

		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>I. IDPH Facility ID Number: <u>0037754</u></p> <p>Facility Name: <u>The Imperial Grove Pavilion</u></p> <p>Address: <u>1366 West Fullerton</u> <u>Chicago</u> <u>60614</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 539-2122</u> Fax # <u>(773) 935-0036</u></p> <p>IDPA ID Number: <u>363796886001</u></p> <p>Date of Initial License for Current Owners: <u>01/31/92</u></p> <p>Type of Ownership:</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>IRS Exemption Code _____</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>In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page</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	IRS Exemption Code _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</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="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1155 738 1291 820"></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1155 803 1291 820"></td> <td data-bbox="1291 803 1950 868">(Title) _____</td> </tr> <tr> <td data-bbox="1155 820 1291 1031">Paid Preparer</td> <td data-bbox="1291 820 1950 885">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td data-bbox="1155 885 1291 1031"></td> <td data-bbox="1291 885 1950 950">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1155 950 1291 1031"></td> <td data-bbox="1291 950 1950 1015">(Firm Name & Address) <u>Altschuler, Melvoim and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td data-bbox="1155 1015 1291 1031"></td> <td data-bbox="1291 1015 1950 1031">(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></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) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoim and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion

0037754 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 N/A

	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	248	Skilled (SNF)	248	90,520	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	248	TOTALS	248	90,520	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	64,110	5,830	
9	SNF/PED					9
10	ICF	4,926	1,074		6,000	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,036	6,904	8,938	84,878	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.77%

D. How many bed-hold days during this year were paid by Public Aid? 511 (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 Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 01/31/1992

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/1998 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 248 and days of care provided 8,938

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/02 Fiscal Year: 12/31/02

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

STATE OF ILLINOIS

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 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
A. General Services											
1	Dietary	389,645	10,524	770,709	1,170,878	1,170,878	(57,546)	1,113,332			1
2	Food Purchase		71,360		71,360	71,360		71,360			2
3	Housekeeping	53,097	58,964	297,960	410,021	410,021	12,013	422,034			3
4	Laundry		20,176	189,600	209,776	209,776		209,776			4
5	Heat and Other Utilities			263,689	263,689	263,689	3,335	267,024			5
6	Maintenance	98,913	66,004	140,690	305,607	305,607	(4,612)	300,995			6
7	Other (specify):*										7
8	TOTAL General Services	541,655	227,028	1,662,648	2,431,331	2,431,331	(46,810)	2,384,521			8
B. Health Care and Programs											
9	Medical Director			23,000	23,000	23,000		23,000			9
10	Nursing and Medical Records	3,232,107	354,136	313,870	3,900,113	3,900,113		3,900,113			10
10a	Therapy	40,465		506,109	546,574	546,574		546,574			10a
11	Activities	135,812	51,481	2,369	189,662	189,662		189,662			11
12	Social Services	65,010		5,884	70,894	70,894		70,894			12
13	Nurse Aide Training			922	922	922		922			13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,473,394	405,617	852,154	4,731,165	4,731,165		4,731,165			16
C. General Administration											
17	Administrative	257,299		277,882	535,181	535,181	(277,882)	257,299			17
18	Directors Fees										18
19	Professional Services			209,181	209,181	209,181	(102,107)	107,074			19
20	Dues, Fees, Subscriptions & Promotions			72,021	72,021	72,021	6,171	78,192			20
21	Clerical & General Office Expenses	593,599	69,757	90,217	753,573	753,573	26,730	780,303			21
22	Employee Benefits & Payroll Taxes			704,599	704,599	704,599	139,270	843,869			22
23	Inservice Training & Education										23
24	Travel and Seminar			9,254	9,254	9,254	89	9,343			24
25	Other Admin. Staff Transportation			21,815	21,815	21,815	(3,553)	18,262			25
26	Insurance-Prop.Liab.Malpractice			228,410	228,410	228,410	819	229,229			26
27	Other (specify):*										27
28	TOTAL General Administration	850,898	69,757	1,613,379	2,534,034	2,534,034	(210,463)	2,323,571			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,865,947	702,402	4,128,181	9,696,530	9,696,530	(257,273)	9,439,257			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			163,698	163,698		163,698	456,717	620,415		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			115,102	115,102		115,102	1,274,930	1,390,032		32
33	Real Estate Taxes							403,394	403,394		33
34	Rent-Facility & Grounds			1,862,688	1,862,688		1,862,688	(1,862,688)			34
35	Rent-Equipment & Vehicles			15,781	15,781		15,781	4,383	20,164		35
36	Other (specify):*										36
37	TOTAL Ownership			2,157,269	2,157,269		2,157,269	276,736	2,434,005		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		353,995	1,007	355,002		355,002		355,002		39
40	Barber and Beauty Shops	30,806	779		31,585		31,585		31,585		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			135,780	135,780		135,780		135,780		42
43	Other (specify):* Nonallowable Costs			215,443	215,443		215,443	(215,443)			43
44	TOTAL Special Cost Centers	30,806	354,774	352,230	737,810		737,810	(215,443)	522,367		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,896,753	1,057,176	6,637,680	12,591,609		12,591,609	(195,980)	12,395,629		45

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

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion

0037754

Report Period Beginning: 01/01/02

Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	6,869	30		9
10	Interest and Other Investment Income	(17,788)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,956)	43		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	(1,049)	43		18
19	Entertainment				19
20	Contributions	(20,650)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(41,078)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	6,305	43		24
25	Fund Raising, Advertising and Promotional	(156,572)	43		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 Pg 5A	(216,004)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (446,923)		\$	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)	250,943		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 250,943		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (195,980)		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		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

The Imperial Grove Pavilion

ID# 0037754

Report Period Beginning: 01/01/02

Ending: 12/31/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Deferred maintenance cost (net)	\$ 425	6	1
2	Disallow patient clothing	(15,733)	43	2
3	Disallow billable Lab/X-Ray	(19,968)	43	3
4	Disallow trust fees	(100)	43	4
5	Disallow collection expenses	(720)	43	5
6	Nonallowable real estate taxes	(97,104)	33	6
7	Disallow personal use of automobile	(3,553)	25	7
8	Offset cable tv, telephone income	(1,110)	21	8
9	To capitalize repairs and maintenance	(9,389)	6	9
10	Disallow consulting fees per IDPA	(68,752)	19	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
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26				26
27				27
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(216,004)		49

See Accountant's Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Imperial Grove Pavilion# 0037754

Report Period Beginning:

01/01/02

Ending:

12/31/02

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,763	0	0	0	0	0	0	0	0	3,763	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	12,013	0	0	0	0	0	0	0	0	12,013	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,335	0	0	0	0	0	0	0	0	3,335	5
6	Maintenance	(8,964)	0	4,352	0	0	0	0	0	0	0	0	(4,612)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,964)	0	23,463	0	0	0	0	0	0	0	0	14,499	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(251,436)	(26,446)	0	0	0	0	0	0	0	(277,882)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(109,830)	0	6,182	1,541	0	0	0	0	0	0	0	(102,107)	19
20	Fees, Subscriptions & Promotions	0	0	361	5,810	0	0	0	0	0	0	0	6,171	20
21	Clerical & General Office Expenses	(1,110)	0	24,018	3,822	0	0	0	0	0	0	0	26,730	21
22	Employee Benefits & Payroll Taxes	0	0	69,355	8,606	0	0	0	0	0	0	0	77,961	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	52	37	0	0	0	0	0	0	0	89	24
25	Other Admin. Staff Transportation	(3,553)	0	0	0	0	0	0	0	0	0	0	(3,553)	25
26	Insurance-Prop.Liab.Malpractice	0	0	819	0	0	0	0	0	0	0	0	819	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(114,493)	0	(150,649)	(6,630)	0	(271,772)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(123,457)	0	(127,186)	(6,630)	0	(257,273)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Imperial Grove Pavilion

0037754

Report Period Beginning:

01/01/02

Ending:

12/31/02

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	6,869	432,773	17,075	0	0	0	0	0	0	0	0	456,717	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,788)	1,270,158	22,560	0	0	0	0	0	0	0	0	1,274,930	32
33	Real Estate Taxes	(97,104)	493,248	7,250	0	0	0	0	0	0	0	0	403,394	33
34	Rent-Facility & Grounds	0	(1,862,688)	0	0	0	0	0	0	0	0	0	(1,862,688)	34
35	Rent-Equipment & Vehicles	0	0	4,383	0	0	0	0	0	0	0	0	4,383	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(108,023)	333,491	51,268	0	0	0	0	0	0	0	0	276,736	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(215,443)	0	0	0	0	0	0	0	0	0	0	(215,443)	43
44	TOTAL Special Cost Centers	(215,443)	0	0	0	0	0	0	0	0	0	0	(215,443)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(446,923)	333,491	(75,918)	(6,630)	0	(195,980)	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Robert Hartman	30.00%	See Attached Schedule 6A		ITEX Mgmt. Co.	Lincolnwood	Management Co.
Barry Carr	10.00%			AK Care	Lincolnwood	Management Co.
Michael Harris	20.00%			Care Path Health		
Jack Rajchenbach	20.00%			Network	Lincolnwood	Management Co.
Bernard Hollander	20.00%			The Claridge, LLC	Lincolnwood	Lessor
				Claridge Ivy, LTD	Lincolnwood	Retirement Com.
				JLR Management	Lincolnwood	Management Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	30 Depreciation	\$	The Claridge, L.L.C.	100.00%	\$ 432,773	\$	432,773	1
2	V	32 Interest		The Claridge, L.L.C.	100.00%	1,248,871		1,248,871	2
3	V	32 Amortization of Loan Cost		The Claridge, L.L.C.	100.00%	21,287		21,287	3
4	V	33 Property Taxes		The Claridge, L.L.C.	100.00%	493,248		493,248	4
5	V	34 Rent	1,862,688	The Claridge, L.L.C.	100.00%			(1,862,688)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,862,688			\$ 2,196,179	\$ *	333,491	14

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

NAME OF FACILITY
PROVIDER #
12/31/2002

The Imperial, Grove Pavilion
0037754

Schedule 6A

VII. RELATED PARTIES
RELATED NURSING HOMES
PART A COLUMN 2

NAME	CITY
FOREST VILLA	NILES, IL
CLARK MANOR	CHICAGO, IL
CHEVY CHASE CORPORATION	CHICAGO, IL
HALSTED TERRACE	CHICAGO, IL
JACKSON CORPORATION	CHICAGO, IL
GLENVIEW TERRACE	GLENVIEW, IL
HARMONY NURSING & REHABILITATION	CHICAGO, IL
MONROE CORPORATION	CHICAGO, IL
CALIFORNIA GARDENS CORPORATION	CHICAGO, IL
CLARIDGE HOUSE	NORTH MIAMI, FL
RENAISSANCE HILLSIDE	HILLSIDE, IL
CARLTON AT THE LAKE	CHICAGO, IL
REGENTS PARK OF BOCA RATON	BOCA RATON, FL
SOUTH SHORE RENAISSANCE	CHICAGO, IL
RENAISSANCE 87 TH STREET	CHICAGO, IL
RENAISSANCE MIDWAY	CHICAGO, IL
REGENTS PARK OF ADVENTURA	ADVENTURA, FL

See Accountants' Compilation Report

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	1 Dietary	\$	ITEX Management Company & AK Care	70.00%	\$ 3,763	\$	3,763	15
16	V	3 Housekeeping		ITEX Management Company & AK Care	70.00%	12,013		12,013	16
17	V	5 Utilities		ITEX Management Company & AK Care	70.00%	3,335		3,335	17
18	V	6 Repairs and Maintenance		ITEX Management Company & AK Care	70.00%	4,352		4,352	18
19	V	17 Management Fees	251,436	ITEX Management Company & AK Care	70.00%			(251,436)	19
20	V	19 Professional Fees		ITEX Management Company & AK Care	70.00%	6,182		6,182	20
21	V	20 Dues, Subscriptions, Licenses		ITEX Management Company & AK Care	70.00%	361		361	21
22	V	21 Office Expenses		ITEX Management Company & AK Care	70.00%	24,018		24,018	22
23	V	22 Employee Benefits		ITEX Management Company & AK Care	70.00%	69,355		69,355	23
24	V	24 Education and Seminars		ITEX Management Company & AK Care	70.00%	52		52	24
25	V	26 Insurance		ITEX Management Company & AK Care	70.00%	819		819	25
26	V	30 Depreciation Expense		ITEX Management Company & AK Care	70.00%	17,075		17,075	26
27	V	32 Interest & Amortization Exp		ITEX Management Company & AK Care	70.00%	22,560		22,560	27
28	V	33 Real Estate Taxes		ITEX Management Company & AK Care	70.00%	7,250		7,250	28
29	V	35 Equipment Rental		ITEX Management Company & AK Care	70.00%	4,383		4,383	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 251,436			\$ 175,518	\$ *	(75,918)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Management Fees	\$ 26,446	Care Path Health Network	70.00%	\$	\$ (26,446)	15
16	V	19 Professional Fees		Care Path Health Network	70.00%	1,541	1,541	16
17	V	20 Dues, Subscriptions, Licenses		Care Path Health Network	70.00%	5,810	5,810	17
18	V	21 Office Expenses		Care Path Health Network	70.00%	3,822	3,822	18
19	V	22 Employee Benefits		Care Path Health Network	70.00%	8,606	8,606	19
20	V	24 Education and Seminar		Care Path Health Network	70.00%	37	37	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 26,446			\$ 19,816	\$ * (6,630)	39

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

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 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	Barry Carr	Administrative	Exec. Admin	10.00	* 183,358	15	11.00	Salary	\$ 78,654	L17, C1	1
2	David Hartman	Administrator	Administrator	0.00	* 18,016	40	89.00	Salary	100,394	L17, C1	2
3	Michael Harris	Administrative	Administrative	20.00	None	35	11.00	Salary	78,251	L17, C1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 257,299		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

SEE ACCOUNTANTS' COMPILATION REPORT

The Imperial, Grove Pavilion
0037754
12/31/2002

Schedule 7A

VII. RELATED PARTIES (continued)

**C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board Of Directors.
 Compensation Received From Other Nursing Homes**

Name	Forest Villa	Harmony	Renaissance 87th St.	Renaissance Hillside	Renaissance Midway	Renaissance S.Shore	California	Chevy	Jackson	Monroe	Total
Barry Carr	18,743		18,336	14,669	22,410	21,595	26,078	28,522	20,781	12,224	183,358
David Hartman	1,896		1,896	1,266	2,212	2,212	2,529	2,845	1,896	1,264	18,016
											0
Total Compensation Received From Other Nursing Homes	20639	0	20,232	15,935	24,622	23,807	28,607	31,367	22,677	13,488	201,374

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 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 ITEX Management Company
 Street Address 6633 North Lincoln Avenue
 City / State / Zip Code Lincolnwood, IL 60645
 Phone Number (847) 676-2122
 Fax Number (847) 679-4606

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	Dietary	Bed days available	463,355	5	\$ 19,263	\$ 90,520	\$ 3,763	1
2	3	Housekeeping	Bed days available	463,355	5	61,490	90,520	12,013	2
3	5	Utilities	Bed days available	463,355	5	17,069	90,520	3,335	3
4	6	Repairs and Maintenance	Bed days available	463,355	5	14,954	90,520	2,921	4
5	6	Scavenger and Exterminating	Bed days available	463,355	5	7,328	90,520	1,431	5
6	19	Accounting Fees	Bed days available	463,355	5	1,899	90,520	371	6
7	19	Data Processing	Bed days available	463,355	5	26,825	90,520	5,240	7
8	19	Legal Fees	Bed days available	463,355	5	2,923	90,520	571	8
9	20	Dues and Subscriptions	Bed days available	463,355	5	396	90,520	77	9
10	20	Employment Recruitment Fees	Bed days available	463,355	5	1,455	90,520	284	10
11	21	Bank Services Charges	Bed days available	463,355	5	504	90,520	98	11
12	21	Classified Advertising	Bed days available	463,355	5	702	90,520	137	12
13	21	Office Supplies	Bed days available	463,355	5	36,888	90,520	7,206	13
14	21	Postage	Bed days available	463,355	5	54,979	90,520	10,741	14
15	21	Telephone	Bed days available	463,355	5	29,874	90,520	5,836	15
16	22	Holiday Expense	Bed days available	463,355	5	2,344	90,520	458	16
17	24	Education and Seminars	Bed days available	463,355	5	266	90,520	52	17
18	26	Insurance	Bed days available	463,355	5	4,194	90,520	819	18
19	30	Depreciation	Bed days available	463,355	5	87,403	90,520	17,075	19
20	32	Amortization Loan Costs	Bed days available	463,355	5	1,921	90,520	375	20
21	32	Interest Expense	Bed days available	463,355	5	113,562	90,520	22,185	21
22	33	Real Estate Taxes	Bed days available	463,355	5	37,112	90,520	7,250	22
23	35	Equipment Rental	Bed days available	463,355	5	22,434	90,520	4,383	23
24									24
25	TOTALS				\$ 545,785	\$		\$ 106,621	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion

0037754 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 ITEX Management Company
 Street Address 6633 North Lincoln Avenue
 City / State / Zip Code Lincolnwood, IL 60645
 Phone Number (847) 676-2122
 Fax Number (847) 679-4606

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	22	Health Insurance	Direct Allocation	1	\$ 200,350	\$	1	\$ 51,561	1
2	22	401 (k) expense	Direct Allocation	1	3,474		1	894	2
3	22	Payroll Taxes	Direct Allocation	1	61,375		1	15,795	3
4	22	Workers' Compensation Ins	Direct Allocation	1	2,514		1	647	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				\$ 267,713	\$		\$ 68,897	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion

0037754 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 Care Path Health Network
 Street Address 6633 North Lincoln Avenue
 City / State / Zip Code Lincolnwood, IL 60645
 Phone Number (847) 676-2122
 Fax Number (847) 679-4606

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	19	Accounting Fees	617,442	13	\$ 1,992	\$	63,064	\$ 203	1
2	19	Data Processing	617,442	13	12,301		63,064	1,256	2
3	19	Legal Fees	617,442	13	804		63,064	82	3
4	20	Classified Advertising	617,442	13	56,887		63,064	5,810	4
5	21	Office Supplies	617,442	13	15,861		63,064	1,620	5
6	21	Outside Office Help	617,442	13	3,156		63,064	322	6
7	21	Postage	617,442	13	102		63,064	10	7
8	21	Telephone	617,442	13	18,305		63,064	1,870	8
9	22	Employee Health Welfare	617,442	13	53,781		63,064	5,493	9
10	22	Payroll Taxes	617,442	13	30,474		63,064	3,113	10
11	24	Education and Seminars	617,442	13	365		63,064	37	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				\$ 194,028	\$		\$ 19,816	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 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	2	3	4	5	6		7	8	9	10		
						Original	Balance						
	Name of Lender	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										
	A. Directly Facility Related												
	Long-Term												
1	Lincoln National Life Insurance	X		Mortgage ***	\$80,255.00	09/01/89	\$ 6,254,345	\$ 5,448,907	09/01/07	0.1050	\$ 583,113	1	
2	Lincoln National Life Insurance	X		Mortgage ***	\$13,595.00	09/01/89	1,036,602	906,981	09/01/07	0.1088	100,476	2	
3	Lincoln National Life Insurance	X		Mortgage ***	\$6,538.00	11/01/92	509,189	454,821	11/01/07	0.1094	50,535	3	
4	LaSalle National Bank		X	Mortgage	\$64,321.00	10/01/98	7,345,625	6,855,920	10/01/23	0.0744	514,671	4	
5	Hill Rom		X	Purchase of Equipment	\$890.00	03/16/00	21,357		03/15/02	0.1000	22	5	
	Working Capital												
6	Shareholder Loans	X		Working Capital	Interest Only	12/21/00	550,000	550,000	12/31/03	0.0800		6	
7	LaSalle National Bank	X		Working Capital	Interest Only	12/22/01	3,500,000		08/14/02	P+.0075	108,285	7	
8	LaSalle National Bank	X		Working Capital	Interest Only	12/22/02	4,000,000	2,294,505	08/14/03	P+.0075	1,072	8	
9	TOTAL Facility Related				\$165,599.00		\$ 23,217,118	\$ 16,511,134			\$ 1,358,174	9	
	B. Non-Facility Related*												
10	See Schedule 9A						7,202	580			5,799	10	
11										Interest income offset	(17,788)	11	
12	*** These loans were assumed by The Claridge, L.L.C. as of 10/01/98 under the same terms as the original										Amortization of mortgage cost	21,287	12
13	mortgage holder									Allocated from management co.	22,560	13	
14	TOTAL Non-Facility Related						\$ 7,202	\$ 580			\$ 31,858	14	
15	TOTALS (line 9+line14)						\$ 23,224,320	\$ 16,511,714			\$ 1,390,032	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

FACILITY NAME THE IMPERIAL, GROVE PAVILION

PROVIDER # 0037754

PERIOD 12/31/2002

SCHEDULE 9A

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

Name of Lender	Related		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
	YES	NO				Original	Balance			
A. Directly Facility Related										
Long-Term										
Wells Fargo		X	Purchase of Equipment	298	8/30/2000	\$ 7,202	\$ 580	8/30/2002	0.0933	\$ 88
Working Capital										
										0
										0
										0
TOTAL Facility Related				298		\$ 7,202	\$ 580			\$ 88
B. Non-Facility Related										
						\$	\$			\$
										5,711
TOTAL Non-Facility Related						\$ 7,202	\$ 580			\$ 5,799

See Accountants' Compilation Report

Facility Name & ID Number **The Imperial Grove Pavilion**

0037754 Report Period Beginning: **01/01/02** Ending: **12/31/02**

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2001 report.			\$	467,040	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.)	2001		\$	479,808	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	12,768	3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	480,480	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Allocated from Mgmt. Co. Adjust taxes paid to 67%		7,250 (97,104)	
	TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	403,394	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:						
	1997	475,537	8			
	1998	483,979	9			
	1999	480,730	10			
	2000	467,646	11			
	2001	479,808	12			
** 2001 Real Estate Tax Bill	479,808	*2001 Total Real Estate Tax Bill		571,200		
Estimated Increase	1	Imperial portion for financial stmt.	479,808	84%		
2002 Accrual	480,480	Imperial portion for cost report	382,704	67%		
		Adjustment	(97,104)			

FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2001 \$
14	PLUS APPEAL COST FROM LINE 5 \$
15	LESS REFUND FROM LINE 6 \$
16	AMOUNT TO USE FOR RATE CALCULATION \$

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 The Imperial Grove Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037754

CONTACT PERSON REGARDING THIS REPORT James Slesur

TELEPHONE (773) 539-2122 FAX #: (773) 935-0036

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>14-29-321-040</u>	<u>Nursing Home</u>	\$ <u>571,199.92</u>	\$ <u>382,704.95</u>
2. <u>10-35-312-022</u>	<u>Nursing Home</u>	\$ <u>39,312.00</u>	\$ <u>7,250.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>610,511.92</u>	\$ <u>389,954.95</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 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 which is normally paid during 2002.

Facility Name & ID Number The Imperial Grove Pavilion# 0037754 Report Period Beginning:01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,703 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 6C. 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)

Claridge Lincoln Park, Ltd.; Retirement apartment rental; 119 unitsF. 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	<u>Resident Care</u>	<u>Not Available</u>	<u>1998</u>	<u>\$ 40,000</u>	1
2					2
3	TOTALS			\$ 40,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion

0037754

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	248	1998	1984	\$ 14,437,336	\$	40	\$ 360,933	\$ 360,933	\$ 1,533,965	4
5		1993	1993	313,364		35	8,953	8,953	85,801	5
6										6
7										7
8										8
Improvement Type**										
9	Leasehold Improvements		1992	60,378	3,032	20	3,032		31,835	9
10	Leasehold Improvements		1993	59,308	2,965	20	2,965		28,168	10
11	Leasehold Improvements		1994	10,638	532	20	532		4,522	11
12	Leasehold Improvements		1995	43,191	2,160	20	2,160		16,200	12
13	Furnace		1996	1,843	92	20	92		598	13
14	Door Locks		1996	2,357	118	20	118		767	14
15	Windows		1996	8,365	418	20	418		2,717	15
16	Electrical Wiring		1996	4,880	244	20	244		1,586	16
17	Fence		1996	1,067	53	20	53		345	17
18	Gutters		1996	1,574	79	20	79		513	18
19	Brick Wall		1996	2,560	128	20	128		832	19
20	Ceiling Lights		1996	5,501	274	20	274		1,783	20
21	Nurse Station		1996	2,500	124	20	124		807	21
22	Countertops		1996	2,610	131	20	131		850	22
23	Convection Oven		1996	7,515	376	20	376		2,443	23
24	Boiler		1996	2,927	146	20	146		949	24
25	Fence		1997	1,050	53	20	53		291	25
26	Electrical Improvements		1997	1,671	84	20	84		462	26
27	Nurse Call Station		1997	3,501	175	20	175		963	27
28	Public Address System		1997	1,360	68	20	68		374	28
29	Brick Wall		1997	5,110	256	20	256		1,408	29
30	Floor Tile		1997	21,705	1,085	20	1,085		5,968	30
31	Fire Doors		1997	4,096	205	20	205		1,127	31
32	Carpeting		1997	3,243	162	20	162		891	32
33	Inspection Improvements		1997	9,884	494	20	494		2,717	33
34	Door Restrictors		1997	8,475	424	20	424		2,332	34
35	Fire Alarm		1997	2,082	103	20	103		568	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion

0037754

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	Sheet Metal	1998	\$ 11,981	\$ 599	20	\$ 599	\$	\$ 2,696	37
38	Lighting	1998	7,156	358	20	358		1,611	38
39	Screens	1998	2,704	135	20	135		608	39
40	Piping	1998	4,145	207	20	207		932	40
41	Fire Alarms & Fire Proofing	1998	12,534	627	20	627		2,821	41
42	Tile	1998	967	49	20	49		220	42
43	Driveway	1998	7,342	367	20	367		1,652	43
44	Tuckpointing	1998	39,242	1,962	20	1,962		8,828	44
45	Ground Fuel Tank	1999	17,985	899	20	899		3,147	45
46	Carpet	1999	28,114	1,406	20	1,406		4,921	46
47	Wallcovering	1999	36,585	1,830	20	1,830		6,404	47
48	Floor in Dining Room	1999	9,850	493	20	493		1,725	48
49	Signs	1999	1,765	88	20	88		308	49
50	Electrical Work	1999	20,508	1,025	20	1,025		3,588	50
51	Brick & Masonry Work	1999	12,345	617	20	617		2,159	51
52	Gas Line Improvements	1999	1,633	82	20	82		287	52
53	Alarm System	1999	1,388	69	20	69		242	53
54	Wallcovering	2000	21,554	1,078	20	1,078		2,695	54
55	Flooring	2000	13,293	664	20	664		1,660	55
56	Carpet	2000	8,284	414	20	414		1,035	56
57	Over Bed Lights	2000	4,593	230	20	230		575	57
58	Compactor	2000	6,800	340	20	340		850	58
59	Paging System	2000	9,909	496	20	496		1,240	59
60	CCTV System	2000	5,456	272	20	272		680	60
61	Wander Guard System	2000	18,540	928	20	928		2,320	61
62	Handrails, Kickplates, Wallbases	2000	6,038	302	20	302		755	62
63	Fuel Tank Project	2000	1,444	72	20	72		180	63
64	FirstQ System	2000	1,378	68	20	68		170	64
65	Chain Link Fence	2000	745	38	20	38		95	65
66	Alarm System	2000	5,051	252	20	252		630	66
67	Service P.A. System	2000	1,924	96	20	96		240	67
68	Remodel 13 Bedrooms	2000	18,112	906	20	906		2,265	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 15,369,456	\$ 30,950		\$ 400,836	\$ 369,886	\$ 1,789,321	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Imperial Grove Pavilion

0037754

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		
1	Totals from Page 12A, Carried Forward	\$ 15,369,456	\$ 30,950		\$ 400,836	\$ 369,886	\$ 1,789,321		1
2	Repair Elevator	2000 990	50	20	50		125		2
3	Remodel Smoking Room	2000 23,565	1,178	20	1,178		2,945		3
4	Remodel Old Smoking Room to Library	2000 4,690	234	20	234		585		4
5	Remodel 1st Floor	2000 10,540	528	20	528		1,320		5
6	Remodel 6th Floor Dining Room	2000 4,970	248	20	248		620		6
7	Remodel 3rd Floor Dining Room	2000 959	48	20	48		120		7
8	Call Station	2000 4,475	224	20	224		560		8
9	Landscaping	2000 2,785		n/a					9
10	Roof repair	2001 3,830	192	20	192		288		10
11	Masonry repair	2001 15,227	762	20	762		1,143		11
12	Stainless steel toilet bars	2001 1,645	80	20	80		120		12
13	Masonry repair	2001 3,700	186	20	186		279		13
14	New tile	2001 3,633	182	20	182		274		14
15	Tile coating	2001 4,540	228	20	228		342		15
16	New Wanderguard system	2001 4,407	220	20	220		330		16
17	New relay rack	2001 3,788	190	20	190		285		17
18	CCTV	2002 1,146	29	20	29		29		18
19	CCTV	2002 1,440	36	20	36		36		19
20	Masonry repair	2002 10,000	250	20	250		250		20
21	Roof repair	2002 3,350	84	20	84		843		21
22	Masonry repair	2002 15,760	394	20	394		394		22
23	Masonry repair	2002 4,275	107	20	107		107		23
24	Locking system	2002 1,843	46	20	46	(0)	46		24
25	Pallet warmer	2002 3,272	82	20	82	0	82		25
26									26
27	Allocated from Management Company	1993 39,430		20	1,972	1,972	19,136		27
28	Allocated from Management Company	1994 21,179		20	1,059	1,059	8,770		28
29	Allocated from Management Company	1995 3,609		20	180	180	1,299		29
30	Allocated from Management Company	1996 204		20	10	10	72		30
31	Allocated from Management Company	1997 6,089		20	304	304	1,674		31
32	Allocated from Management Company	1999 677		20	34	34	135		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 15,575,474	\$ 36,528		\$ 409,973	\$ 373,445	\$ 1,831,530		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 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	\$ 1,940,150	\$ 118,078	\$ 189,918	\$ 71,840	10	\$ 1,066,760	71
72	Current Year Purchases	100,048	5,002	5,002	(0)	10	5,002	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt. Co. & Related Parties	120,707		11,432	11,432		80,925	74
75	TOTALS	\$ 2,160,905	\$ 123,080	\$ 206,352	\$ 83,272		\$ 1,152,687	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	Patient Care	1994 Ford Van	1994	\$ 30,750	\$	\$	\$	5 Yrs.	\$ 30,750	76
77	Patient Care	1998 Ford Van	1999	20,449	4,090	4,090		5 Yrs.	14,315	77
78										78
79										79
80	TOTALS			\$ 51,199	\$ 4,090	\$ 4,090	\$		\$ 45,065	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	17,827,578	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	163,698	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	620,415	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	456,717	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	3,029,282	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	TOTAL				\$			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2003</u>	\$ _____
13.	<u>/2004</u>	\$ _____
14.	<u>/2005</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease _____

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 13,088 Description: Medical Equipment \$4,805; Copier \$3,900; Allocated from Mgmt. Co. \$4,383
 (Attach a schedule detailing the breakdown of movable equipment)

* 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.

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Administrative</u>	<u>2003 Infiniti G35</u>	\$ <u>687.00</u>	\$ <u>7,076</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 687.00	\$ 7,076	21

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$ 922	\$	\$ 922
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	\$	\$ 922	\$	\$ 922
10 SUM OF line 9, col. 1 and 2 (e)	\$	922		

- (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.

\$ N/A

D. NUMBER OF AIDES TRAINED

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

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

The Imperial Grove Pavilion

Provider #: 0037754

01/01/02 to 12/31/02

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

Service	Line Reference	Staff Units of Service	Staff Cost	Outside Practioner Units	Outside Practioner Cost	Supplies
Oxygen	L39, C2					14,704
Air Flotation Mattress	L39, C2					15,724
Licensed Respiratory Therapist	L10a, C1	2154 hrs	40,465			
Transportation	L39, C3			21	1,007	
Total		<u>2,154</u>	<u>40,465</u>	<u>21</u>	<u>1,007</u>	<u>30,428</u>

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 17

Facility Name & ID Number The Imperial Grove Pavilion

0037754

Report Period Beginning: 01/01/02

Ending:

12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 589,017	\$ 589,017	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 250,000)	4,249,079	4,249,079	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	141,939	141,939	6
7	Other Prepaid Expenses	458,494	458,494	7
8	Accounts Receivable (owners or related parties)	112,962	1,125,279	8
9	Other(specify): See Schedule 17A	983,274	1,487,274	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,534,765	\$ 8,051,082	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,785	42,785	13
14	Buildings, at Historical Cost		14,821,888	14
15	Leasehold Improvements, at Historical Cost	741,671	750,801	15
16	Equipment, at Historical Cost	1,373,002	2,212,104	16
17	Accumulated Depreciation (book methods)	(992,187)	(3,029,282)	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): Loan Costs		205,899	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,125,271	\$ 15,004,195	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,660,036	\$ 23,055,277	25

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 418,701	\$ 418,701	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	64,620	64,620	28
29	Short-Term Notes Payable	580	580	29
30	Accrued Salaries Payable	180,398	180,398	30
31	Accrued Taxes Payable (excluding real estate taxes)	95,039	95,039	31
32	Accrued Real Estate Taxes(Sch.IX-B)		480,480	32
33	Accrued Interest Payable	11,947	114,497	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,317,756	1,317,756	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,089,041	\$ 2,672,071	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,844,505	16,511,134	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,844,505	\$ 16,511,134	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,933,546	\$ 19,183,205	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,726,490	\$ 3,872,072	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,660,036	\$ 23,055,277	48

FACILITY NAME THE IMPERIAL, GROVE PAVILION
PROVIDER # 0037754
12/31/2002

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Current Assets

<u>Other (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Employee Loans	59,477	59,477
Officers' Notes Receivable	-	504,000
Due from AK Care	50,966	50,966
Due from Related Parties	872,831	872,831
Total Line 9 - Other(specify):	983,274	1,487,274

C. Current Liabilities

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to Related Parties	226,948	226,948
Short Term Loan Exchanges	(10,959)	(10,959)
Resident Credit Balances	1,105,042	1,105,042
Other Accrued Expenses	(3,275)	(3,275)
Total Line 36 - Other Current Liabilities(specify):	1,317,756	1,317,756

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,151,200	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,151,199	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	575,291	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)	\$ 575,291	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,726,490	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,948,654	1
2	Discounts and Allowances for all Levels	(891,587)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,057,067	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,309,932	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,309,932	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	29,683	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	590,775	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	82,834	19
20	Radiology and X-Ray		20
21	Other Medical Services	64,809	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 768,101	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,788	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,788	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	14,012	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,012	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,166,900	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,431,331	31
32	Health Care	4,731,165	32
33	General Administration	2,534,034	33
B. Capital Expense			
34	Ownership	2,157,269	34
C. Ancillary Expense			
35	Special Cost Centers	602,030	35
36	Provider Participation Fee	135,780	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,591,609	40
41	Income before Income Taxes (line 30 minus line 40)**	575,291	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 575,291	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.
Entity is a cash basis taxpayer

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

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

FACILITY NAME: THE IMPERIAL, GROVE PAVILION
PROVIDER # 0037754
12/31/2002

Schedule 19A

XVII. INCOME STATEMENT
Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Miscellaneous Income	1,050
Vending Commission	12,902
Wage Assignment Fees	<u>60</u>
Total Line 28 - Other Revenue (specify):	<u><u>14,012</u></u>

See Accountants' Compilation Report

Facility Name & ID Number The Imperial Grove Pavilion

0037754

Report Period Beginning: 01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,888	1,993	\$ 88,734	\$ 44.52	1
2	Assistant Director of Nursing	4,367	4,583	131,027	28.59	2
3	Registered Nurses	24,871	26,695	652,152	24.43	3
4	Licensed Practical Nurses	38,703	40,591	822,886	20.27	4
5	Nurse Aides & Orderlies	116,820	122,773	1,163,150	9.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,032	2,072	40,465	19.53	7
8	Rehab/Therapy Aides	8,975	10,121	126,737	12.52	8
9	Activity Director					9
10	Activity Assistants	14,851	16,210	135,812	8.38	10
11	Social Service Workers	6,191	6,415	65,010	10.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	12,037	13,215	122,168	9.24	14
15	Cook Helpers/Assistants	34,576	36,570	267,477	7.31	15
16	Dishwashers					16
17	Maintenance Workers	6,877	7,365	98,913	13.43	17
18	Housekeepers	6,861	7,676	53,097	6.92	18
19	Laundry					19
20	Administrator	6,096	6,240	257,299	41.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	42,313	43,808	593,599	13.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care See Sch 20a	12,315	13,124	247,421	18.85	32
33	Other(specify) Beautician	1,847	2,047	30,806	15.05	33
34	TOTAL (lines 1 - 33)	341,620	361,498	\$ 4,896,753 *	\$ 13.55	34

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	Monthly	\$ 34,074	L1, C3	35
36	Medical Director	Monthly	23,000	L9, C3	36
37	Medical Records Consultant	72	2,969	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	L10, C3	39
40	Physical Therapy Consultant	209	10,459	L10A, C3	40
41	Occupational Therapy Consultant	174	8,681	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	2,369	L11, C3	44
45	Social Service Consultant	32	1,684	L12, C3	45
46	Other(specify)				46
47	Religious Service	Monthly	4,200	L12, C3	47
48	Dental Consultant	Monthly	600	L10, C3	48
49	TOTAL (lines 35 - 48)	539	\$ 89,836		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	630	\$ 26,175	L10, C3	50
51	Licensed Practical Nurses	8,157	280,196	L10, C3	51
52	Nurse Aides	237	2,130	L10, C3	52
53	TOTAL (lines 50 - 52)	9,024	\$ 308,501		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name **The Imperial, Grove Pavillion**
PROVIDER # **37754**
Period Ending **12/31/2002**

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

	Hours Worked	Hours Paid	Salary	Avg Hr Wage	Cost Report Line
Ward Clerk	8,274	8,923	113,102	\$ 12.68	10
Nursing Administrative	4,041	4,201	134,319	\$ 31.97	10
Total Line 32 - Other Health Care	12,315	13,124	\$ 247,421	\$ 18.85	

See Accountants' Compilation Report

The Imperial Grove Pavilion
 Provider #: 0037754
 01/01/02 to 12/31/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Sachnoff & Weaver, Ltd.	Legal	9,495
Stone, McGuire & Benjamir	Legal	17,219
Winston & Strawn	Legal	1,192
Myers & Miller	Legal	1,731
Segal & Segal	Legal	37,321
Klein, Dub & Holleb, Ltd.	Legal	746
Madel, Lipton & Stevenson	Legal	1,597
Medi	Data Processing	514
American Express	Data Processing	140
Platinum Plus	Data Processing	310
GE Information Service	Data Processing	343
Victory Communications	Data Processing	291
Extended Care	Data Processing	1,920
CDW Software	Data Processing	568
SAS Architects & Planners	Architectural	320
Total (agree to Schedule V, line 19, column 3)		<u>209,181</u>
Disallowed legal fees:		
Sachnoff & Weaver, Ltd.		(445)
Stone, McGuire & Benjamin		(1,104)
Myers & Miller		(101)
Segal & Segal		(37,321)
Klein, Dub & Holleb, Ltd.		(507)
Madel, Lipton & Stevenson		<u>(1,597)</u>
Disallowed consulting		<u>(68,752)</u>
		<u>(109,827)</u>
Professional fees allocated from Itex		
Data Processing		5,240
Legal		571
Accounting		<u>368</u>
		<u>6,179</u>
Professional fees allocated from Care Path Health Network		
Data Processing		1,256
Legal		82
Accounting		<u>203</u>
		<u>1,541</u>
Total (agree to Schedule V, line 19, column 8)		<u><u>107,074</u></u>

See Accountants' Compilation Report

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Repairs to Chiller	\$ 2,550	3	\$ 425	\$ 850	\$ 850	\$ 425	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$ 2,550		\$ 425	\$ 850	\$ 850	\$ 425	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion# 0037754Report Period Beginning: 01/01/02Ending: 12/31/02**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long-Term Care \$14,286
- (3) Did the nursing home make political contributions or payments to a political 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? N/A
- (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 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,196 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. N/A
- (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 N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 135,780
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. \$ 61,309 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

The Imperial Grove Pavi 03:13 PM 11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-195,980	equal to	-195,980	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	1,390,032	equal to	1,390,032	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	403,394	equal to	403,394	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	620,415	equal to	620,415	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	20,164	equal to	20,164	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	922	equal to	922	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	40,465	equal to	0	O.K.	Pg16 N32	N/A		14	3	Pg4 E22	N/A	39	1
Therapy Services	506,109	equal to	546,574	-40,465	FAILED	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	353,995	equal to	353,995	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	2,431,331	equal to	2,431,331	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,731,165	equal to	4,731,165	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	2,534,034	equal to	2,534,034	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	2,157,269	equal to	2,157,269	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	602,030	equal to	602,030	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38b41+43	4
Income Stat. Prov. Partic.	135,780	equal to	135,780	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,857,949	equal to	3,232,107	-374,158	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	O.K.	Pg20 K16	A.		6	3	Pg3 E23	N/A	13	1
Staff-Licensee Therapist	40,465	equal to	0	O.K.	Pg20 K17	A.		7	3	Pg4 E22	N/A	39	1
Staff- Activities	135,812	equal to	135,812	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	65,010	equal to	65,010	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	389,645	equal to	389,645	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	98,913	equal to	98,913	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	53,097	equal to	53,097	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to	0	O.K.	Pg20 K29	A.		19	3	Pg3 E12	N/A	4	1
Staff- Administrative	257,299	equal to	257,299	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	593,599	equal to	593,599	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	O.K.	Pg20 K37	A.		27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,896,753	equal to	4,896,753	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	34,074	< or = to	770,709	-736,635	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	23,000	< or = to	23,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	313,270	< or = to	313,870	-600	O.K.	Pg20 X14..X16+	B. & C.	37b39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,369	< or = to	2,369	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,684	< or = to	5,884	-4,200	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	257,299	equal to	257,299	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	277,882	equal to	277,882	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	209,181	equal to	209,181	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	843,869	equal to	843,869	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	78,192	equal to	78,192	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	9,343	equal to	9,343	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	135,780	equal to	135,780	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	61,309	< or = to	139,270	-77,961	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	61,309	equal to	61,309	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4		Pg3 E23	N/A	13	1
Days of medicare provided	8,938	equal to	8,938	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	250,943	equal to	250,943	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4f	B.	14	8
Total loan balance	16,511,714	equal to	16,511,714	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	480,480	equal to	480,480	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	40,000	equal to	42,785	-2,785	FAILED	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	15,575,474	equal to	15,572,689	2,785	FAILED	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	2,212,104	equal to	2,212,104	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	3,029,282	equal to	3,029,282	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,726,490	equal to	2,726,490	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	575,291	equal to	575,291	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	O.K.	Pg22 F31-J31..S	H.		20	3	Pg17 K30	N/A	18	2
Balance Sheet	7,660,036	equal to	7,660,036	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen Total	
1. Dietary	389,645	10,524	770,709	1,170,878	0	1,170,878	-57,546	1,113,332
2. Food Purchase	0	71,360	0	71,360	0	71,360	0	71,360
3. Housekeeping	53,097	58,964	297,960	410,021	0	410,021	12,013	422,034
4. Laundry	0	20,176	189,600	209,776	0	209,776	0	209,776
5. Heat and Other Utilities	0	0	263,689	263,689	0	263,689	3,335	267,024
6. Maintenance	98,913	66,004	140,690	305,607	0	305,607	-4,612	300,995
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	541,655	227,028	1,662,648	2,431,331	0	2,431,331	-46,810	2,384,521
9. Medical Director	0	0	23,000	23,000	0	23,000	0	23,000
10. Nursing & Medical Records	3,232,107	354,136	313,870	3,900,113	0	3,900,113	0	3,900,113
10a. Therapy	40,465	0	506,109	546,574	0	546,574	0	546,574
11. Activities	135,812	51,481	2,369	189,662	0	189,662	0	189,662
12. Social Services	65,010	0	5,884	70,894	0	70,894	0	70,894
13. Nurse Aide Training	0	0	922	922	0	922	0	922
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,473,394	405,617	852,154	4,731,165	0	4,731,165	0	4,731,165
17. Administrative	257,299	0	277,882	535,181	0	535,181	-277,882	257,299
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	209,181	209,181	0	209,181	-102,107	107,074
20. Fees, Subscriptions & Promotion	0	0	72,021	72,021	0	72,021	6,171	78,192
21. Clerical & General Office	593,599	69,757	90,217	753,573	0	753,573	26,730	780,303
22. Employee Benefits & Payroll	0	0	704,599	704,599	0	704,599	139,270	843,869
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	9,254	9,254	0	9,254	89	9,343
25. Other Admin. Staff Trans	0	0	21,815	21,815	0	21,815	-3,553	18,262
26. Insurance-Prop.Liab.Malpractice	0	0	228,410	228,410	0	228,410	819	229,229
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	850,898	69,757	1,613,379	2,534,034	0	2,534,034	-210,463	2,323,571
29. Total General Administrative	4,865,947	702,402	4,128,181	9,696,530	0	9,696,530	-257,273	9,439,257
30. Depreciation	0	0	163,698	163,698	0	163,698	456,717	620,415
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	115,102	115,102	0	115,102	1,274,930	1,390,032
33. Real Estate	0	0	0	0	0	0	403,394	403,394
34. Rent - Facility & Grounds	0	0	1,862,688	1,862,688	0	1,862,688	#####	0
35. Rent - Equipment & Vehicles	0	0	15,781	15,781	0	15,781	4,383	20,164
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	2,157,269	2,157,269	0	2,157,269	276,736	2,434,005
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	353,995	1,007	355,002	0	355,002	0	355,002
40. Barber and Beauty Shop	30,806	779	0	31,585	0	31,585	0	31,585
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	135,780	135,780	0	135,780	0	135,780
43. Other (specify):*	0	0	215,443	215,443	0	215,443	-215,443	0
44. Total Special Cost Ce	30,806	354,774	352,230	737,810	0	737,810	-215,443	522,367
45. Grand Total	4,896,753	1,057,176	6,637,680	#####	0	#####	-195,980	#####

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	589,017	589,017
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	4,249,079	4,249,079
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	141,939	141,939
7. Other Prepaid Expenses	458,494	458,494
8. Accounts Receivable-Owner/Related Party	112,962	1,125,279
9. Other (specify):	983,274	1,487,274
10. Total current assets	6,534,765	8,051,082
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	2,785	42,785
14. Buildings, at Historical Cost	0	14,821,888
15. Leasehold Improvements, Historical Cost	741,671	750,801
16. Equipment, at Historical Cost	1,373,002	2,212,104
17. Accumulated Depreciation (book methods)	-992,187	-3,029,282
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	205,899
24. Total Long-Term Assets	1,125,271	15,004,195
25. Total Assets	7,660,036	23,055,277
CURRENT LIABILITIES		
26. Accounts Payable	418,701	418,701
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	64,620	64,620
29. Short-Term Notes Payable	580	580
30. Accrued Salaries Payable	180,398	180,398
31. Accrued Taxes Payable	95,039	95,039
32. Accrued Real Estate Taxes	0	480,480
33. Accrued Interest Payable	11,947	114,497
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	1,317,756	1,317,756
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,089,041	2,672,071
LONG TERM LIABILITES		
39. Long-Term Notes Payable	2,844,505	16,511,134
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	2,844,505	16,511,134
46. Total Liabilities	4,933,546	19,183,205
47. Total Equity	2,726,490	3,872,072
48. Total Liabilities and Equity	7,660,036	23,055,277

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	11,948,654
2. Discounts and Allowances for all Levels	-891,587
Subtotal - Inpatient Care	11,057,067
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,309,932
7. Oxygen	0
Subtotal - Ancillary Revenue	1,309,932
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	29,683
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	590,775
18. Sale of Supplies to Non-Patients	0
19. Laboratory	82,834
20. Radiology and X-Ray	0
21. Other Medical Services	64,809
22. Laundry	0
Subtotal - Other Operating Revenue	768,101
24. Contributions	0
25. Interest and Other Investments Income	17,788
Subtotal - Non-Operating Revenue	17,788
27. Other Revenue (specify):	14,012
28. Other Revenue (specify):	0
Subtotal - Other Revenue	14,012
30. Total Revenue	13,166,900
31. General Services	2,431,331
32. Health Care	4,731,165
33. General Administration	2,534,034
34. Ownership	2,157,269
35. Special Cost Centers	602,030
35. Provider Participation Fee	135,780
37. Other	0
40. Total Expenses	12,591,609
41. Income Before Income Taxes	575,291
42. Income Taxes	0
43. Net Income or Loss for the Year	575,291

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9 Line 16 for mortgage insurance.

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