

		FOR OHF USE				

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**2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)**

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

<p><b>I. IDPH Facility ID Number:</b> <u>0041954</u></p> <p><b>Facility Name:</b> <u>EXCEPTIONAL HEALTH CENTER</u></p> <p><b>Address:</b> <u>5701 WEST 79TH STREET</u> <u>BURBANK</u> <u>60459</u>  Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>708-499-5400</u> Fax # <u>708-499-5571</u></p> <p><b>IDPA ID Number:</b> <u>52-1979253-001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>07/96</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  Name: <u>TRISH KELLY</u> Telephone Number: <u>410-773-5681</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1159 673 1297 824">Officer or Administrator of Provider</td> <td data-bbox="1297 673 1950 743">(Signed) _____ (Date) _____ (Type or Print Name) <u>PAM PALINKAS</u></td> </tr> <tr> <td data-bbox="1159 824 1297 1036">Paid Preparer</td> <td data-bbox="1297 824 1950 1036">(Title) <u>VICE-PRESIDENT - FACILITY FINANCIAL</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>PAM PALINKAS</u>	Paid Preparer	(Title) <u>VICE-PRESIDENT - FACILITY FINANCIAL</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
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Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>PAM PALINKAS</u>																												
Paid Preparer	(Title) <u>VICE-PRESIDENT - FACILITY FINANCIAL</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____																												

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER# 0041954 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 55

	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>55</u>	Skilled (SNF)	<u>55</u>	<u>20,075</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>55</u>	TOTALS	<u>55</u>	<u>20,075</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>12,154</u>	<u>2,135</u>	
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,154</u>	<u>2,135</u>	<u>3,851</u>	<u>18,140</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.36%D. How many bed-hold days during this year were paid by Public Aid?  
123 (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? YESG. 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 07/01/96J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 07/01/96 NO K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 28 and days of care provided 3,049Medicare Intermediary CAREFIRST OF MARYLAND

## 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 EXCEPTIONAL HEALTH CENTER # 0041954 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				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	141,108	7,698	13,421	162,227		162,227		162,227		1
2	Food Purchase		78,643		78,643		78,643	4	78,647		2
3	Housekeeping	49,953	14,837	6,889	71,679		71,679		71,679		3
4	Laundry	16,890	6,100	8,817	31,807		31,807		31,807		4
5	Heat and Other Utilities			108,231	108,231		108,231	1,718	109,949		5
6	Maintenance	31,813	9,972	34,733	76,518		76,518	3,163	79,681		6
7	Other (specify):*			14,077	14,077		14,077		14,077		7
8	<b>TOTAL General Services</b>	239,764	117,250	186,168	543,182		543,182	4,885	548,067		8
<b>B. Health Care and Programs</b>											
9	Medical Director			66,000	66,000		66,000		66,000		9
10	Nursing and Medical Records	1,370,196	234,998	15,646	1,620,840		1,620,840	18,755	1,639,595		10
10a	Therapy	278,136	53,642	47,095	378,873		378,873		378,873		10a
11	Activities	24,320	3,521	3,342	31,183		31,183		31,183		11
12	Social Services	37,541	689	955	39,185		39,185		39,185		12
13	Nurse Aide Training		739		739		739		739		13
14	Program Transportation			50	50		50		50		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,710,193	293,589	133,088	2,136,870		2,136,870	18,755	2,155,625		16
<b>C. General Administration</b>											
17	Administrative	94,711		131,529	226,240		226,240	(132,519)	93,721		17
18	Directors Fees										18
19	Professional Services			5,961	5,961		5,961	18,383	24,344		19
20	Dues, Fees, Subscriptions & Promotions			30,612	30,612		30,612	(27,579)	3,033		20
21	Clerical & General Office Expenses	80,981	17,775	62,132	160,888		160,888	142,005	302,893		21
22	Employee Benefits & Payroll Taxes			369,023	369,023		369,023	(36,714)	332,309		22
23	Inservice Training & Education			3,606	3,606		3,606		3,606		23
24	Travel and Seminar			5,458	5,458		5,458	3,192	8,650		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			42,443	42,443		42,443	(16,061)	26,382		26
27	Other (specify):*			(1,496)	(1,496)		(1,496)	1,496			27
28	<b>TOTAL General Administration</b>	175,692	17,775	649,268	842,735		842,735	(47,797)	794,938		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,125,649	428,614	968,524	3,522,787		3,522,787	(24,157)	3,498,630		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 &amp; ID Number

EXCEPTIONAL HEALTH CENTER

#0041954

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	
	<b>D. Ownership</b>											
30	Depreciation			96,755	96,755		96,755	2	96,757			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			84,590	84,590		84,590	10,368	94,958			33
34	Rent-Facility & Grounds			255,564	255,564		255,564		255,564			34
35	Rent-Equipment & Vehicles			40,876	40,876		40,876	1,693	42,569			35
36	Other (specify):*							84,822	84,822			36
37	<b>TOTAL Ownership</b>			477,785	477,785		477,785	96,885	574,670			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		122,923	15,539	138,462		138,462		138,462			39
40	Barber and Beauty Shops			3,261	3,261		3,261		3,261			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,968	30,968		30,968		30,968			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		122,923	49,768	172,691		172,691		172,691			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,125,649	551,537	1,496,077	4,173,263		4,173,263	72,728	4,245,991			45

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

**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	51	2		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				9
10	Interest and Other Investment Income	(1,807)	17		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	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	(14,014)	21		24
25	Fund Raising, Advertising and Promotional	(20,752)	20		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 (See Schedule 5A)	(98,787)	Var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (135,356)		\$	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)	208,084		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 208,084		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 72,728		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		X			45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

STATE OF ILLINOIS  
**EXCEPTIONAL HEALTH CENTER**

ID# 0041954  
 Report Period Beginning: 01/01/02  
 Ending: 12/31/02

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	REAL ESTATE TAX ADJUST TO ACTUAL	\$ 10,368	33	1
2	ADJUST LEGAL FEES TO ACTUAL	(3,085)	19	2
3				3
4	EMPLOYEE PATIENT LOSS FUND	(128)	21	4
5	RESIDENT GIFTS	(849)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14	HEALTH INSURANCE	(45,838)	22	14
15	WORKER'S COMP	(7,580)	22	15
16	GENERAL LIABILITY INSURANCE	(15,494)	26	16
17	PROPERTY INSURANCE	(567)	26	17
18	DEPRECIATION	2	30	18
19	REMOVE COMMUNITY REL (DEPT 515)	(24,765)	21	19
20	REMOVE COMMUNITY REL (DEPT 530)	(12,347)	20	20
21	REMOVE CONTRIBUTIONS	1,496	27	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	<b>Total</b>	(98,787)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER# 0041954 Report Period Beginning:01/01/02Ending: 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	4	0	0	0	0	0	0	0	0	0	0	4	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	1,718	0	0	0	0	0	0	0	0	0	1,718	5
6	Maintenance	0	3,163	0	0	0	0	0	0	0	0	0	3,163	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	4	4,881	0	0	0	0	0	0	0	0	0	4,885	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	18,755	0	0	0	0	0	0	0	0	0	18,755	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	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	<b>TOTAL Health Care and Programs</b>	0	18,755	0	0	0	0	0	0	0	0	0	18,755	16
	<b>C. General Administration</b>													
17	Administrative	(1,807)	(130,712)	0	0	0	0	0	0	0	0	0	(132,519)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,085)	21,468	0	0	0	0	0	0	0	0	0	18,383	19
20	Fees, Subscriptions & Promotions	(33,948)	6,369	0	0	0	0	0	0	0	0	0	(27,579)	20
21	Clerical & General Office Expenses	(38,907)	180,912	0	0	0	0	0	0	0	0	0	142,005	21
22	Employee Benefits & Payroll Taxes	(53,418)	16,704	0	0	0	0	0	0	0	0	0	(36,714)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,192	0	0	0	0	0	0	0	0	0	3,192	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(16,061)	0	0	0	0	0	0	0	0	0	0	(16,061)	26
27	Other (specify):*	1,496	0	0	0	0	0	0	0	0	0	0	1,496	27
28	<b>TOTAL General Administration</b>	(145,730)	97,933	0	0	0	0	0	0	0	0	0	(47,797)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(145,726)	121,569	0	0	0	0	0	0	0	0	0	(24,157)	29



Facility Name & ID Number EXCEPTIONAL HEALTH CENTER

# 0041954

Report Period Beginning:

01/01/02

Ending:

12/31/02

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
INTEGRATED HEALTH SERVICES, INC.	100	GOVERNORS PARK	BARRINGTON			

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	5 HEAT & OTHER UTILITIES	\$	INTEGRATED HEALTH SERVICES, INC.	100.00%	\$ 1,718	\$ 1,718	1
2	V	6 MAINTENANCE		INTEGRATED HEALTH SERVICES, INC.		3,163	3,163	2
3	V	17 ADMINISTRATIVE	131,529	INTEGRATED HEALTH SERVICES, INC.		817	(130,712)	3
4	V	19 PROFESSIONAL SERVICES		INTEGRATED HEALTH SERVICES, INC.		21,468	21,468	4
5	V	20 DUES, FEES, & SUBSCRIPTIONS		INTEGRATED HEALTH SERVICES, INC.		6,369	6,369	5
6	V	21 CLERICAL & GENERAL		INTEGRATED HEALTH SERVICES, INC.		180,912	180,912	6
7	V	22 EMPLOYEE BENEFITS		INTEGRATED HEALTH SERVICES, INC.		16,704	16,704	7
8	V	24 TRANSPORTATION		INTEGRATED HEALTH SERVICES, INC.		3,192	3,192	8
9	V	10 INSURANCE - PROPERTY LIAB.		INTEGRATED HEALTH SERVICES, INC.		18,755	18,755	9
10	V	36 OTHER HOME OFFICE CAPITAL		INTEGRATED HEALTH SERVICES, INC.		84,822	84,822	10
11	V	35 RENT - EQUIPMENT & VEHICLES		INTEGRATED HEALTH SERVICES, INC.		1,693	1,693	11
12	V							12
13	V							13
14	Total		\$ 131,529			\$ 339,613	\$ * 208,084	14

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

Facility Name & ID Number      EXCEPTIONAL HEALTH CENTER      #      0041954      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	N/A								\$	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 EXCEPTIONAL HEALTH CENTER # 0041954 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 INTEGRATED HEALTH SERVICES, INC  
 Street Address 910 RIDGEBROOK ROAD, BLDG 300  
 City / State / Zip Code SPARKS, MD 21152  
 Phone Number ( 410-773-5681  
 Fax Number ( )

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					\$	\$		\$	1
2	<b>DIRECT TRACKING OF EXPENSES AND ALLOCATION OF POOLED COSTS BASED ON PERCENT OF TOTAL COSTS</b>								
3	<b>SEE HOME OFFICE COST REPORT</b>								
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number **EXCEPTIONAL HEALTH CENTER** # **0041954** 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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$		\$		9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$		14
15	<b>TOTALS (line 9+line14)</b>						\$	\$		\$		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.)



**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 EXCEPTIONAL HEALTH CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0041954

CONTACT PERSON REGARDING THIS REPORT TRISH KELLY

TELEPHONE 410-773-5681 FAX #: 410-773-5829

**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 tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l 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>19-32-205-023-0000</u>	<u>LONG TERM CARE FACILITY</u>	\$ <u>91,033.69</u>	\$ <u>91,033.69</u>
2. <u>19-32-204-006-0000</u>	<u>LONG TERM CARE FACILITY</u>	\$ <u>3,914.23</u>	\$ <u>3,914.23</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>94,947.92</u>	\$ <u>94,947.92</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 hom (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 whic is normally paid during 2002.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 13,728 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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 ground: (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)

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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				\$	1
2					2
3	<b>TOTALS</b>			\$	3

Facility Name &amp; ID Number EXCEPTIONAL HEALTH CENTER

# 0041954

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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	COMPRESSOR		1997	825	55	15	55		284	9
10	ELECTRIC		1998	1,457	73	20	73		341	10
11	BUILDING IMPROVEMENTS		1998	2,511	251	10	251		1,232	11
12	REPAIR OF WATER MAIN		1998	1,216	61	20	61		259	12
13	SIDEWALK		1998	4,600	307	15	307		1,303	13
14	PLUMBING REPAIR		1998	1,416	283	5	283		1,203	14
15	HEAT/COOL A/C SLEEVE		1998	1,225	245	5	245		1,001	15
16	ELECTRIC FEED WIRING		1998	6,063	303	20	303		1,339	16
17	WATER MAIN BREAK SERVICE		1998	13,223	661	20	661		2,810	17
18	WINDOWS		1999	1,066	71	15	71		272	18
19	FLOORING		1999	1,461	73	20	73		268	19
20	ALARM SYSTEM		1999	13,804	1,380	20	1,380		5,027	20
21	FIRE DOORS		1999	18,906	1,260	15	1,260		4,096	21
22	ELECTRIC INSTALLATION		1999	750	75	10	75		300	22
23	HEATER A/C UNITS		1999	3,611	241	15	241		923	23
24	BATTERY PACKS & DOCKING B.		1999	47,226	4,723	10	4,723		15,742	24
25	TBIRD VENTS		1999	37,800	3,780	10	3,780		12,600	25
26	PRESSURE ALARM		1999	4,992	499	10	499		1,622	26
27	VENT BATTERY & CABLES		1999	1,020	102	10	102		332	27
28	ELECTRIC REPAIRS		1999	1,504	75	20	75		300	28
29	7.5 TON ROOFTOP AC W/ECONOMIZER		2000	7,700	770	10	770		1,797	29
30	INSTALL NEW PHONE SYSTEM - 50% DOWN		2000	3,564	356	10	356		802	30
31	INSTALL NEW PHONE SYSTEM-BALANCE DUE		2000	3,564	356	10	356		742	31
32	MOBILIZATION OF NURSE CALL SYSTEM		2001	29,500	2,950	10	2,950		5,064	32
33	RELANDSCAPE		2001	10,263	1,260	10	1,260		1,710	33
34	ROOM A/C UNITS		2001	6,736	1,347	5	1,347		2,075	34
35	WALL A/C UNITS		2001	4,201	840	5	840		1,312	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 &amp; ID Number EXCEPTIONAL HEALTH CENTER

# 0041954

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	PAVING - EAST AND WEST PARK	2001	\$ 5,850	\$ 731	8	\$ 731	\$	\$ 1,158		37
38	DOORS AND FRAMES	2001	4,595	230	20	230		364		38
39	CONCRETE WALKS	2001	9,450	630	15	630		998		39
40	PLANTING BEDS AT ENTRANCE	2001	2,395	120	20	120		190		40
41	BRICK REPAIR	2001	3,885	194	20	194		291		41
42	REMODEL RECEPTION AREA	2001	2,600	130	20	130		195		42
43	LANDSCAPING	2001	10,263	1,026	10	1,026		1,539		43
44	PAVING	2001	1,000	125	8	125		188		44
45	GENERATOR POWER LOAD INSPECTION	2001	1,290	258	5	258		387		45
46	VALANCES FOR AWNINGS	2001	2,860	191	15	191		286		46
47	HEAT-A/C UNITS	2001	3,534	707	5	707		1,060		47
48	GALVANIZED FENCE	2001	8,425	562	15	562		796		48
49	REMOVE/REPLACE CONCRETE	2001	8,740	583	15	583		825		49
50	GRANITE AT ENTRANCE	2001	1,235	62	20	62		82		50
51	INSTALL SPRINKLER SYSTEM	2001	11,225	449	25	449		636		51
52	REPAIR GENERATOR	2001	1,507	301	5	301		427		52
53	AIR COMPRESSOR UNIT	2001	5,373	448	12	448		634		53
54	MASONRY - CLEAN AND REPAIR	2001	9,065	453	20	453		604		54
55	REPLACE DOORS	2001	13,670	911	15	911		1,215		55
56	NURSE STATION REMODELING	2001	13,583	906	15	906		1,207		56
57	REMODELING AND HANDRAILS	2001	9,866	493	20	493		658		57
58	WALL COVERINGS/HANDRAILS	2001	6,692	446	15	446		558		58
59	ENTRANCE AWNING	2001	2,970	198	15	198		264		59
60	WALL A/C UNITS	2001	4,321	864	5	864		1,152		60
61	REPLACE CONDENSING UNITS	2001	5,631	375	15	375		469		61
62	REPAIR A/C UNIT	2001	798	160	5	160		199		62
63	STORAGE GARAGE	2001	30,840	1,568	20	1,568		1,829		63
64	ELECTRICAL WIRING	2001	7,744	394	20	394		459		64
65	PAINTING AND WALLPAPERING	2001	36,788	7,358	5	7,358		7,970		65
66	FENCE	2001	4,633	309	15	309		335		66
67	A/C UNIT	2001	9,550	955	10	955		1,035		67
68	CONCRETE PAD FOR GARAGE	2002	3,520	117	15	117		117		68
69	FENCE REPAIR	2002	3,480	116	15	116		116		69
70	TOTAL (lines 4 thru 69)		\$ 477,582	\$ 44,767		\$ 44,767	\$	\$ 92,999		70

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

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0041954 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	\$ 662,356	\$ 51,757	\$ 51,757	\$		\$ 142,735	71
72	Current Year Purchases	7,958	233	233			233	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 670,314	\$ 51,990	\$ 51,990	\$		\$ 142,968	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	2	
	Reference	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)	\$ 1,147,896	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,757	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,757	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 235,967	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.



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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

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

**C. CONTRACTUAL INCOME**

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

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

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

- (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.



## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number EXCEPTIONAL HEALTH CENTER

# 0041954

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 117,016	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	696,550		3
4	Supply Inventory (priced at )	12,709		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 826,275	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	553,944		15
16	Equipment, at Historical Cost	593,952		16
17	Accumulated Depreciation (book methods)	(235,967)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	(9,214)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 902,715	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,728,990	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 22,248	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,815		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,695		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(7,242)		35
	<b>Other Current Liabilities(specify):</b>			
36	Employee Withholdings	7,477		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 94,993	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	Intercompany Transfer	4,866,699		43
44	Rounding	(1)		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,866,698	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,961,691	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,232,701)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,728,990	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,712,065)	1
2	Restatements (describe):		2
3	Prior Year Audit Adjustment	(103,303)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,815,368)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(417,333)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (417,333)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (3,232,701)	24 *

\* This must agree with page 17, line 47.

**VII. 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,871,279	1
2	Discounts and Allowances for all Levels	(3,986,395)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,884,884	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,588,813	6
7	Oxygen	80	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,588,893	8
<b>C. Other Operating Revenue</b>			
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	(51)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	225,802	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,071	19
20	Radiology and X-Ray	5,513	20
21	Other Medical Services	3,720	21
22	Laundry	16,291	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 280,346	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Interest Income</b>	1,807	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,807	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,755,930	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	543,182	31
32	Health Care	2,136,870	32
33	General Administration	842,740	33
<b>B. Capital Expense</b>			
34	Ownership	477,785	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	141,723	35
36	Provider Participation Fee	30,968	36
<b>D. Other Expenses (specify):</b>			
37	<b>ROUNDING</b>	(5)	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,173,263	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(417,333)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (417,333)	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 EXCEPTIONAL HEALTH CENTER # 0041954

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	2,001	2,292	\$ 69,845	\$ 30.47	1
2	Assistant Director of Nursing	973	1,050	27,431	26.12	2
3	Registered Nurses	25,812	27,445	675,975	24.63	3
4	Licensed Practical Nurses	2,980	3,168	64,768	20.44	4
5	Nurse Aides & Orderlies	37,295	39,654	497,726	12.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,079	3,210	24,320	7.58	10
11	Social Service Workers	1,914	2,082	37,541	18.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,633	14,680	141,108	9.61	15
16	Dishwashers					16
17	Maintenance Workers	2,402	2,582	31,813	12.32	17
18	Housekeepers	6,111	6,573	49,953	7.60	18
19	Laundry	1,997	2,189	16,890	7.72	19
20	Administrator	1,896	2,112	94,711	44.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,309	6,829	80,981	11.86	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	891	1,053	9,631	9.15	31
32	Other Health Care Licensed R/T	13,686	14,552	278,136	19.11	32
33	Other(specify) Central Supply	1,769	2,036	24,820	12.19	33
34	TOTAL (lines 1 - 33)	122,748	131,507	\$ 2,125,649 *	\$ 16.16	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	As Needed	\$ 15,039	1-3	35
36	Medical Director	Monthlt	66,000	9-3	36
37	Medical Records Consultant	Monthly	4,523	10-3	37
38	Nurse Consultant	As Needed	2,957	10-3	38
39	Pharmacist Consultant	Monthly	2,118	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	Monthly	3,568	11-3	44
45	Social Service Consultant	As Needed	955	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 95,160		49

C. CONTRACT NURSES

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





XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,753 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. \$ 30,968  
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 benefit: on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? YES Indicate the amount. \$ 51
- (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? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: KPMG 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. AUDIT NO FINISHED
- (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? NA  
Attach invoices and a summary of services for all architect and appraisal fees.