	40	12	12,000	12,000		
10	17	ADMIN.CMP.- NON-OWNER	" "	45	12	170,636	170,636		
11	21	CLERICAL CMP.- S.AARON	" "	40	12	67,785	67,785	3	4,864
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					\$ 1,093,401	\$ 1,093,401		\$ 28,420

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP.BEN. - D.NEHMER	WGHTD AVG.HOURS	40	12	\$ 5,362		\$	1
2	27	EMP.BEN. - M. MAUER	" "	40	12	11,631	3	835	2
3	27	EMP.BEN. - M. AARON	" "	40	12	13,532			3
4	27	EMP.BEN. - F. AARON	" "	47	12	42,295			4
5	27	EMP.BEN. - S. GOLDSTEIN	" "	45	12	33,649			5
6	27	EMP.BEN. - S. KOPLIN	" "	40	12	25,376			6
7	27	EMP.BEN. - D. MAGAFAS	" "	45	12	8,470			7
8	27	EMP.BEN. - S. LEVY	" "	45	12	24,807	3	1,781	8
9	27	EMP.BEN. - H. ALTER	" "	40	12	1,105			9
10	27	EMP.BEN. - NON-OWNER	" "	45	12	27,997			10
11	27	EMP.BEN. - S.AARON	" "	40	12	15,016	3	1,077	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					\$ 209,240		\$ 3,693	25

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>DYNAMIC REHAB CONSULTANTS</u>				\$	\$		\$	1
2	<u>10A THERAPY</u>	<u>DIRECT ALLOCATION</u>							2
3	<u>19 PROFESSIONAL FEES</u>	" "							3
4	<u>22 EMPLOYEE BENEFITS</u>	" "							4
5	<u>39 ANCILLARY SERVICES</u>	" "							5
6									6
7									7
8	<u>LINCOLN MEDICAL SUPPLIES</u>								8
9	<u>10 MEDICAL SUPPLIES</u>	<u>DIRECT ALLOCATION</u>			259			259	9
10	<u>39 ANCILLARY EXPENSES</u>	" "			2,436			2,436	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,695	\$		\$ 2,695	25

Facility Name & ID Number

GROSSE POINTE MANOR

0045203

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	MB FINANCIAL		X	MORTGAGE			\$	\$ 4,703,721			\$	303,791						
2																		
3																		
4																		
5																		
Working Capital																		
6	MB FINANCIAL		X	WORKING CAPITAL				1,250,000				68,082						
7			X	INSURANCE FINANCING								2,362						
8	RELATED PARTY	X		LINE OF CREDIT								1,976						
9	TOTAL Facility Related						\$	\$ 5,953,721			\$	376,211						
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$							
15	TOTALS (line 9+line14)						\$	\$ 5,953,721			\$	376,211						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.		\$	140,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	137,619	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,381)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	140,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	137,619	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	_____	8
	2001	_____	9
	2002	105,501	10
	2003	132,906	11
	2004	137,619	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED

ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

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:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROSSE POINTE MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045203

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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>10-31-205-031-0000</u>	<u>NURSING HOME</u>	\$ <u>94,769.93</u>	\$ <u>94,769.93</u>
2. <u>10-31-205-030-0000</u>	<u>NURSING HOME</u>	\$ <u>42,849.11</u>	\$ <u>42,849.11</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>137,619.04</u>	\$ <u>137,619.04</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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number **GROSSE POINTE MANOR**

0045203

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99	2001		\$ 3,862,200	\$ 140,444	27.5	\$ 140,444	\$	\$ 678,836	4
5										5
6										6
7										7
8					814		907	93		8
Improvement Type**										
9	ICE MACHINE DRAIN/COOLING PUMP/WATER PUMP		2001	6,224	226	27.5	226		1,124	9
10	ROOFING		2001	34,800	1,266	27.5	1,266		5,494	10
11	SURVEILLANCE EQUIP/ANTENNA		2001	2,250	82	27.5	82		386	11
12	TELEPHONE / SPLITTERS		2001	609		7			609	12
13	DINING CAR/ROOM SIGNS		2001	8,744	318	27.5	318		1,331	13
14	MONITOR / CAMERA		2002	5,303	193	27.5	193		727	14
15	MEZUZAHS		2002	2,240	81	27.5	81		309	15
16	WIRING / WATER VALVE / PUMP / VENTILATOR		2002	7,756	282	27.5	282		999	16
17	COMPRESSOR		2003	1,364	50	27.5	50		123	17
18	SATELLITE DISH SYSTEM		2003	1,054	38	27.5	38		94	18
19	WALK IN COOLER		2003	3,920	143	27.5	143		351	19
20	DRAIN		2003	923	34	27.5	34		83	20
21	SMOKE DETECTORS		2003	1,761	64	27.5	64		157	21
22	VIDEO CAMERA		2003	896	32	27.5	32		80	22
23	FIRE SUPPRESSION SYSTEM		2004	4,315	156	27.5	156		228	23
24	TOWER PUMP		2004	4,328	158	27.5	158		230	24
25	A/C CHILLER		2004	1,458	53	27.5	53		77	25
26	BEARING ASSEMBLY / DOORS		2005	3,543	59	27.5	59		59	26
27	FIRE ALARM REPAIR		2005	2,935	48	27.5	48		48	27
28	A/C TOWER / GEARBOX PULLY / WALL HEATER		2005	4,834	81	27.5	81		81	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

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,961,457	\$ 144,622		\$ 144,715	\$ 93	\$ 691,426	70

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

Facility Name & ID Number **GROSSE POINTE MANOR**

0045203

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 54,504	\$ 5,331	\$ 5,450	\$ 119	10	\$ 16,964	71
72	Current Year Purchases	10,644	2,129	532	(1,597)	10	532	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		40,478	41,746	1,268			74
75	TOTALS	\$ 65,148	\$ 47,938	\$ 47,728	\$ (210)		\$ 17,496	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	RELATED PARTY									77
78					796	831	35			78
79										79
80	TOTALS			\$	\$ 796	\$ 831	\$ 35		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,600,253	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 193,356	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 193,274	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (82)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 708,922	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: NA

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,844 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		<u>NISSAN</u>	\$ <u>463.45</u>	\$ <u>5,561</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>463.45</u>	\$ <u>5,561</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2006 \$ _____

13. _____/2007 \$ _____

14. _____/2008 \$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA 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 CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs 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 CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 41,481	\$		\$ 41,481	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,327			1,327	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			106,094			106,094	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				59,331		59,331	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES,RADIOLOGY,LAB RENT Other (specify):	39-2					19,682		19,682	13
14	TOTAL			\$		\$ 148,902	\$ 79,013		\$ 227,915	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 CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (24,966))	1,074,709		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,628		6
7	Other Prepaid Expenses	5,933		7
8	Accounts Receivable (owners or related parties)	51,190		8
9	Other(specify): R.E TAX ESCROW	17,475		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,187,935	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	99,257		15
16	Equipment, at Historical Cost	65,148		16
17	Accumulated Depreciation (book methods)	(60,929)		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): DEPOSITS	1,020		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 104,496	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,292,431	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 411,227	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,250,000		29
30	Accrued Salaries Payable	119,137		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,223		31
32	Accrued Real Estate Taxes(Sch.IX-B)	140,000		32
33	Accrued Interest Payable	4,741		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,940,328	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	452,500		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 452,500	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,392,828	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,100,397)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,292,431	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,247,516)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,247,516)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	147,119	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 147,119	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,100,397)	24 *

* This must agree with page 17, line 47.

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	\$ 4,143,400	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,143,400	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	137,240	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 137,240	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT	778	28
28a	VENDING COMMISSIONS NET OF COST	123	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 901	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,281,541	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	845,582	31
32	Health Care	1,494,435	32
33	General Administration	969,402	33
	B. Capital Expense		
34	Ownership	542,885	34
	C. Ancillary Expense		
35	Special Cost Centers	227,915	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,134,422	40
41	Income before Income Taxes (line 30 minus line 40)**	147,119	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 147,119	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	1,918	2,216	\$ 72,620	\$ 32.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,243	5,887	159,927	27.17	3
4	Licensed Practical Nurses	14,028	15,071	378,910	25.14	4
5	CNAs & Orderlies	49,550	53,283	642,661	12.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,673	1,929	28,928	15.00	9
10	Activity Assistants	7,320	7,927	84,488	10.66	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,889	2,173	30,560	14.06	13
14	Head Cook	4,689	4,990	66,806	13.39	14
15	Cook Helpers/Assistants	9,830	10,287	92,665	9.01	15
16	Dishwashers	4,823	5,440	47,460	8.72	16
17	Maintenance Workers	3,778	4,163	62,970	15.13	17
18	Housekeepers	4,781	5,065	42,822	8.45	18
19	Laundry	5,593	6,266	64,779	10.34	19
20	Administrator	2,006	2,262	79,195	35.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,229	10,049	175,119	17.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,350	137,008	\$ 2,029,910 *	\$ 14.82	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$ 3,840	1-3	35	
36	Medical Director	12,000	9-3	36	
37	Medical Records Consultant	1,340	10-3	37	
38	Nurse Consultant	0	10-3	38	
39	Pharmacist Consultant	1,688	10-3	39	
40	Physical Therapy Consultant	6	410	10a-3	40
41	Occupational Therapy Consultant	34	2,819	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	24	813	10a-3	43
44	Activity Consultant		576	11-3	44
45	Social Service Consultant	12	540	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	76	\$ 24,026		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$	10-3	50	
51	Licensed Practical Nurses	816	35,881	10-3	51
52	Certified Nurse Assistants/Aides	140	3,147	10-3	52
53	TOTAL (lines 50 - 52)	956	\$ 39,028		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
SHERRY MAUER	ADMIN		\$ 79,195	Workers' Compensation Insurance	\$ 46,578	IDPH License Fee	\$	
				Unemployment Compensation Insurance	49,272	Advertising: Employee Recruitment	6,617	
				FICA Taxes	155,749	Health Care Worker Background Check	260	
				Employee Health Insurance	139,540	(Indicate # of checks performed)		
				Employee Meals	18,068	MARKETING/ADV/PROMO	60,212	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	100	
				EMPLOYEE BENEFITS - OTHER	7,280	LICENSES & PERMITS	3,801	
						DUES & SUBSCRIPTIONS	130	
						MGMT CO ALLOCATION	603	
						TRUST/FRANCHISE/CONTRIB/ETC	(100)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 79,195			Less: Public Relations Expense	(0)	
B. Administrative - Other						Non-allowable advertising	(60,212)	
Description			Amount			Yellow page advertising	(0)	
			\$ 0					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 416,487	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,411	
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							MGMT CO ALLOCATION	66
							Seminar Expense	
								0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
SEE SCHEDULE ATTACHED			50,990	TOTAL		\$	TOTAL	\$ 66
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 50,990					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GROSSE POINTE MANOR# 0045203Report Period Beginning: 01/01/2005Ending: 12/31/2005**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,079 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, 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. \$ 18,068 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees