

Facility Name & ID Number DEERBROOK CARE CENTRE# 0040741 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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 beds03/19/02

	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>217</u>	Skilled (SNF)	<u>214</u>	<u>78,341</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>217</u>	TOTALS	<u>214</u>	<u>78,341</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,518</u>	<u>1,042</u>	<u>9,688</u>	<u>15,248</u>	8
9	SNF/PED					9
10	ICF	<u>38,771</u>	<u>9,099</u>	<u>3,580</u>	<u>51,450</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,289</u>	<u>10,141</u>	<u>13,268</u>	<u>66,698</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.14%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONEF. 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 04/01/94

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

YES Date 04/01/94 NO

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

YES NO If YES, enter numberof beds certified 214 and days of care provided 5,240Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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	227,115	27,913	12,237	267,265		267,265	(860)	266,405		1
2	Food Purchase		238,842		238,842		238,842	(1,807)	237,035		2
3	Housekeeping	186,777	41,367		228,144		228,144	2,432	230,576		3
4	Laundry	87,479	16,774	1,345	105,598		105,598	(89)	105,509		4
5	Heat and Other Utilities			141,565	141,565		141,565		141,565		5
6	Maintenance	58,793	40,010	38,914	137,717		137,717	35	137,752		6
7	Other (specify):*			9,889	9,889		9,889		9,889		7
8	TOTAL General Services	560,164	364,906	203,950	1,129,020		1,129,020	(289)	1,128,731		8
	B. Health Care and Programs										
9	Medical Director			13,300	13,300		13,300		13,300		9
10	Nursing and Medical Records	2,440,152	130,443	49,413	2,620,008		2,620,008	(6,946)	2,613,062		10
10a	Therapy			21,465	21,465		21,465		21,465		10a
11	Activities	167,680	13,533		181,213		181,213	(1,029)	180,184		11
12	Social Services	35,628		829	36,457		36,457		36,457		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,643,460	143,976	85,007	2,872,443		2,872,443	(7,975)	2,864,468		16
	C. General Administration										
17	Administrative	306,325		736,229	1,042,554		1,042,554	(719,507)	323,047		17
18	Directors Fees										18
19	Professional Services			231,031	231,031		231,031	116,389	347,420		19
20	Dues, Fees, Subscriptions & Promotions			224,037	224,037		224,037	(199,176)	24,861		20
21	Clerical & General Office Expenses	329,167	56,449	62,926	448,542		448,542	155,516	604,058		21
22	Employee Benefits & Payroll Taxes			741,082	741,082		741,082		741,082		22
23	Inservice Training & Education			10,179	10,179		10,179		10,179		23
24	Travel and Seminar			717	717		717	10,228	10,945		24
25	Other Admin. Staff Transportation			7,655	7,655		7,655		7,655		25
26	Insurance-Prop.Liab.Malpractice			162,790	162,790		162,790	176,391	339,181		26
27	Other (specify):*			53,343	53,343		53,343	(53,343)			27
28	TOTAL General Administration	635,492	56,449	2,229,989	2,921,930		2,921,930	(513,502)	2,408,428		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,839,116	565,331	2,518,946	6,923,393		6,923,393	(521,766)	6,401,627		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 **DEERBROOK CARE CENTRE**

#0040741

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			74,278	74,278		74,278	211,782	286,060			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,111	49,111		49,111	294,578	343,689			32
33	Real Estate Taxes			86,101	86,101		86,101		86,101			33
34	Rent-Facility & Grounds			792,050	792,050		792,050	(772,961)	19,089			34
35	Rent-Equipment & Vehicles			36,664	36,664		36,664	8,805	45,469			35
36	Other (specify):* STORAGE			1,812	1,812		1,812		1,812			36
37	TOTAL Ownership			1,040,016	1,040,016		1,040,016	(257,796)	782,220			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		297,795	306,820	604,615		604,615		604,615			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,512	117,512		117,512		117,512			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		297,795	424,332	722,127		722,127		722,127			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,839,116	863,126	3,983,294	8,685,536		8,685,536	(779,562)	7,905,974			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 **DEERBROOK CARE CENTRE**

0040741

Report Period Beginning: **01/01/2002**

Ending: **12/31/2002**

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	(20,852)	30		9
10	Interest and Other Investment Income	(49,111)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,807)	2		13
14	Non-Care Related Interest	(21,085)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(116)	21		18
19	Entertainment	(110,234)	20		19
20	Contributions	(5,450)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,873)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,343)	27		24
25	Fund Raising, Advertising and Promotional	(72,401)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,933)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(16,869)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (366,074)		\$	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)	(413,488)	PG6&6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (413,488)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (779,562)		37

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

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

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

DEERBROOK CARE CENTRE

ID# 0040741

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	DEFERRED MAINTENANCE	\$ 1,732	6	1
2	VACATION ACCRUAL	(860)	1	2
3	VACATION ACCRUAL	2,432	3	3
4	VACATION ACCRUAL	(89)	4	4
5	VACATION ACCRUAL	(1,697)	6	5
6	VACATION ACCRUAL	(19,773)	10	6
7	VACATION ACCRUAL	(1,029)	11	7
8	VACATION ACCRUAL	(2,875)	17	8
9	VACATION ACCRUAL	5,290	21	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	(16,869)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DEERBROOK CARE CENTRE

0040741

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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	(860)	0	0	0	0	0	0	0	0	0	0	(860)	1
2	Food Purchase	(1,807)	0	0	0	0	0	0	0	0	0	0	(1,807)	2
3	Housekeeping	2,432	0	0	0	0	0	0	0	0	0	0	2,432	3
4	Laundry	(89)	0	0	0	0	0	0	0	0	0	0	(89)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	35	0	0	0	0	0	0	0	0	0	0	35	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(289)	0	0	0	0	0	0	0	0	0	0	(289)	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	(19,773)	12,827	0	0	0	0	0	0	0	0	0	(6,946)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,029)	0	0	0	0	0	0	0	0	0	0	(1,029)	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	(20,802)	12,827	0	0	0	0	0	0	0	0	0	(7,975)	16
	C. General Administration													
17	Administrative	(2,875)	(716,632)	0	0	0	0	0	0	0	0	0	(719,507)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,873)	6,372	111,890	0	0	0	0	0	0	0	0	116,389	19
20	Fees, Subscriptions & Promotions	(201,018)	1,842	0	0	0	0	0	0	0	0	0	(199,176)	20
21	Clerical & General Office Expenses	5,174	149,386	956	0	0	0	0	0	0	0	0	155,516	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	10,228	0	0	0	0	0	0	0	0	0	10,228	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	5,958	170,433	0	0	0	0	0	0	0	0	176,391	26
27	Other (specify):*	(53,343)	0	0	0	0	0	0	0	0	0	0	(53,343)	27
28	TOTAL General Administration	(253,935)	(542,846)	283,279	0	(513,502)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(275,026)	(530,019)	283,279	0	(521,766)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DEERBROOK CARE CENTRE# 0040741

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

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	(20,852)	6,964	225,670	0	0	0	0	0	0	0	0	211,782	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(70,196)	0	364,774	0	0	0	0	0	0	0	0	294,578	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	19,089	(792,050)	0	0	0	0	0	0	0	0	(772,961)	34
35	Rent-Equipment & Vehicles	0	8,805	0	0	0	0	0	0	0	0	0	8,805	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(91,048)	34,858	(201,606)	0	(257,796)	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	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(366,074)	(495,161)	81,673	0	(779,562)	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
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		FIRST HEALTH CARE ASSOCIATES, LTD. (DIVISION OF FHC ENTERPRISE, INC.)	ROSEMONT	MANAGEMENT/CONSULTANT
				DEERBROOK NURSING CENTRE	ROSEMONT	REAL ESTATE

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 NURSING	\$	FHC ENTERPRISE INC.		\$ 12,827	\$ 12,827	1
2	V	17 ADMINISTRATIVE	736,229	MR. BELLOWS OWNS 19% OF THIS FACILITY AND 100% OF FHC ENTERPRISES		19,597	(716,632)	2
3	V	19 PROFESSIONAL FEES				6,372	6,372	3
4	V	20 DUES & SUBSCRIPTIONS		" "		1,842	1,842	4
5	V	21 CLERICAL		" "		149,386	149,386	5
6	V	24 TRAVEL		" "		10,228	10,228	6
7	V	26 INSURANCE		" "		5,958	5,958	7
8	V	30 DEPRECIATION		" "		6,964	6,964	8
9	V	34 RENT		" "		19,089	19,089	9
10	V	35 RENT-EQUIPMENT & VEH		" "		8,805	8,805	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 736,229			\$ 241,068	\$ * (495,161)	14

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

Facility Name & ID Number DEERBROOK CARE CENTRE

0040741

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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	34 RENT	\$ 792,050	DEERBROOK NURSING CENTRE		\$	\$ (792,050)
16	V	19 ACCOUNTING FEES		" "		11,500	11,500
17	V	19 LEGAL FEES		" "		350	350
18	V	26 GENERAL INSURANCE		" "		147,406	147,406
19	V	26 MORTGAGE INSURANCE		" "		23,027	23,027
20	V	30 DEPRECIATION-BLDG & IMP		" "		215,956	215,956
21	V	30 DEPRECIATION-EQUIP & FURN.		" "		9,714	9,714
22	V	32 AMORTIZATION-MTG COST		" "		3,136	3,136
23	V	32 MORTGAGE INTEREST		" "		340,553	340,553
24	V	19 OTHER PROFESSIONAL		" "		100,040	100,040
25	V	21 BANK CHARGES		" "		956	956
26	V	32 INTEREST - OTHER		" "		21,085	21,085
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 792,050			\$ 873,723	\$ * 81,673

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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	RELATED PARTY - FHC ENTERPRISES INC.								\$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	0.19	SEE ATTACHED	3.25	13.43	SALARY	19,597	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,597		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 DEERBROOK CARE CENTRE

0040741 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

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 FHC ENTERPRISES INC.
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	496,459	9	\$ 95,479	\$ 66,698	\$ 12,827	1
2	17	ADMINISTRATIVE	PATIENT DAYS	496,459	9	145,864	66,698	19,597	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	496,459	9	47,431	66,698	6,372	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	496,459	9	13,714	66,698	1,842	4
5	21	CLERICAL	PATIENT DAYS	496,459	9	190,601	66,698	25,607	5
6	21	CLERICAL	DIRECT COST	1	1	123,779	1	123,779	6
7	24	TRAVEL	PATIENT DAYS	496,459	9	76,130	66,698	10,228	7
8	26	INSURANCE	PATIENT DAYS	496,459	9	44,347	66,698	5,958	8
9	30	DEPRECIATION	PATIENT DAYS	496,459	9	51,835	66,698	6,964	9
10	34	RENT	PATIENT DAYS	496,459	9	142,084	66,698	19,089	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	496,459	9	65,539	66,698	8,805	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					\$ 996,803	\$ 365,122	\$ 241,068	25

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	RELATED PARTY - DEERBROOK NURSING HOME						\$	\$			\$	1						
2	GMAC		X	MORTGAGE	\$31,776.00	09/97	4,775,900	4,593,653	09/32	7.3750	340,553	2						
3	GMAC		X	LOAN COST	AMORT - 35 YRS		109,773	93,048			3,136	3						
4												4						
5												5						
Working Capital																		
6	AMERICAN NATIONAL BNK		X	WORKING CAPITAL	DEMAND	DEMAND	416,200	410,900	VARIES	PRIME +	46,471	6						
7	CRESTWOOD HEIGHTS	X		WORKING CAPITAL	DEMAND	DEMAND	50,000		DEMAND	VARIES	2,640	7						
8	FIRST HEALTH CARE	X		WORKING CAPITAL					DEMAND			8						
9	TOTAL Facility Related				\$31,776.00		\$ 5,351,873	\$ 5,097,601			\$ 392,800	9						
B. Non-Facility Related*																		
10	RELATED PARTY	X		WORKING CAPITAL	DEMAND	DEMAND		233,532	DEMAND	VARIES	21,085	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	233,532			\$ 21,085	14						
15	TOTALS (line 9+line14)						\$ 5,351,873	\$ 5,331,133			\$ 413,885	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 DEERBROOK CARE CENTRE# 0040741 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	80,724	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.)			\$	82,957	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,233	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	83,868	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.			\$	86,101	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
1997	<u>72,146</u>	<u>8</u>			
1998	<u>72,376</u>	<u>9</u>			
1999	<u>75,926</u>	<u>10</u>			
2000	<u>79,847</u>	<u>11</u>			
2001	<u>82,957</u>	<u>12</u>			
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 2001 TAX BILL.					
			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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DEERBROOK CARE CENTRE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0040741

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

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>30-07-07-401-034-0000</u>	<u>NURSING HOME</u>	\$ <u>82,956.82</u>	\$ <u>82,956.82</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>82,956.82</u>	\$ <u>82,956.82</u>

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

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing 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 DEERBROOK CARE CENTRE

0040741

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,380 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

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, 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>105,000</u>	<u>1975</u>	<u>\$ 247,500</u>	1
2	<u>754 BASIS ADJ.</u>		<u>1992</u>	<u>13,220</u>	2
3	TOTALS	105,000		\$ 260,720	3

Facility Name & ID Number DEERBROOK CARE CENTRE

0040741

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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	214			1975	\$ 1,849,704	\$ 29,750	35	\$ 52,849	\$ 23,099	\$ 1,439,058	4
5				1980	168,687		20			168,687	5
6	754 ADJ			1992	125,584	3,987	31.5	3,987		41,865	6
7	754 ADJ			2001	29,192	1,062	27.5	1,062		2,124	7
8											8
	Improvement Type**										
9	RELATED PARTY - DEERBROOK NURSING CENTRE										
10	IMPROVEMENTS			1984	33,823	1,516	20	1,691	175	31,283	10
11	IMPROVEMENTS			1986	21,535	1,120	20	1,077	(43)	17,770	11
12	IMPROVEMENTS			1987	78,860	2,504	20	3,943	1,439	61,562	12
13	IMPROVEMENTS			1988	48,614	1,544	31.5	1,544		22,044	13
14	IMPROVEMENTS			1989	60,430	1,919	31.5	1,919		26,687	14
15	IMPROVEMENTS			1990	30,485	967	3.5	967		11,743	15
16	IMPROVEMENTS			1991	53,134	1,688	31.5	1,688		19,280	16
17	IMPROVEMENTS			1992	117,363	3,725	31.5	3,725		38,489	17
18	IMPROVEMENTS			1993	29,335	932	39	932		9,171	18
19	IMPROVEMENTS			1993	29,864	767	27.5	767		7,159	19
20	IMPROVEMENTS			1994	37,711	1,371	27.5	1,371		11,408	20
21	VINYL SLIDER UNITS			1995	3,070	112	27.5	112		835	21
22	DOORS			1995	2,564	93	27.5	93		694	22
23	ROOF			1996	24,069	875	27.5	875		5,724	23
24	OUR TOWN			1996	74,400	2,705	27.5	2,705		16,343	24
25	ROOF/REMODEL KITCHEN/DUMPSTER/FLOORS			1997	448,432	16,005	27.5	16,005		86,438	25
26	ALZHEIMERS WING CONSTRUCTION			1997	1,590,575	57,833	27.5	57,833		307,886	26
27	OUR TOWN			1998	21,500	782	27.5	782		3,877	27
28	ALZHEIMERS WING CONSTRUCTION - FINAL DRAW			1998	17,009	618	27.5	618		3,065	28
29	DINING ROOM FLOOR - TILES			1998	30,000	1,091	27.5	1,091		5,410	29
30	DOOR ALARM SYSTEMS			1998	24,760	900	27.5	900		4,463	30
31	SPRINKLERS			1998	3,500	127	27.5	127		630	31
32	DINING ROOM - WALLPAPER/TILE BASE			1998	14,900	542	27.5	542		2,642	32
33	RENOVATE 2 ROOMS/REPLACE ELEVATOR FLOORS			1998	9,400	342	27.5	342		1,639	33
34	REMODELING OF ELEVATOR - LOBBY			1998	7,050	256	27.5	256		1,206	34
35	LANDSCAPING			1998	2,815	102	27.5	102		481	35
36	ROOF TOP PTAC UNITS			1998	3,508	128	27.5	128		602	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number DEERBROOK CARE CENTRE

0040741

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

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	DINING & RESIDENT ROOM FLOORS	1998	\$ 15,268	\$ 555	27.5	\$ 555	\$	\$ 2,567	37
38	HOT WATER TANK	1998	1,780	65	27.5	65		300	38
39	REMODELING - SHOWER ROOM	1998	3,830	139	27.5	139		608	39
40	ASPHALT PARKING LOT & SPEED BUMPS	1998	17,156	624	27.5	624		2,626	40
41	WALLCOVERING/WINDOW TRMTS/TILES	1998	18,635	678	27.5	678		2,853	41
42	REMODELING - RESIDENT ROOMS	1998	37,050	1,347	27.5	1,347		5,443	42
43	WINDOW TREATMENTS/REMODEL RMS	1999	18,066	657	27.5	657		2,601	43
44	FIRE ALARM & HVAC/CEILING/HALLS/CALL LIGHTS	1999	25,000	909	27.5	909		3,523	44
45	REPAIR & REMODEL HALLWAY/DOOR MONITOR SYS	1999	23,425	852	27.5	852		3,230	45
46	REMODEL ROOMS/DOOR MONITOR SYS	1999	45,989	1,672	27.5	1,672		6,201	46
47	REMODEL RMS/LANDSCAPING	1999	53,572	1,948	27.5	1,948		7,062	47
48	WALLCOVERING/WINDOW TRMTS/TILES	1999	6,950	253	27.5	253		896	48
49	REMODELING RMS	1999	16,205	589	27.5	589		2,037	49
50	WALLCOVERING/FLOOR TILES/HANDRAILS	1999	28,464	1,035	27.5	1,035		3,493	50
51	REMODELING RMS	1999	47,115	1,713	27.5	1,713		5,639	51
52	NURSE STATION/ELEVATOR DOORS	1999	18,030	656	27.5	656		2,105	52
53	REMODELING ROOMS/WINDOW TRMTS	1999	170,712	6,207	27.5	6,207		18,880	53
54	FIRE DAMPERS	2000	4,950	180	27.5	180		533	54
55	REMODELING-WASHROOMS/MEDICAL REC. RM	2000	35,550	1,293	27.5	1,293		3,609	55
56	FENCES	2000	3,557	129	27.5	129		350	56
57	WALLCOVERING/WINDOW TRMTS-RES & DINING RMS	2000	69,939	2,543	27.5	2,543		6,464	57
58	DFIREWALL/RESIDENT ROOM SEILINGS/TUCKPOINTING	2000	85,160	3,096	27.5	3,096		7,870	58
59	MAGNETIC DOOR/STEAMER	2000	16,334	451	27.5	451		1,224	59
60	HANDRAILS	2000	8,101	295	27.5	295		725	60
61	REMODELING - NURSE STATION/CORRIDOR/DINING RM	2000	126,731	4,608	27.5	4,608		11,329	61
62	PTAC UNITS	2000	3,550	129	27.5	129		317	62
63	CONCRETE PAVING	2000	11,700	425	27.5	425		1,045	63
64	IRRIGATION SYSTEM & ROOM PLATES	2000	10,425	379	27.5	379		900	64
65	DESIGN & BUILD ENABLING GARDEN	2000	19,832	1,323	15	1,323		3,306	65
66	CARPETING/WINDOW TREATMENT	2000	14,549	529	27.5	529		1,212	66
67	PTAC UNITS	2000	3,550	129	27.5	129		296	67
68	REMODELING - BREAK ROOM, MEDICATION TM	2000	39,886	1,450	27.5	1,450		3,323	68
69	SIDEWALK	2000	2,240	81	27.5	81		179	69
70	TOTAL (lines 4 thru 69)		\$ 5,995,174	\$ 172,302		\$ 196,972	\$ 24,670	\$ 2,463,011	70

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

Facility Name & ID Number DEERBROOK CARE CENTRE

0040741

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,995,174	\$ 172,302		\$ 196,972	\$ 24,670	\$ 2,463,011	1
2									2
3	REMODELING - RESIDENT RMS, LOBBY, MAILROOM	2000	60,826	2,212	27.5	2,212		4,885	3
4	PTAC UNITS	2000	4,644	169	27.5	169		373	4
5	WOOD BLINDS FOR OFFICES	2001	3,538	129	27.5	129		252	5
6	CUBICLES	2001	8,332	303	27.5	303		593	6
7	REMODEL - ALL 2ND FLOOR RESIDENT ROOMS	2001	370,353	13,466	27.5	13,466		26,373	7
8	VERICAL BLINDS FOR 2ND FLOOR ROOMS	2001	3,847	140	27.5	140		274	8
9	CARPETING FIRST FLOOR OFFICES/PLUMBING	2001	8,850	322	27.5	322		577	9
10	DROP & CHANGE SPRINKLER HEADS IN CORRIDOR	2001	5,097	185	27.5	185		316	10
11	REPAIR CEILING ON FIRST FLOOR	2001	25,000	909	27.5	909		1,553	11
12	REPAIR CORRIDOR IN LAUNDRY AREA	2001	10,000	364	27.5	364		561	12
13	TEN TON COMPRESSOR FOR KITCHEN UNIT	2001	4,441	161	27.5	161		208	13
14		2002	11,300	394	27.5	394		394	14
15		2002	8,000	158	27.5	158		158	15
16		2002	1,186	23	27.5	23		23	16
17		2002	1,337	26	27.5	26		26	17
18		2002	1,379	23	27.5	23		23	18
19									19
20			ADJ TO SL	24,670			(24,670)		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	TOTAL (lines 1 thru 33)		\$ 6,523,304	\$ 215,956		\$ 215,956	\$	\$ 2,499,600	34

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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	\$ 509,614	\$ 62,661	\$ 50,522	\$ (12,139)	3-10 YRS	\$ 179,326	71
72	Current Year Purchases	58,087	11,617	2,904	(8,713)	3-10 YRS	2,904	72
73	Fully Depreciated Assets							73
74	RELATED PARTIES	819,358	16,678	16,678			764,594	74
75	TOTALS	\$ 1,387,059	\$ 90,956	\$ 70,104	\$ (20,852)		\$ 946,824	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)	\$ 8,171,083	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 306,912	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 286,060	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,852)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,446,424	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

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 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: \$ 23,707

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>ADMIN.</u>	<u>2000 LEXUS 400</u>	\$ <u>760.00</u>	\$ <u>9,120</u>	17
18	<u>FACILITY USE</u>	<u>99 DODGE DURANGO</u>	<u>295.13</u>	<u>3,837</u>	18
19					19
20					20
21	TOTAL		\$ 1,055.13	\$ 12,957	21

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input 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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></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		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	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	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	116,497	\$		\$	116,497	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				62,461				62,461	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				125,520				125,520	4
5	Physician Care	39-3	visits				2,342				2,342	5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescripts					184,678			184,678	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	X-RAY, LAB, I.V. THERAPY, RENTALS Other (specify):	39-2						113,117			113,117	13
14	TOTAL			\$		\$	306,820	\$	297,795	\$	604,615	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 **DEERBROOK CARE CENTRE**# **0040741**Report Period Beginning: **01/01/2002**

Ending:

12/31/2002**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2002** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 321,053	\$ 369,935	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 27,627)	2,168,301	2,168,301	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,510	134,297	6
7	Other Prepaid Expenses	15,169	15,169	7
8	Accounts Receivable (owners or related parties)	919,448	1,153,587	8
9	Other(specify): ESCROW DEPOSITS		36,453	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,466,481	\$ 3,877,742	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		247,500	13
14	Buildings, at Historical Cost		1,976,814	14
15	Leasehold Improvements, at Historical Cost		4,506,657	15
16	Equipment, at Historical Cost	563,591	563,591	16
17	Accumulated Depreciation (book methods)	(392,189)	(2,913,531)	17
18	Deferred Charges		93,048	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		329,793	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 171,402	\$ 4,803,872	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,637,883	\$ 8,681,614	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 465,186	\$ 535,969	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	115,520	115,520	28
29	Short-Term Notes Payable	410,900	410,900	29
30	Accrued Salaries Payable	56,401	56,401	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,543	7,543	31
32	Accrued Real Estate Taxes(Sch.IX-B)		83,868	32
33	Accrued Interest Payable	944	944	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	MANAGEMENT FEES	28,049	28,049	36
37	DUE TO IDPA	91,482	91,482	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,176,025	\$ 1,330,676	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	12,308	186,308	39
40	Mortgage Payable		4,593,653	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)	\$ 12,308	\$ 4,779,961	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,188,333	\$ 6,110,637	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,449,550	\$ 2,570,977	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,637,883	\$ 8,681,614	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,764,389	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,764,395	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	678,832	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) SEC 754 BASIS ADJ.	6,323	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 685,155	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)	\$ 2,449,550	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	\$ 9,251,487	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,251,487	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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***	124,885	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 124,885	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,376,372	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,129,020	31
32	Health Care	2,872,443	32
33	General Administration	2,921,930	33
B. Capital Expense			
34	Ownership	1,040,016	34
C. Ancillary Expense			
35	Special Cost Centers	604,615	35
36	Provider Participation Fee	117,512	36
D. Other Expenses (specify):			
37	NET VENDING COSTS	12,004	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,697,540	40
41	Income before Income Taxes (line 30 minus line 40)**	678,832	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 678,832	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 **DEERBROOK CARE CENTRE**

0040741

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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	1,805	2,086	\$ 89,153	\$ 42.74	1
2	Assistant Director of Nursing	3,730	4,211	119,082	28.28	2
3	Registered Nurses	38,765	43,776	1,004,538	22.95	3
4	Licensed Practical Nurses	16,873	17,860	317,959	17.80	4
5	Nurse Aides & Orderlies	79,071	83,573	886,667	10.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,344	5,744	82,512	14.36	9
10	Activity Assistants	11,987	12,881	85,168	6.61	10
11	Social Service Workers	1,887	2,284	35,628	15.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	10,636	11,390	147,554	12.95	14
15	Cook Helpers/Assistants	11,497	12,377	79,561	6.43	15
16	Dishwashers					16
17	Maintenance Workers	3,839	4,220	58,793	13.93	17
18	Housekeepers	20,193	21,631	186,777	8.63	18
19	Laundry	12,878	13,745	87,479	6.36	19
20	Administrator	3,877	4,616	141,199	30.59	20
21	Assistant Administrator	2,879	3,205	165,126	51.52	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,466	21,511	329,167	15.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,915	2,242	22,753	10.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	246,642	267,352	\$ 3,839,116 *	\$ 14.36	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	204	\$ 11,249	1-3	35
36	Medical Director	133	13,300	9-3	36
37	Medical Records Consultant	11	844	10-3	37
38	Nurse Consultant	1,325	29,091	10-3	38
39	Pharmacist Consultant	192	4,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	16	829	12-3	45
46	Other(specify) PSYCHOLOGIST	270	9,552	10-3	46
47	UTILIZATION REVIEW	25	3,750	10-3	47
48					48
49	TOTAL (lines 35 - 48)	2,176	\$ 72,815		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			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **DEERBROOK CARE CENTRE**

0040741

Report Period Beginning: **01/01/2002**

Ending: **12/31/2002**

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	
BRIAN LEVINSON	ADMIN		\$ 141,199	Workers' Compensation Insurance	\$ 72,109	IDPH License Fee	\$ 5,336	
JUDY WONOGAS	ASST ADMIN		87,148	Unemployment Compensation Insurance	25,042	Advertising: Employee Recruitment	5,336	
SID SIDDIQUE	ASST ADMIN		47,172	FICA Taxes	286,009	Health Care Worker Background Check	1,246	
JEREMY AMSTER	ADM IN TRAINING		30,806	Employee Health Insurance	341,749	(Indicate # of checks performed)		
				Employee Meals	0	MARKETING/ADV/PROMO	195,568	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	5,450	
				EMPLOYEE BENEFITS - OTHER	16,017	LICENSES & PERMITS	1,439	
				EMPLOYEE PHYSICAL EXAMS	156	DUES & SUBSCRIPTIONS	14,998	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	1,842	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 306,325	CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(5,450)	
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(110,234)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(72,401)	
						Yellow page advertising	(12,933)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 741,082	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,861	
B. Administrative - Other								
Description			Amount					
FRIST HEALTH CARE - MANAGEMENT FEES			\$ 736,229					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 736,229					
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount		
			\$			\$		
SEE SCHEDULE ATTACHED			231,031					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 231,031	TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DEERBROOK CARE CENTRE

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY1999	6 FY2000	7 FY2001	8 FY2002	9 FY2003	10 FY2004	11 FY2005	12 FY2006	13 FY2007
1	PAINT/DECORATING	06/2000	\$ 3,136	3	\$	\$ 523	\$ 1,045	\$ 1,045	\$ 523	\$	\$	\$	\$
2	PAINT/DECORATING	06/2001	2,061	3			344	687	687	343			
3	PAINT/DECORATING												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,197		\$	\$ 523	\$ 1,389	\$ 1,732	\$ 1,210	\$ 343	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE-\$12,186.72
- (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? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,645 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 of Public Aid during this cost report period. \$ 117,512
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. \$ 0 Has any meal income been offset against related costs? N/A 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. \$ _____
- (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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	11,249
	REPAIRS & MAINTENANCE	988
		0
		12,237
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,345
		0
		1,345
5	HEAT & OTHER UTILITIES	
	GAS HEAT	17,780
	ELECTRICITY	84,267
	WATER	39,518
	CABLE TV - LOBBY	0
		0
		141,565
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,814
	PAINTING & DECORATING	672
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	14,599
	ELEVATOR MAINTENANCE & REPAIR	9,687
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,225
	FIRE SERVICE	3,684
	DEFERRED MAINTENANCE	233
		0
		0
		38,914
7	OTHER	
	SCAVENGER	9,726
	SECURITY SERVICE	163
		9,889
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	13,300
		13,300

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	1,976
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	844
	PHARMACY CONSULTANT XVIII B 39-2	4,200
	UTILIZATION REVIEW FEES XVIII B 47-2	3,750
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	29,091
	PSYCHOLOGIST XVIII B 46-2	9,552
		0
		49,413
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	5,658
	SPEECH THERAPY SERVICES	138
	OCCUPATIONAL THERAPY SERVICES	15,669
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		21,465
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	829
		0
		829
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	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	736,229
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	18,461
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	212,570
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	110,234
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	72,401
	EMPLOYEE WANT ADS XIX F	5,336
	CONTRIBUTIONS VI 20 XIX F	950
	DUES & SUBSCRIPTIONS XIX F	14,998
	LICENSES & PERMITS XIX F	1,439
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	12,933
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	4,500
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,246
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,406
	EQUIPMENT REPAIR & MAINTENANCE	9,962
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	116
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	2,871
	TELEPHONE	47,010
	MESSENGER SERVICE	561
		0
		62,926

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	286,009
	UNEMPLOYMENT COMPENSATION XIX D	25,042
	WORKERS COMPENSATION INSURANC XIX D	72,109
	HOSPITALIZATION INSURANCE XIX D	341,749
	EMPLOYEE BENEFITS - OTHER XIX D	16,017
	EMPLOYEE PHYSICAL EXAMS XIX D	156
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	10,179
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	717
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,655
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	162,790
27	OTHER	
	BAD DEBTS VI 24	53,343
		0
		53,343

GRAND TOTAL COLUMN 3 OTHER

2,518,946

DEERBROOK CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2002

TOTAL FOOD PURCHASE	238,842	PATIENT MEALS	200094
LESS SALES TAX	(1,807)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	237,035	TOTAL MEALS/YEAR	200094
TOTAL PATIENT CENSUS	66,698	NET FOOD	237035
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	200094

TOTAL PATIENT MEALS	200094	COST PER MEAL	1.18
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

DEERBROOK CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S									9,202,858	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	2,872,443	741,082	517,315	105,598	506,107	2,180,848	117,512	1,040,016		3,839,116
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	6,205		5,458			25,001		(36,664)		
CABLE TV			0			0				
CONTRACT NURSING										
INTEREST INCOME							(124,885)			
NET VENDING COMMISSIONS							12,004			
EMPLOYEE PHYSICAL EXAMS		(156)				156				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(736,229)		736,229		
O2 INCOME/RENT INSURANCE						(147,406)		147,406		
BAD DEBTS						(53,343)	53,343			
DISCOUNTS LOST							0			
ANCILLARIES	604,615							0		
SETTLEMENT INTEREST										
RECLASSIFIED SALARIES	(22,753)	0	0	0	0	22,753	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	(48,629)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	3,460,510	740,926	522,773	105,598	506,107	1,291,780	9,345	1,886,987	8,524,026	3,839,116
PER FINANCIAL STATEMENTS	3,460,510	740,926	522,773	105,598	506,107	1,291,780	9,345	1,886,987	678,832	3,839,116
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									678,832	

DEERBROOK CARE CENTRE - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		78,341			79205		(864)	79422			
CENSUS DAYS		66,698			64206		2,492	66900			
OCCUPANCY %		85.14%			81.06%			84.23%			
SALARIES											
TOTAL General Services	8-1	560,164	7.09%	8.40	568552	7.87%	8.86	(8,388)	546511	8.24%	8.17
Social Services	12-1	35,628	0.45%	0.53	32637	0.45%	0.51	2,991	54369	0.82%	0.81
TOTAL Health Care and Programs	16-1	2,643,460	33.44%	39.63	2448853	33.91%	38.14	194,607	2272372	34.25%	33.97
Clerical & General Office Expenses:	21-1	329,167	4.16%	4.94	254123	3.52%	3.96	75,044	197802	2.98%	2.96
TOTAL General Administration	28-1	635,492	8.04%	9.53	622260	8.62%	9.69	13,232	516251	7.78%	7.72
TOTAL Operation Expense	29-1	3,839,116	48.56%	57.56	3639665	50.41%	56.69	199,451	3335134	50.27%	49.85
ADJUSTED TOTALS											
Food	2-8	237,035	3.00%	3.55	237889	3.29%	3.71	(854)	206693	3.12%	3.09
Heat and Other Utilities	5-8	141,565	1.79%	2.12	159451	2.21%	2.48	(17,886)	156105	2.35%	2.33
Maintenance	6-8	137,752	1.74%	2.07	138551	1.92%	2.16	(799)	152926	2.31%	2.29
TOTAL General Services	8-8	1,128,731	14.28%	16.92	1158017	16.04%	18.04	(29,286)	1167099	17.59%	17.45
Administrative	17-8	323,047	4.09%	4.84	392651	5.44%	6.12	(69,604)	332136	5.01%	4.96
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	347,420	4.39%	5.21	222132	3.08%	3.46	125,288	290797	4.38%	4.35
Fees, Subscriptions, Promotions	20-8	24,861	0.31%	0.37	38768	0.54%	0.60	(13,907)	24608	0.37%	0.37
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	200	0.00%	0.00
License Fee-Other	Pg21	1,439	0.02%	0.02	1027	0.01%	0.02	412	597	0.01%	0.01
Clerical & General Office Expenses:	21-8	604,058	7.64%	9.06	492781	6.82%	7.67	111,277	410955	6.19%	6.14
Employee Benefits & Payroll Taxes	22-8	741,082	9.37%	11.11	617539	8.55%	9.62	123,543	516895	7.79%	7.73
Payroll Taxes	Pg21	311,051	3.93%	4.66	299740	4.15%	4.67	11,311	289627	4.37%	4.33
W/C Insurance	Pg21	72,109	0.91%	1.08	64810	0.90%	1.01	7,299	49387	0.74%	0.74
Health Insurance	Pg21	341,749	4.32%	5.12	221793	3.07%	3.45	119,956	135785	2.05%	2.03
Inservice Training & Education	23-8	10,179	0.13%	0.15	9524	0.13%	0.15	655	10884	0.16%	0.16
Travel and Seminar	24-8	10,945	0.14%	0.16	14152	0.20%	0.22	(3,207)	14275	0.22%	0.21
Other Admin. Staff Transportation	25-8	7,655	0.10%	0.11	8411	0.12%	0.13	(756)	5641	0.09%	0.08
Insurance-Prop.Liab.Malpractice	26-8	339,181	4.29%	5.09	180782	2.50%	2.82	158,399	145294	2.19%	2.17
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
TOTAL General Administration	28-8	2,408,428	30.46%	36.11	1976740	27.38%	30.79	431,688	1751485	26.40%	26.18
TOTAL Operation Expense	29-8	6,401,627	80.97%	95.98	5809841	80.46%	90.49	591,786	5335943	80.43%	79.76
Real Estate Taxes	33-3	86,101	1.09%	1.29	83807	1.16%	1.31	2,294	79514	1.20%	1.19
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	7,905,974	100.00%	118.53	7220628	100.00%	112.46	685,346	6634016	100.00%	99.16
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		3026879.9	38.29%	45.38	2719262.1	37.66%	42.35	307,618	2566400.9	38.69%	38.36

DEERBROOK CARE CENTRE - DIAGNOSTICS - 12/31/2002

This report DOES NOT REFLECT a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

Deferred maint. adj. on Page 5A Line 1 consists of 1732 from Page 22 and 0 from Page 3 Line 6-3.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-364774

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.

Deprn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-232634

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.

Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 = Page 21-B.

Professional fees on Page 3 Line 19-3 = Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 = Page 21-G.