

		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>0038760</u></p> <p><b>Facility Name:</b> <u>FLORA PAVILION NURSING HOME CENTER</u></p> <p><b>Address:</b> <u>701 SHADWELL</u> <u>FLORA</u> <u>62839</u>  Number City Zip Code</p> <p><b>County:</b> <u>CLAY</u></p> <p><b>Telephone Number:</b> <u>(847)974-4700</u> <b>Fax #</b> <u>(847)674-4733</u></p> <p><b>IDPA ID Number:</b> <u>37-1304216</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>02/01/93</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <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 type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" 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>  <b>Name:</b> <u>DON FIETS</u> <b>Telephone Number:</b> <u>(847) 674-4700 X40</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 type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" 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>01/01/2002</u> to <u>12/31/2002</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 style="width:100%"> <tr> <td style="width:30%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>BRADLEY ALTER</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>BOB KAGDA PARTNER</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>KRKUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD. 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>BRADLEY ALTER</u>			(Title) <u>VICE PRESIDENT</u>		<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____		(Print Name and Title) <u>BOB KAGDA PARTNER</u>			(Firm Name & Address) <u>KRKUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD. 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712</u>			(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER

# 0038760 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 beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,440	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,710	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	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			3,550	3,550	8
9	SNF/PED					9
10	ICF	17,681	4,535	195	22,411	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,681	4,535	3,745	25,961	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.66%

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)

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/93 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 14 and days of care provided 3,550

Medicare Intermediary ADMINASTAR FEDERAL

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 FLORA PAVILION NURSING HOME CEN # 0038760 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
	<b>A. General Services</b>										
1	Dietary	123,401	6,685	5,697	135,783		135,783		135,783		1
2	Food Purchase		107,500		107,500		107,500	(435)	107,065		2
3	Housekeeping	87,075	20,965		108,040		108,040	345	108,385		3
4	Laundry	33,192	9,010	1,465	43,667		43,667		43,667		4
5	Heat and Other Utilities			60,567	60,567		60,567	1,048	61,615		5
6	Maintenance	32,327	8,427	17,464	58,218		58,218	562	58,780		6
7	Other (specify):*			7,585	7,585		7,585		7,585		7
8	<b>TOTAL General Services</b>	275,995	152,587	92,778	521,360		521,360	1,520	522,880		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	862,925	55,451	3,500	921,876		921,876	12,752	934,628		10
10a	Therapy	89,335	2,189	4,641	96,165		96,165		96,165		10a
11	Activities	54,401	2,645		57,046		57,046		57,046		11
12	Social Services	25,771		3,146	28,917		28,917		28,917		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,032,432	60,285	20,287	1,113,004		1,113,004	12,752	1,125,756		16
	<b>C. General Administration</b>										
17	Administrative	48,207		11,975	60,182		60,182	24,355	84,537		17
18	Directors Fees										18
19	Professional Services			51,141	51,141		51,141	(28,937)	22,204		19
20	Dues, Fees, Subscriptions & Promotions			30,060	30,060		30,060	(14,624)	15,436		20
21	Clerical & General Office Expenses	46,428	20,107	109,505	176,040		176,040	(38,625)	137,415		21
22	Employee Benefits & Payroll Taxes			241,727	241,727		241,727	17,295	259,022		22
23	Inservice Training & Education			1,328	1,328		1,328		1,328		23
24	Travel and Seminar			2,178	2,178		2,178	1,720	3,898		24
25	Other Admin. Staff Transportation			3,453	3,453		3,453	3,133	6,586		25
26	Insurance-Prop.Liab.Malpractice			59,566	59,566		59,566	1,274	60,840		26
27	Other (specify):*			10,204	10,204		10,204	(10,204)			27
28	<b>TOTAL General Administration</b>	94,635	20,107	521,137	635,879		635,879	(44,613)	591,266		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,403,062	232,979	634,202	2,270,243		2,270,243	(30,341)	2,239,902		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

FLORA PAVILION NURSING HOME CENTER

#0038760

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			27,694	27,694		27,694	136,127	163,821			30
31	Amortization of Pre-Op. & Org.							2,438	2,438			31
32	Interest			17,517	17,517		17,517	334,620	352,137			32
33	Real Estate Taxes			47,736	47,736		47,736		47,736			33
34	Rent-Facility & Grounds			467,615	467,615		467,615	(463,519)	4,096			34
35	Rent-Equipment & Vehicles			6,891	6,891		6,891	202	7,093			35
36	Other (specify):* <b>STORAGE</b>			1,120	1,120		1,120		1,120			36
37	<b>TOTAL Ownership</b>			568,573	568,573		568,573	9,868	578,441			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,012	12,151	87,163		87,163		87,163			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		75,012	72,376	147,388		147,388		147,388			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,403,062	307,991	1,275,151	2,986,204		2,986,204	(20,473)	2,965,731			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	(2,398)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(435)	2		13
14	Non-Care Related Interest		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	(2,315)	21		18
19	Entertainment		20		19
20	Contributions	(975)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,204)	27		24
25	Fund Raising, Advertising and Promotional	(12,272)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,535)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	509			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (29,625)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	9,152		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 9,152		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (20,473)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>OHF USE ONLY</b>						
48		49		50		51
						52

## FLORA PAVILION NURSING HOME CENTER

ID# 0038760

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 509	6
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
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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>	509	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number FLORA PAVILION NURSING HOME CENTER

# 0038760

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(435)	0	0	0	0	0	0	0	0	0	0	(435)	2
3	Housekeeping	0	0	345	0	0	0	0	0	0	0	0	345	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,048	0	0	0	0	0	0	0	0	1,048	5
6	Maintenance	509	0	53	0	0	0	0	0	0	0	0	562	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	74	0	1,446	0	0	0	0	0	0	0	0	1,520	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	0	12,752	0	0	0	0	0	0	0	0	12,752	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	0	12,752	0	0	0	0	0	0	0	0	12,752	16
	<b>C. General Administration</b>													
17	Administrative	0	(11,975)	36,330	0	0	0	0	0	0	0	0	24,355	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(32,410)	3,473	0	0	0	0	0	0	0	0	(28,937)	19
20	Fees, Subscriptions & Promotions	(14,782)	0	158	0	0	0	0	0	0	0	0	(14,624)	20
21	Clerical & General Office Expenses	(2,315)	(93,984)	57,674	0	0	0	0	0	0	0	0	(38,625)	21
22	Employee Benefits & Payroll Taxes	0	0	17,295	0	0	0	0	0	0	0	0	17,295	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,720	0	0	0	0	0	0	0	0	1,720	24
25	Other Admin. Staff Transportation	0	0	3,133	0	0	0	0	0	0	0	0	3,133	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,274	0	0	0	0	0	0	0	0	1,274	26
27	Other (specify):*	(10,204)	0	0	0	0	0	0	0	0	0	0	(10,204)	27
28	<b>TOTAL General Administration</b>	(27,301)	(138,369)	121,057	0	0	0	0	0	0	0	0	(44,613)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(27,227)	(138,369)	135,255	0	0	0	0	0	0	0	0	(30,341)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER# 0038760

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	(2,398)	136,848	1,677	0	0	0	0	0	0	0	0	136,127	30
31	Amortization of Pre-Op. & Org.	0	2,438	0	0	0	0	0	0	0	0	0	2,438	31
32	Interest	0	334,619	1	0	0	0	0	0	0	0	0	334,620	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(467,615)	4,096	0	0	0	0	0	0	0	0	(463,519)	34
35	Rent-Equipment & Vehicles	0	0	202	0	0	0	0	0	0	0	0	202	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,398)</b>	<b>6,290</b>	<b>5,976</b>	<b>0</b>	<b>9,868</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(29,625)</b>	<b>(132,079)</b>	<b>141,231</b>	<b>0</b>	<b>(20,473)</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEALTH MANAGEMENT	SKOKIE	MANAGEMENT/BOOKKEEPING

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$ 11,975	CERTIFIED HEALTH MANAGEMENT		\$	\$ (11,975)	1
2	V	21 BOOKKEEPING FEES	94,666	" "			(94,666)	2
3	V	19 ADMIN CONSULTING FEES	32,410	" "			(32,410)	3
4	V							4
5	V	34 RENT	467,615	FLORA PAVILION NURSING HOME LLC			(467,615)	5
6	V	21 OFFICE EXPENSE		" " " " "		682	682	6
7	V	30 DEPRECIATION		" " " " "		136,848	136,848	7
8	V	31 AMORTIZATION		" " " " "		2,438	2,438	8
9	V	32 INTEREST		" " " " "		334,619	334,619	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 606,666			\$ 474,587	\$ * (132,079)	14

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

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER# 0038760Report 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	3 HOUSEKEEPING	\$			\$ 345	\$ 345
16	V	5 ELECTRIC & GAS				1,048	1,048
17	V	6 MAINTENANCE				53	53
18	V	10 NURSING/MEDICAL RECORDS				12,752	12,752
19	V	17 ADMIN SALARIES				36,330	36,330
20	V	19 PROFESSIONAL FEES				3,473	3,473
21	V	20 FEE, SUBSCRIPTIONS				158	158
22	V	21 OFFICE EXP.				57,674	57,674
23	V	22 EMPLOYEE BENEFITS				17,295	17,295
24	V	24 TRAVEL/SEMINAR				1,720	1,720
25	V	25 TRANSPORTATION				3,133	3,133
26	V	26 INSURANCE				1,274	1,274
27	V	30 DEPRECIATION				1,677	1,677
28	V	32 INTEREST				1	1
29	V	34 OFFICE RENT				4,096	4,096
30	V	35 EQUIPMENT RENTAL				202	202
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 141,231	\$ * 141,231

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

Facility Name & ID Number FLORA PAVILION NURSING HOME CE # 0038760 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	BRADLEY ALTER		ADMINISTRATIVE			SCHEDULE ATTACHED			\$ 10,270	17-3	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	\$ 10,270		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 FLORA PAVILION NURSING HOME CENTER # 0038760 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 CERTIFIED HEALTH MANAGEMENT  
 Street Address 3856 OAKTON SUTIE 200  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

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	3	HOUSEKEEPING	PER PATIENT DAY	272,818	8	\$ 3,625	\$ 25,961	\$ 345	1
2	5	ELECTRIC & GAS	" " "	272,818	8	11,011	25,961	1,048	2
3	6	MAINTENANCE	" " "	272,818	8	557	25,961	53	3
4	10	NURSING/MEDICAL RECORD	" " "	272,818	8	134,010	134,010	12,752	4
5	17	ADMIN SALARIES	" " "	272,818	8	381,783	381,783	36,330	5
6	19	PROFESSIONAL FEES	" " "	272,818	8	36,495	25,961	3,473	6
7	20	FEE, SUBSCRIPTIONS	" " "	272,818	8	1,662	25,961	158	7
8	21	OFFICE EXP.	" " "	272,818	8	606,084	496,771	57,674	8
9	22	EMPLOYEE BENEFITS	" " "	272,818	8	181,747	25,961	17,295	9
10	24	TRAVEL/SEMINAR	" " "	272,818	8	18,072	25,961	1,720	10
11	25	TRANSPORTATION	" " "	272,818	8	32,928	25,961	3,133	11
12	26	INSURANCE	" " "	272,818	8	13,389	25,961	1,274	12
13	30	DEPRECIATION	" " "	272,818	8	17,618	25,961	1,677	13
14	32	INTEREST	" " "	272,818	8	9	25,961	1	14
15	34	OFFICE RENT	" " "	272,818	8	43,046	25,961	4,096	15
16	35	EQUIPMENT RENTAL	" " "	272,818	8	2,124	25,961	202	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,484,160	\$ 1,012,564	\$ 141,231	25

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 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 FLORA PAVILION NURSING HOME LLC  
 Street Address 3856 OAKTON SUITE 200  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

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	<u>21</u>	<u>OFFICE EXPENSE</u>	<u>DIRECT COST</u>	1	1	\$ 682	\$ 1	\$ 682	1
2	<u>30</u>	<u>DEPRECIATION</u>		1	1	136,848	1	136,848	2
3	<u>31</u>	<u>AMORTIZATION</u>		1	1	2,438	1	2,438	3
4	<u>32</u>	<u>INTEREST</u>		1	1	334,619	1	334,619	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 474,587	\$	\$ 474,587	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	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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	CIB BANK		X	MORTGAGE			\$ 2,354,244	\$ 2,241,471	3/20	9.7500	\$ 223,270	1							
2	GERSHON BASSMAN	X		MORTGAGE			1,014,760	962,380	3/20	9.7500	94,729	2							
3	BANK FINANCIAL		X				405,904	257,890	9/03	10.5000	16,620	3							
4	URBANA CARE & REHAB	X									910	4							
5	INS FINANCING		X								1,051	5							
<b>Working Capital</b>																			
6	CIB BANK		X	WORKING CAPITAL				383,702		PRIME+	8,681	6							
7	SHAREHOLDER/OFFICER	X		WORKING CAPITAL				479,969			6,875	7							
8	RELATED PARTY	X									1	8							
9	<b>TOTAL Facility Related</b>						\$ 3,774,908	\$ 4,325,412			\$ 352,137	9							
<b>B. Non-Facility Related*</b>																			
10	IRS, IDR, ETC		X	LATE FEES								10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 3,774,908	\$ 4,325,412			\$ 352,137	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.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2001 report.		\$	<b>60,773</b>	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.)		\$	<b>53,717</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(7,056)</b>	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>54,792</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>47,736</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	<b>49,158</b>		8
	1998	<b>52,251</b>		9
	1999	<b>48,634</b>		10
	2000	<b>52,608</b>		11
	2001	<b>53,717</b>		12
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>				
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.</b>				
			<b>FOR OHF USE ONLY</b>	
	13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME FLORA PAVILION NURSING HOME CENTER COUNTY CLAY

FACILITY IDPH LICENSE NUMBER 0038760

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE ( 847 ) 674-4700 X40 FAX #: ( 847 ) 674-4733

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

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-25-200-005</u>	<u>NURSING HOME</u>	\$ <u>53,717.00</u>	\$ <u>53,717.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>53,717.00</u>	\$ <u>53,717.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ 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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 165,000	1
2					2
3	TOTALS			\$ 165,000	3

**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	110		2000		\$ 2,970,000	\$ 108,000	27.5	\$ 108,000	\$	\$ 292,507	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	FANS		1993		1,891	48	39	48	0	458	9
10	ROOF		1993		15,000	385	39	385	(0)	3,642	10
11	DRIVEWAY		1993		16,855	432	39	432	0	3,978	11
12	STRIP PARKING LOT		1993		280	7	39	7	0	62	12
13	AWNING		1993		948	24	39	24	0	220	13
14	FROOF		1994		1,909	49	39	49	(0)	402	14
15	FRONT ENTRY REPAIR		1996		4,236	109	39	109	(0)	740	15
16	DUCT MODIFICATION		1996		11,970	307	39	307	(0)	1,957	16
17	CONCRETE WORK		1996		5,510	367	15	367	0	2,390	17
18	CONSULT REROOFING		1997		540	14	39	14	(0)	79	18
19	DOOR ALARM SYSTEM		1997		700	18	39	18	(0)	94	19
20	REPLACE ROOF		1997		14,760	378	39	378	0	1,906	20
21	ROOF TOP AC		1998		10,372	266	39	266	(0)	1,164	21
22	ROLLING DOOR		1998		2,962	76	39	76	(0)	320	22
23	CARPET		1998		3,160	81	39	81	0	341	23
24	ROOF REPAIR		1999		16,688	428	39	428	(0)	1,697	24
25	PAINTING/FLOORING		1999		19,553	501	39	501	0	1,947	25
26	SEWER LINE/PUMP/SOIL TESTING		1999		3,537	91	39	91	(0)	315	26
27	HOT WATER HEATER		2000		4,579	654	7	654	0	996	27
28	ROOF REPAIR		2000		21,518	782	27.5	782	0	1,720	28
29	WASH/PAINT BUILDING		2000		4,820	175	27.5	175	0	445	29
30	BATHROOM REMODEL		2000		10,925	397	27.5	397	0	811	30
31	AC RETURN		2000		1,000	36	27.5	36	0	86	31
32	ROOF REPAIR		2001		25,160	915	27.5	915	(0)	1,487	32
33			2001		3,062	111	27.5	111	0	171	33
34	FIRE SUPPRESSION SYSTEM		2002		1,893	9	27.5	34	25	25	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
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57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
			3,173,828	114,660	114,688	28	319,962	

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

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760

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	\$ 183,522	\$ 19,906	\$ 18,352	\$ (1,554)	5-10 YRS	\$ 88,889	71
72	Current Year Purchases	2,563	1,128	256	(872)	5 YRS	256	72
73	Fully Depreciated Assets							73
74	<u>RELATED PARTY</u>		30,525	30,525				74
75	TOTALS	\$ 186,085	\$ 51,559	\$ 49,134	\$ (2,426)		\$ 89,145	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)	\$ 3,524,913	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,219	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 163,821	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,398)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 409,108	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

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	<b>TOTAL</b>				\$			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: \$ 3,508 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>1997 DODGE VAN</u>	\$ <u>391.00</u>	\$ <u>3,383</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>391.00</u>	\$ <u>3,383</u>	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><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

- (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.

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	\$		\$	5,139	\$		\$	5,139	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				5,800				5,800	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				1,212				1,212	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescripts					59,875			59,875	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	MEDICAL SUPPLIES Other (specify): <b>LABORATORY</b>	39-2 39-2						8,395 6,742			8,395 6,742	13
14	TOTAL			\$		\$	12,151	\$	75,012	\$	87,163	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 FLORA PAVILION NURSING HOME CENTER# 0038760Report Period Beginning: 01/01/2002Ending: 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	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>47,500</u> )	328,449		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,087		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	9,912		8
9	Other(specify): <u>REAL ESTATE ESCROW</u>	23,660		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 378,108	\$	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	203,829		15
16	Equipment, at Historical Cost	186,084		16
17	Accumulated Depreciation (book methods)	(176,068)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 213,845	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 591,953	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 225,515	\$	26
27	Officer's Accounts Payable	479,969		27
28	Accounts Payable-Patient Deposits	1,000		28
29	Short-Term Notes Payable	983,409		29
30	Accrued Salaries Payable	52,395		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,633		31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,792		32
33	Accrued Interest Payable	7,897		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	_____			36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,811,610	\$	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	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,811,610	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,219,657)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 591,953	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,264,238)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,264,238)</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>44,581</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>44,581</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,219,657)</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,933,365	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,933,365	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	95,966	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 95,966	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		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	37	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 37	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>DISCOUNTS</u>	1,417	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,417	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,030,785	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	521,360	31
32	Health Care	1,113,004	32
33	General Administration	635,879	33
<b>B. Capital Expense</b>			
34	Ownership	568,573	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	87,163	35
36	Provider Participation Fee	60,225	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,986,204	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	44,581	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 44,581	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 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.

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	2,000	2,080	\$ 44,632	\$ 21.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,752	8,999	152,793	16.98	3
4	Licensed Practical Nurses	10,027	10,302	137,611	13.36	4
5	Nurse Aides & Orderlies	48,918	51,371	466,337	9.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,274	5,574	89,335	16.03	8
9	Activity Director	2,536	2,688	31,900	11.87	9
10	Activity Assistants	2,157	2,860	22,501	7.87	10
11	Social Service Workers	2,313	2,425	25,771	10.63	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,080	20,482	9.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,704	7,171	55,104	7.68	15
16	Dishwashers	6,503	6,518	47,815	7.34	16
17	Maintenance Workers	1,941	2,149	32,327	15.04	17
18	Housekeepers	11,983	12,268	87,075	7.10	18
19	Laundry	5,415	5,435	33,192	6.11	19
20	Administrator	1,952	2,000	48,207	24.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,843	2,354	29,843	12.68	23
24	Clerical	1,769	2,068	16,585	8.02	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	2,156	2,236	23,644	10.57	31
32	Other Health Care(specify)					32
33	Other(specify) CARE PLAN COO	2,000	2,080	37,908	18.23	33
34	TOTAL (lines 1 - 33)	126,251	132,658	\$ 1,403,062 *	\$ 10.58	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	123	\$ 5,535	1-3	35
36	Medical Director	monthly	9,000	9-3	36
37	Medical Records Consultant	31	1,203	10-3	37
38	Nurse Consultant	32	1,622	10-3	38
39	Pharmacist Consultant	monthly	675	10-3	39
40	Physical Therapy Consultant	25	991	10a-3	40
41	Occupational Therapy Consultant	102	2,550	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	28	1,100	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	105	3,146	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	446	\$ 25,822		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	NONE	\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53



**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	6 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	<b>PAINTING/DECORATING</b>	<b>1999</b>	<b>\$ 3,051</b>	<b>3</b>	<b>\$ 508</b>	<b>\$ 1,017</b>	<b>\$ 1,017</b>	<b>\$ 509</b>
2													
3													
4													
5													
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12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		<b>\$ 3,051</b>		<b>\$ 508</b>	<b>\$ 1,017</b>	<b>\$ 1,017</b>	<b>\$ 509</b>	\$	\$	\$	\$	\$

Facility Name &amp; ID Number FLORA PAVILION NURSING HOME CENTER

# 0038760

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL HEALTHCARE ASSOC \$5,918
- (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. \$ 0 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. \$ 60,225  
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. \$ #REF! Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	5,535
	REPAIRS & MAINTENANCE	162
		0
		5,697
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	1,465
		0
		1,465
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	10,130
	ELECTRICITY	39,135
	WATER	11,302
	CABLE TV - LOBBY	0
		0
		60,567
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	7,071
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,433
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	920
	FIRE SERVICE	40
		0
		0
		0
		17,464
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	7,585
	SECURITY SERVICE	0
		7,585
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,203
	PHARMACY CONSULTANT XVIII B 39-2	675
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	1,622
		0
		0
		3,500
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	
	OCCUPATIONAL THERAPY SERVICES	
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	991
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	2,550
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	1,100
		4,641
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,146
		0
		3,146
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	11,975
<b>18</b>	<b>DIRECTORS FEES</b>	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	5,710
	ADMINISTRATIVE CONSULTANTS XIX C	32,410
	PROFESSIONAL FEES XIX C	13,021
		0
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	51,141
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	12,272
	EMPLOYEE WANT ADS XIX F	5,969
	CONTRIBUTIONS VI 20 XIX F	475
	DUES & SUBSCRIPTIONS XIX F	7,514
	LICENSES & PERMITS XIX F	1,795
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,535
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	500
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	30,060
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	305
	OUTSIDE CLERICAL SERVICES	94,666
	PENALTIES / OVERDRAFT CHARGES VI 18	2,315
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	823
	TELEPHONE	11,396
		109,505

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	105,455
	UNEMPLOYMENT COMPENSATION XIX D	25,448
	WORKERS COMPENSATION INSURANC XIX D	30,195
	HOSPITALIZATION INSURANCE XIX D	77,248
	EMPLOYEE BENEFITS - OTHER XIX D	1,107
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	2,274
	CHICAGO HEAD TAX XIX D	0
		241,727
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,328
		1,328
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	2,178
		0
		0
		2,178
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	3,453
		3,453
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	59,566
		59,566
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	10,204
		0
		10,204

GRAND TOTAL COLUMN 3 OTHER

634,202