

Facility Name & ID Number Applewood Center# 0037887 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>41,975</u>	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	<u>115</u>	TOTALS	<u>115</u>	<u>41,975</u>	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	<u>20,818</u>	<u>7,178</u>	<u>9,056</u>	<u>37,052</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,818</u>	<u>7,178</u>	<u>9,056</u>	<u>37,052</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.27%

D. How many bed-hold days during this year were paid by Public Aid?

401 (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/AF. 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 05/01/92

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

YES Date 05/01/92 NO

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

YES NO If YES, enter number of beds certified 115 and days of care provided 8,679Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/02 Fiscal Year: 12/31/02

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

STATE OF ILLINOIS

Facility Name & ID Number Applewood Center # 0037887 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	204,464	20,043	52,601	277,108	1,866	278,974		278,974		1
2	Food Purchase		165,243		165,243		165,243	(1,688)	163,555		2
3	Housekeeping	123,455	17,855	5,965	147,275	(6,595)	140,680		140,680		3
4	Laundry	26,752	12,612	40,111	79,475	9,410	88,885		88,885		4
5	Heat and Other Utilities			80,393	80,393		80,393		80,393		5
6	Maintenance	59,280	10,955	29,712	99,947	(151)	99,796		99,796		6
7	Other (specify):* Trash Removal			6,095	6,095		6,095		6,095		7
8	TOTAL General Services	413,951	226,708	214,877	855,536	4,530	860,066	(1,688)	858,378		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,762,577	241,487	145,321	2,149,385	(4,373)	2,145,012	(1,786)	2,143,226		10
10a	Therapy	9,275	1,137	669,097	679,509	(372)	679,137	(56,197)	622,940		10a
11	Activities	70,916	3,919	7,510	82,345	288	82,633	(2,236)	80,397		11
12	Social Services	114,276	755	1,734	116,765	(470)	116,295		116,295		12
13	Nurse Aide Training			1,759	1,759	(1,759)					13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,957,044	247,298	837,421	3,041,763	(6,686)	3,035,077	(60,219)	2,974,858		16
	C. General Administration										
17	Administrative	211,812	3,256	416,751	631,819	342	632,161	69,030	701,191		17
18	Directors Fees										18
19	Professional Services			1,040	1,040		1,040		1,040		19
20	Dues, Fees, Subscriptions & Promotions			7,434	7,434	1,613	9,047	(552)	8,495		20
21	Clerical & General Office Expenses		21,310	47,240	68,550	411	68,961	99	69,060		21
22	Employee Benefits & Payroll Taxes			554,787	554,787	(1,506)	553,281	(35)	553,246		22
23	Inservice Training & Education					1,663	1,663	(9)	1,654		23
24	Travel and Seminar			4,951	4,951	96	5,047		5,047		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			43,871	43,871		43,871		43,871		26
27	Other (specify):* Miscellaneous Exp			1,794,026	1,794,026		1,794,026	(1,793,355)	671		27
28	TOTAL General Administration	211,812	24,566	2,870,100	3,106,478	2,619	3,109,097	(1,724,822)	1,384,275		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,582,807	498,572	3,922,398	7,003,777	463	7,004,240	(1,786,729)	5,217,511		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 Applewood Center

#0037887

Report Period Beginning:

01/01/02

Ending:

12/31/02

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			47,653	47,653		47,653	31,942	79,595			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(24,197)	(24,197)		(24,197)	227,310	203,113			32
33	Real Estate Taxes			228,226	228,226		228,226		228,226			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			33,223	33,223	(463)	32,760	(96)	32,664			35
36	Other (specify):*											36
37	TOTAL Ownership			284,905	284,905	(463)	284,442	259,156	543,598			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,629	2,629		2,629		2,629			38
39	Ancillary Service Centers			353,406	353,406		353,406	(2,491)	350,915			39
40	Barber and Beauty Shops			15,406	15,406		15,406		15,406			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,791	62,791		62,791		62,791			42
43	Other (specify):* See Attached			1,627,744	1,627,744		1,627,744	(1,600,000)	27,744			43
44	TOTAL Special Cost Centers			2,061,976	2,061,976		2,061,976	(1,602,491)	459,485			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,582,807	498,572	6,269,279	9,350,658		9,350,658	(3,130,064)	6,220,594			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 **Applewood Center**

0037887

Report Period Beginning: **01/01/02**

Ending: **12/31/02**

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	(1,170)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,236)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(53,368)	30		9
10	Interest and Other Investment Income	(407)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(317)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	183,027	27		24
25	Fund Raising, Advertising and Promotional	(6,634)	27		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)	\$ 118,895		\$	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)	322,831		34
35	Other- Attach Schedule	(3,571,790)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,248,959)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (3,130,064)		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

Applewood Center

ID# 0037887

Report Period Beginning: 01/01/02

Ending: 12/31/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Cable TV Expense	\$ (1,490)	10	1
2	PAC Dues	(552)	20	2
3	Non-recurring Charges	(1,600,000)	43	3
4	Miscellaneous Expense	(1,969,748)	27	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	(3,571,790)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Applewood Center# 0037887

Report Period Beginning:

01/01/02

Ending:

12/31/02

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,487)	(201)	0	0	0	0	0	0	0	0	0	(1,688)	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,487)	(201)	0	(1,688)	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	(1,490)	(296)	0	0	0	0	0	0	0	0	0	(1,786)	10
10a	Therapy	0	(56,197)	0	0	0	0	0	0	0	0	0	(56,197)	10a
11	Activities	(2,236)	0	0	0	0	0	0	0	0	0	0	(2,236)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,726)	(56,493)	0	(60,219)	16								
	C. General Administration													
17	Administrative	0	69,030	0	0	0	0	0	0	0	0	0	69,030	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(552)	0	0	0	0	0	0	0	0	0	0	(552)	20
21	Clerical & General Office Expenses	0	99	0	0	0	0	0	0	0	0	0	99	21
22	Employee Benefits & Payroll Taxes	0	(35)	0	0	0	0	0	0	0	0	0	(35)	22
23	Inservice Training & Education	0	(9)	0	0	0	0	0	0	0	0	0	(9)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,793,355)	0	0	0	0	0	0	0	0	0	0	(1,793,355)	27
28	TOTAL General Administration	(1,793,907)	69,085	0	(1,724,822)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,799,120)	12,391	0	(1,786,729)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Applewood Center# 0037887 Report Period Beginning:

01/01/02 Ending:

12/31/02

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(53,368)	85,310	0	0	0	0	0	0	0	0	0	31,942 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(407)	0	227,717	0	0	0	0	0	0	0	0	227,310 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	(65)	(31)	0	0	0	0	0	0	0	0	(96) 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(53,775)	85,245	227,686	0	259,156 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	(2,491)	0	0	0	0	0	0	0	0	0	(2,491) 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):*	(1,600,000)	0	0	0	0	0	0	0	0	0	0	(1,600,000) 43
44	TOTAL Special Cost Centers	(1,600,000)	(2,491)	0	0	0	0	0	0	0	0	0	(1,602,491) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,452,895)	95,145	227,686	0	(3,130,064) 45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Genesis Health Ventures	100	See Attached List		ANR, Inc.	Hackensack, NJ	Property Owner
				Neighborcare	Willowbrook, IL	Pharmacy
				Genesis Rehab.	Kennett Square, PA	Therapy
				Genesis Hospitality	Kennett Square, PA	Dietary
				Genesis Staffing	Kennett Square, PA	Staffing
				Respiratory Health	Kennett Square, PA	Respiratory serv

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	30 Depreciation	\$	ANR, Inc.		\$ 85,310	\$	85,310	1
2	V	21 Quarterly & Annual Reports		ANR, Inc.		100		100	2
3	V	17 Administrative	416,751	Genesis Health Ventures	100.00%	485,781		69,030	3
4	V	2 Related Party Mark-up	201	Neighborcare				(201)	4
5	V	10 Related Party Mark-up	267	Neighborcare				(267)	5
6	V	21 Related Party Mark-up	1	Neighborcare				(1)	6
7	V	22 Related Party Mark-up	35	Neighborcare				(35)	7
8	V	23 Related Party Mark-up	9	Neighborcare				(9)	8
9	V	35 Related Party Mark-up	65	Neighborcare				(65)	9
10	V	39 Related Party Mark-up	2,491	Neighborcare				(2,491)	10
11	V	10a Related Party Mark-up	5	Neighborcare				(5)	11
12	V	10a Related Party Mark-up	56,192	Genesis Rehab				(56,192)	12
13	V	10 Related Party Mark-up	29	Respiratory Health				(29)	13
14	Total		\$ 476,046			\$ 571,191	\$ *	95,145	14

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

Facility Name & ID Number Applewood Center

0037887

Report Period Beginning: 01/01/02

Ending: 12/31/02

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	32 Interest	\$ (24,197)	Genesis Health Ventures		\$ 203,520	\$ 227,717	15
16	V	35 Related Party Mark-Up	31	Respiratory Health			(31)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ (24,166)			\$ 203,520	\$ * 227,686	39

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

Facility Name & ID Number Applewood Center # 0037887 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	Facility is owned by publicly traded company								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Applewood Center # 0037887 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 Genesis Health Ventures
 Street Address 101 E. Street
 City / State / Zip Code Kennett Square, PA
 Phone Number (610)9254076
 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	17	Administrative	Accumulated Costs	373	\$ 140,141,312	\$		\$ 485,781	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				\$ 140,141,312	\$		\$ 485,781	25

Facility Name & ID Number Applewood Center

0037887

Report Period Beginning:

01/01/02

Ending:

12/31/02

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		Mellon Bank Revolving Credit		X				\$	\$ 3,072,455			6.6300	\$ 203,520	1					
2														2					
3														3					
4														4					
5														5					
		Working Capital																	
6														6					
7														7					
8														8					
9		TOTAL Facility Related					\$	\$ 3,072,455				\$ 203,520	9						
		B. Non-Facility Related*																	
10														10					
11														11					
12														12					
13														13					
14		TOTAL Non-Facility Related					\$	\$				\$	14						
15		TOTALS (line 9+line14)					\$	\$ 3,072,455				\$ 203,520	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 Applewood Center# 0037887 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 2001 report.			\$	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.)			\$	198,994 2
3.	Under or (over) accrual (line 2 minus line 1).			\$	198,994 3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	29,232 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.			\$	228,226 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	186,940	8	
		1998	175,858	9	
		1999	152,922	10	
		2000	186,574	11	
		2001	198,994	12	
				FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2001	\$	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:** 2001 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 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 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 2002 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.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Applewood Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037887

CONTACT PERSON REGARDING THIS REPORT Laura Hillenbrand

TELEPHONE 304-599-0395 FAX #: 304-285-0624

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 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 2001.

(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>31-22-114-023-0000</u>	<u>Long Term Care</u>	\$ <u>15,744.37</u>	\$ _____
2. <u>31-22-114-024-0000</u>	<u>Long Term Care</u>	\$ <u>165,192.27</u>	\$ _____
3. <u>31-22-114-025-0000</u>	<u>Long Term Care</u>	\$ <u>4,785.46</u>	\$ _____
4. <u>31-22-114-026-0000</u>	<u>Long Term Care</u>	\$ <u>13,271.94</u>	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>198,994.04</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 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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Applewood Center# 0037887 Report Period Beginning:01/01/02 Ending:12/31/02**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 34,449 B. General Construction Type: Exterior Brick Frame Steel Stud 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	Facility	191,664	1992	\$ 25,000	1
2					2
3	TOTALS	191,664		\$ 25,000	3

Facility Name & ID Number Applewood Center

0037887

Report Period Beginning:

01/01/02

Ending:

12/31/02

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	115		1992	1967	\$ 1,050,000	\$ 85,310	30	\$ 35,000	\$ (50,310)	\$ 367,499	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9			1993		33,144		20	1,657	1,657	15,039	9
10			1994		66,019		20	3,301	3,301	27,304	10
11			1995		89,716		20	4,486	4,486	35,184	11
12			1996		99,104		20	4,531	4,531	29,521	12
13			1997		28,689		20	1,428	1,428	7,998	13
14			1997		1,031		35	35	35	186	14
15			1998		28,796		35	497	497	2,485	15
16			1999		232		35	7	7	28	16
17			1999		321		35	9	9	36	17
18			2000		1,450		35	41	41	123	18
19			2000		3,652		35	104	104	312	19
20			2001		3,161		35	90	90	180	20
21			2001		2,694		35	77	77	154	21
22			2002		8,495	405	35	243	(162)	243	22
23			2002		1,392	50	35	40	(10)	40	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Applewood Center

0037887

Report Period Beginning:

01/01/02

Ending:

12/31/02

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)		\$ 1,417,896	\$ 85,765		\$ 51,546	\$ (34,219)	\$ 486,332		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	\$ 208,263	\$ 44,617	\$ 25,377	\$ (19,240)	5-7	\$ 143,760	71
72	Current Year Purchases	34,550	2,581	2,581		7	2,581	72
73	Fully Depreciated Assets	608,918					608,918	73
74								74
75	TOTALS	\$ 851,731	\$ 47,198	\$ 27,958	\$ (19,240)		\$ 755,259	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 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)	\$ 2,294,627	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 132,963	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 79,504	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (53,459)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,241,591	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: _____
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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

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>/2003</u>	\$ _____
13.	<u>/2004</u>	\$ _____
14.	<u>/2005</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: \$ 33,223 Description: Admin \$7668, Ancillary \$3325, Nrsrg \$22,230

(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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	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	10a, 2 & 3	hrs	\$	4,320	\$	249,551	\$	773		4,320	\$	250,324	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		609		33,863				609		33,863	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a, 2 & 3	hrs		6,342		385,683		364		6,342		386,047	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39, 3	# of prescripts						350,860				350,860	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			\$	11,271	\$	669,097	\$	351,997		11,271	\$	1,021,094	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Applewood Center

0037887

Report Period Beginning: 01/01/02

Ending:

12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02

(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	\$ 85,971	\$ 85,971	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	597,593	597,593	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,865	1,865	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 685,429	\$ 685,429	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		482,770	13
14	Buildings, at Historical Cost	(1,591,506)	1,252,170	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	251,974	251,974	16
17	Accumulated Depreciation (book methods)	(62,953)	(176,700)	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):	11,873	11,873	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ (1,390,612)	\$ 1,822,087	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (705,183)	\$ 2,507,516	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 158,333	\$ 158,333	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	137,605	137,605	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	438,807	438,807	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Other Liabilities	(900)	(900)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 733,845	\$ 733,845	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	Inter Company Due To / From	1,275,816	4,658,263	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,275,816	\$ 4,658,263	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,009,661	\$ 5,392,108	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,714,844)	\$ (2,884,592)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (705,183)	\$ 2,507,516	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (542,191)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (542,191)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(2,912,972)	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) <u>Fresh Start Bankruptcy Entry</u>	736,103	15
16	Other (describe) <u>Depreciation Adjustment</u>	4,214	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,172,655)	17
B. Transfers (Itemize):			
18	<u>Rounding</u>	2	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 2	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,714,844)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Applewood Center

0037887

Report Period Beginning: 01/01/02

Ending: 12/31/02

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	\$ 4,920,724	1
2	Discounts and Allowances for all Levels	(1,117,691)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,803,033	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,024,966	6
7	Oxygen	48,092	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,073,058	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	20,774	13
14	Non-Patient Meals	1,170	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	380,402	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	47,709	19
20	Radiology and X-Ray	28,673	20
21	Other Medical Services	1,057,626	21
22	Laundry	26,595	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,562,949	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	407	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 407	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	(1,761)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1,761)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,437,686	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	855,536	31
32	Health Care	3,041,763	32
33	General Administration	3,106,478	33
B. Capital Expense			
34	Ownership	284,905	34
C. Ancillary Expense			
35	Special Cost Centers	1,999,185	35
36	Provider Participation Fee	62,791	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,350,658	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,912,972)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,912,972)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 **Applewood Center**

0037887

Report Period Beginning: **01/01/02**

Ending:

12/31/02

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	1,783	2,011	\$ 55,902	\$ 27.80	1
2	Assistant Director of Nursing	846	933	22,417	24.03	2
3	Registered Nurses	18,210	19,924	479,354	24.06	3
4	Licensed Practical Nurses	17,688	19,137	362,431	18.94	4
5	Nurse Aides & Orderlies	68,466	75,726	783,172	10.34	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,227	1,227	8,903	7.26	8
9	Activity Director					9
10	Activity Assistants	7,171	7,629	71,204	9.33	10
11	Social Service Workers	5,531	6,110	113,806	18.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,228	21,439	206,269	9.62	15
16	Dishwashers					16
17	Maintenance Workers	3,680	4,138	59,129	14.29	17
18	Housekeepers	11,152	12,994	116,861	8.99	18
19	Laundry	3,147	3,580	36,162	10.10	19
20	Administrator	1,805	2,084	77,648	37.26	20
21	Assistant Administrator					21
22	Other Administrative	10,357	11,241	134,621	11.98	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	4,086	4,497	54,928	12.21	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,377	192,670	\$ 2,582,807 *	\$ 13.41	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	\$		35	
36	Medical Director	monthly	12,000	9, 3	36
37	Medical Records Consultant		452	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	per bed charge	6,728	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,734	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	20,914		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,536	\$ 83,387	10, 3	50
51	Licensed Practical Nurses	1,308	45,531	10, 3	51
52	Nurse Aides	317	6,252	10, 3	52
53	TOTAL (lines 50 - 52)	3,161	\$ 135,170		53

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. IL HEALTH CARE ASSOC \$5438
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 81,494 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. \$ 62,791
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 1,170
- (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? NA
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
- 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? YES
Firm Name: KPMG Peat Marwick LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Not yet Available
- (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.

APPLEWOOD

MEDICAID #: 22-3152534001

COST REPORT PERIOD : 01-01-02 THUR 12-31-02

SPECIAL COST CENTERS

Page 4 - Line 43

	<u>REFER.</u>	<u>COST</u>
Business Privilege Tax	V4.4303	
Laboratory Fees	V4.4303	8,581
X-Ray Expense	V4.4303	19,163
		<hr/>
		27,744

APPLEWOOD

MEDICAID #: 22-3152534001

COST REPORT PERIOD : 01-01-01 THUR 12-31-01

MISCELLANEOUS REVENUE

<u>Misc Revenue Summary</u>	<u>Amount</u>
Prior period patient revenue	(1,984)
Current period patient revenue	(20)
Medical Record Copies	162
Accuchecks	81
	<hr/>
TOTAL	<u><u>(1,761)</u></u>