

		FOR OHF USE					

LL1

**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>0045740</u></p> <p>Facility Name: <u>LaSalle HealthCare Center</u></p> <p>Address: <u>1445 Chartres Street</u> <u>LaSalle</u> <u>61301</u> Number City Zip Code</p> <p>County: <u>LaSalle</u></p> <p>Telephone Number: <u>(815) 223-4700</u> Fax # <u>(815) 223-6630</u></p> <p>IDPA ID Number: <u>36-2795206</u></p> <p>Date of Initial License for Current Owners: <u>02/19/1992</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 checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Sherry DeBons</u> Telephone Number: <u>281-599-5022</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	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>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>01/01/2002</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 border="1"> <tr> <td data-bbox="1505 820 1693 1031" rowspan="2">Officer or Administrator of Provider</td> <td data-bbox="1693 820 2607 860">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1693 860 2607 917">(Type or Print Name) <u>Linda Holtzscheiter</u></td> </tr> <tr> <td data-bbox="1505 1031 1693 1071"></td> <td data-bbox="1693 917 2607 990">(Title) <u>Reimbursement Manager</u></td> </tr> <tr> <td data-bbox="1505 1071 1693 1323" rowspan="4">Paid Preparer</td> <td data-bbox="1693 990 2607 1031">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1693 1031 2607 1071">(Print Name and Title) <u>N/A</u></td> </tr> <tr> <td data-bbox="1693 1071 2607 1112">(Firm Name & Address) _____</td> </tr> <tr> <td data-bbox="1693 1112 2607 1153">(Telephone) <u>()</u> Fax # ()</td> </tr> <tr> <td colspan="2" data-bbox="1693 1153 2607 1448"> <p align="center">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> </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Linda Holtzscheiter</u>		(Title) <u>Reimbursement Manager</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) <u>N/A</u>	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # ()	<p align="center">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>	
<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 checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																			
	<input type="checkbox"/> "Sub-S" Corp.																																				
	<input type="checkbox"/> Limited Liability Co.																																				
	<input type="checkbox"/> Trust																																				
	<input type="checkbox"/> Other _____																																				
Officer or Administrator of Provider	(Signed) _____ (Date) _____																																				
	(Type or Print Name) <u>Linda Holtzscheiter</u>																																				
	(Title) <u>Reimbursement Manager</u>																																				
Paid Preparer	(Signed) _____ (Date) _____																																				
	(Print Name and Title) <u>N/A</u>																																				
	(Firm Name & Address) _____																																				
	(Telephone) <u>()</u> Fax # ()																																				
<p align="center">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>																																					

Facility Name & ID Number LaSalle HealthCare Center

0045740 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	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,615	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				
		2 Public Aid Recipient	Private Pay	4 Other	5 Total	
8	SNF	2,355	574	3,066	5,995	8
9	SNF/PED					9
10	ICF	23,523	6,463	30	30,016	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,878	7,037	3,096	36,011	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.68%

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

198 (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 01/01/1992

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

YES Date 01/01/1992 NO

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

YES NO If YES, enter number of beds certified 50 and days of care provided 3,066

Medicare Intermediary AdminStar Kentucky

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 LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	144,025	8,116	7,797	159,938		159,938		159,938		1
2	Food Purchase		125,131		125,131		125,131		125,131		2
3	Housekeeping	75,842	9,162	2,163	87,167		87,167		87,167		3
4	Laundry	59,199	10,979	750	70,928		70,928		70,928		4
5	Heat and Other Utilities			80,372	80,372		80,372	22	80,394		5
6	Maintenance	38,842	21,090	10,193	70,125		70,125	63	70,188		6
7	Other (specify):* <u>Waste/ garbage -See Pg 3.1</u>			16,383	16,383		16,383		16,383		7
8	TOTAL General Services	317,908	174,478	117,658	610,044		610,044	85	610,129		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,342,131	88,170	22,309	1,452,610		1,452,610	15,300	1,467,910		10
10a	Therapy	89,207	2,899	8	92,114		92,114		92,114		10a
11	Activities	56,295	6,346	2,695	65,336		65,336		65,336		11
12	Social Services	31,247		2,612	33,859		33,859		33,859		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,518,880	97,415	36,624	1,652,919		1,652,919	15,300	1,668,219		16
	C. General Administration										
17	Administrative	54,518			54,518		54,518		54,518		17
18	Directors Fees										18
19	Professional Services			4,285	4,285		4,285	5,571	9,856		19
20	Dues, Fees, Subscriptions & Promotions			15,657	15,657		15,657	(5,003)	10,654		20
21	Clerical & General Office Expenses	86,807	8,834	36,878	132,519		132,519	119,591	252,110		21
22	Employee Benefits & Payroll Taxes			426,079	426,079		426,079		426,079		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,389	12,389		12,389	9,496	21,885		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			81,395	81,395		81,395	(19,553)	61,842		26
27	Other (specify):*										27
28	TOTAL General Administration	141,325	8,834	576,683	726,842		726,842	110,103	836,945		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,978,113	280,727	730,965	2,989,805		2,989,805	125,488	3,115,293		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.

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			39,485	39,485		39,485	63,967	103,452			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(107)	(107)		(107)		(107)			32
33	Real Estate Taxes			23,165	23,165		23,165	260	23,425			33
34	Rent-Facility & Grounds			439,332	439,332		439,332	1,741	441,073			34
35	Rent-Equipment & Vehicles							3,959	3,959			35
36	Other (specify):*			3,806,261	3,806,261		3,806,261	(3,797,326)	8,935			36
37	TOTAL Ownership			4,308,136	4,308,136		4,308,136	(3,727,399)	580,737			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,324	46	32,370		32,370		32,370			39
40	Barber and Beauty Shops			12,010	12,010		12,010	(12,010)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*		109	1,243	1,352		1,352		1,352			43
44	TOTAL Special Cost Centers		32,433	68,596	101,029		101,029	(12,010)	89,019			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,978,113	313,160	5,107,697	7,398,970		7,398,970	(3,613,921)	3,785,049			45

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

Facility Name & ID Number LaSalle HealthCare Center

0045740

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(223)	21		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(75)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	748	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(19)	20		28
29	Other-Attach Schedule	(3,783,491)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,783,060)		\$	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	
		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)	169,139		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 169,139		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,613,921)		37

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

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

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

OHF USE ONLY							
48		49		50		51	

LaSalle HealthCare Center

ID# 0045740

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Sales Taxes	\$ (2,448)	21	1
2	Small Balance Adjustments	(3)	21	2
3	Memorium/ Benevolence	(605)	21	3
4	FASB 121 ***	3,722	30	4
5	Activities Program Receipts	0	11	5
6	Depreciation Reconciliation	60,245	30	6
7	Professional Liability Insurance	(19,977)	26	7
8	Barber & Beauty	(12,010)	40	8
9	Public Relation Expense	(562)	20	9
10	Non Allowable Advertising	(5,176)	20	10
11	Entertainment	(417)	24	11
12	Fresh Start	(3,806,261)	36	12
13				13
14				14
15				15
16				16
17	*** This facility re-valued their assets in 1999.			17
18	We have reported the Historical Cost of the assets			18
19	consistent with the prior years, and have ensured			19
20	that depreciation expense is reported on straight			20
21	line. This adjustment is necessary to reverse the			21
22	re-valuation of Historical Cost. (per CR YR 2000)			22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,783,491)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LaSalle HealthCare Center

0045740

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	22	0	0	0	0	0	0	0	0	0	22	5
6	Maintenance	0	63	0	0	0	0	0	0	0	0	0	63	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	85	0	85	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	15,300	0	0	0	0	0	0	0	0	0	15,300	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	15,300	0	15,300	16								
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,571	0	0	0	0	0	0	0	0	0	5,571	19
20	Fees, Subscriptions & Promotions	(5,757)	754	0	0	0	0	0	0	0	0	0	(5,003)	20
21	Clerical & General Office Expenses	(2,606)	122,197	0	0	0	0	0	0	0	0	0	119,591	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(417)	9,913	0	0	0	0	0	0	0	0	0	9,496	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(19,977)	424	0	0	0	0	0	0	0	0	0	(19,553)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(28,756)	138,859	0	110,103	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(28,756)	154,244	0	125,488	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LaSalle HealthCare Center# 0045740

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 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	63,967	0	0	0	0	0	0	0	0	0	0	63,967	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	260	0	0	0	0	0	0	0	0	0	260	33
34	Rent-Facility & Grounds	0	1,741	0	0	0	0	0	0	0	0	0	1,741	34
35	Rent-Equipment & Vehicles	0	3,959	0	0	0	0	0	0	0	0	0	3,959	35
36	Other (specify):*	(3,806,261)	8,935	0	0	0	0	0	0	0	0	0	(3,797,326)	36
37	TOTAL Ownership	(3,742,294)	14,895	0	(3,727,399)	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	(12,010)	0	0	0	0	0	0	0	0	0	0	(12,010)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(12,010)	0	0	0	0	0	0	0	0	0	0	(12,010)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,783,060)	169,139	0	(3,613,921)	45								

Facility Name & ID Number LaSalle HealthCare Center

0045740

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

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
<u>Mariner Health Care</u>	<u>100</u>	<u>See Attached page 6.1</u>		<u>Mariner Health Care</u>	<u>Atlanta, GA</u>	<u>Management</u>

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	<u>5 Utilities</u>	\$	<u>Mariner Health Care</u>	<u>100.00%</u>	\$ <u>22</u>	\$	<u>22</u> 1
2	V	<u>6 Repair & Maintenance</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>63</u>		<u>63</u> 2
3	V	<u>19 Professional Services</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>5,571</u>		<u>5,571</u> 3
4	V	<u>20 Fees, Subscription, Promotions</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>754</u>		<u>754</u> 4
5	V	<u>10 Nursing & Medical Records</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>15,300</u>		<u>15,300</u> 5
6	V	<u>21 Clerial & General Office Exp</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>122,197</u>		<u>122,197</u> 6
7	V	<u>24 Travel & Seminar</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>9,913</u>		<u>9,913</u> 7
8	V	<u>26 Insurance Premium</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>251</u>		<u>251</u> 8
9	V	<u>36 Depreciation</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>8,935</u>		<u>8,935</u> 9
10	V	<u>33 Taxes - Property</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>260</u>		<u>260</u> 10
11	V	<u>35 Rental & Leasing</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>3,959</u>		<u>3,959</u> 11
12	V	<u>34 Lease Expense</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>1,741</u>		<u>1,741</u> 12
13	V	<u>26 Property Insurance</u>		<u>Mariner Health Care</u>	<u>100.00%</u>	<u>173</u>		<u>173</u> 13
14	Total		\$			\$ <u>169,139</u>	\$ *	<u>169,139</u> 14

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

Facility Name & ID Number LaSalle HealthCare Center # 0045740 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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number LaSalle HealthCare Center

0045740

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

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

Name of Related Organization Mariner Health Care
 Street Address One Ravine Dr. Suite 1500
 City / State / Zip Code Atlanta, GA 30346
 Phone Number (770) 379-8203
 Fax Number (770) 399-1971

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	5	Utilities			\$ 192	\$		\$ 22	1
2	6	Repair & Maintenance			556			63	2
3	19	Professional Services			50,336			5,571	3
4	20	Fees, Subscription, Promotions			6,593			754	4
5	10	Nursing & Medical Records			675,703			15,300	5
6	21	Clerial & General Office Exp			527,522			122,197	6
7	24	Travel & Seminar			84,515			9,913	7
8	26	Insurance Premium			2,427			251	8
9	36	Depreciation			81,021			8,935	9
10	33	Taxes - Property			2,346			260	10
11	35	Rental & Leasing			35,937			3,959	11
12	34	Lease Expense			15,801			1,741	12
13	26	Property Insurance			1,581			173	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				\$ 1,484,530	\$		\$ 169,139	25

Facility Name & ID Number LaSalle HealthCare Center

0045740

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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

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

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

Facility Name & ID Number **LaSalle HealthCare Center**# **0045740** Report Period Beginning: **01/01/2002** Ending: **12/31/2002****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.		\$	25,184		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.)		\$	23,548		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,636)		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	24,801		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	23,165		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1997	24,596	8	FOR OHF USE ONLY	
	1998	25,172	9		
	1999	31,824	10	13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
	2000	24,143	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2001	23,548	12	15	LESS REFUND FROM LINE 6 \$ 15
Line 1 adjusted or not equal to prior C/R due to intercompany entries.				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 LaSalle HealthCare Center COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0045740

CONTACT PERSON REGARDING THIS REPORT Sherry DeBons

TELEPHONE 281-579-5022 FAX #: 281-578-4779

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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-09-451-000</u>	<u>PT E 1/2 SE-BEG891.02 NE COR, S4</u>	\$ <u>22,215.34</u>	\$ <u>22,215.34</u>
2. <u>17-09-449-000</u>	<u>PT SE-4-9-33-1 BEG 1291.02' S NE</u>	\$ <u>1,147.52</u>	\$ <u>1,147.52</u>
3. <u>17-09-450-000</u>	<u>IRREG .19ACS NE SE</u>	\$ <u>185.28</u>	\$ <u>185.28</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>23,548.14</u>	\$ <u>23,548.14</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.

Facility Name & ID Number LaSalle HealthCare Center

0045740

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,694 B. General Construction Type: Exterior Brick Frame Wood 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).

N/A

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	<u>N/a</u>			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number LaSalle HealthCare Center

0045740

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	See Attached Schedules			1977	11,239		20			11,239	9
10	See Attached Schedules			1979	474		20			474	10
11	See Attached Schedules			1981	11,327	293	20	293		11,327	11
12	See Attached Schedules			1982	1,272	13	20	13		1,272	12
13	See Attached Schedules			1983	4,927	247	20	247		4,730	13
14	See Attached Schedules			1984	24,032	1,203	20	1,203		22,058	14
15	See Attached Schedules			1985	50,750	2,537	20	2,537		44,634	15
16	See Attached Schedules			1986	327	16	20	16		275	16
17	See Attached Schedules			1987	5,631	283	20	283		4,319	17
18	See Attached Schedules			1988	4,260	213	20	213		3,059	18
19	See Attached Schedules			1989	8,947	447	20	447		5,984	19
20	See Attached Schedules			1990	19,986	1,000	20	1,000		12,008	20
21	See Attached Schedules			1991	158,584	8,126	20	8,126		91,641	21
22	See Attached Schedules			1992	28,134	1,406	20	1,406		14,983	22
23	See Attached Schedules			1993	95,566	4,778	20	4,778		46,412	23
24	See Attached Schedules			1994	25,902	1,295	20	1,295		10,908	24
25											25
26	See Attached Schedules			1978	514		20			514	26
27	See Attached Schedules			1974	700		20			700	27
28	See Attached Schedules			1992	7,158	359	20	359		4,530	28
29	See Attached Schedules			1993	23,691	1,185	20	1,185		10,906	29
30	See Attached Schedules			1995	14,934	747	20	747		4,768	30
31											31
32	See Attached Schedules					8,901		8,901			32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number LaSalle HealthCare Center

0045740

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Parking Lot Repairs	1996	\$ 2,400	\$ 120	20	\$ 120	\$	\$ 768	37
38	Door & Frames	1996	1,679	84	20	84		542	38
39	Therapy Additions	1997	5,709	285	20	285		1,577	39
40	Therapy Room	1997	7,232	362	20	362		1,893	40
41	A/C repair	1996	1,120	56	20	56		380	41
42	Fire Alarm Systems	1996	14,927	746	20	746		4,777	42
43	Plumbing Repair	1996	772	39	20	39		240	43
44									44
45	Security System	1998	806	18	20	18		90	45
46	Exterior Sign/Flagpole	1998	3,221	34	20	34		170	46
47	Water Heater	1998	5,634	106	20	106		530	47
48									48
49	Allocation -Mariner Post Acute			38,347		38,347		153,388	49
50									50
51	1:90 Gal Water Heater	2000	4,700	470	10	470		1,723	51
52									52
53	7.5 Ton Carrier RoofTop Instl	2001	8,250	825	10	825		1,513	53
54	W/N/C RTU Condenser, Evapcoil	2001	4,842	323	15	323		538	54
55									55
56	Rlpc Commerical Water Heater	2002	6,401	631	10	631		631	56
57	6-Interior & 1-entrance Door	2002	15,415	257	20	257		257	57
58	Rprs Leak under Concrete Floor	2002	1,090	32	20	32		32	58
59	Repl Water Heater	2002	6,850	400	10	400		400	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 589,403	\$ 76,184		\$ 76,184	\$	\$ 476,190	70

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

Facility Name & ID Number LaSalle HealthCare Center

0045740

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	\$ 256,404	\$ 25,462	\$ 25,462	\$	10	\$ 224,101	71
72	Current Year Purchases	23,258	1,806	1,806		10	1,806	72
73	Fully Depreciated Assets	203,187					203,187	73
74								74
75	TOTALS	\$ 482,849	\$ 27,268	\$ 27,268	\$		\$ 429,094	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 1,072,252	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 103,452	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 103,452	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 905,284	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	O/H Allocation 06/01/1996	\$ 772	\$ 3	\$ 109	86
87	O/H Allocation 12/01/1996	1,531	6	178	87
88	O/H Allocation 08/01/1997	464	2	39	88
89	O/H Allocation 10/01/1997	215	1	17	89
90					90
91	TOTALS	\$ 2,982	\$ 12	\$ 343	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.

Facility Name & ID Number LaSalle HealthCare Center

0045740

Report Period Beginning:

01/01/2002

Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Nationalwide Health Properties

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:	<u>1973</u>	<u>101</u>	<u>07/01/89</u>	\$ <u>439,332</u>	<u>10</u>	<u>40</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>101</u>		\$ <u>439,332</u>			7

**

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 07/01/1989

Ending 06/01/2048

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

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* 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.

Facility Name & ID Number LaSalle HealthCare Center

0045740

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a	1612	hrs	\$ 30,678		\$	\$		1,612	\$ 30,678	1
2	Licensed Speech and Language Development Therapist	10a	144	hrs	4,324					144	4,324	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10a	580	hrs	37,037					580	37,037	4
5	Physician Care			visits								5
6	Dental Care	39		visits		1	46			1	46	6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy	39		# of prescripts				28,114			28,114	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Exceptional Care Program											12
13	Other (specify):											13
14	TOTAL				\$ 72,039	1	\$ 46	\$ 28,114		2,337	\$ 100,199	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 LaSalle HealthCare Center

0045740

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,150	\$	1
2	Cash-Patient Deposits	7,943		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	564,663		3
4	Supply Inventory (priced at)	15,020		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 588,776	\$	10
B. Long-Term Assets				
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	163,355		15
16	Equipment, at Historical Cost	139,003		16
17	Accumulated Depreciation (book methods)	(26,064)		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): <u>See attachment Schd 17.1</u>	2,259,208		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,535,502	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,124,278	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ (6,573)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,031		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,676		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,801		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See attached Schd 17.1</u>	75,052		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 181,987	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See attached Schd 17.1</u>	(190,569)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (190,569)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (8,582)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,132,856	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,124,274	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,911,109	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,911,109	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,502,597)	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)	\$ (3,502,597)	17
	B. Transfers (Itemize):		
18	Fresh Start Acctg Due to Bankruptcy	1,724,344	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,724,344	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,132,856	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LaSalle HealthCare Center# 0045740Report Period Beginning: 01/01/2002Ending: 12/31/2002**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required****classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,576,685	1
2	Discounts and Allowances for all Levels	(2,238,413)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,338,272	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	344,687	6
7	Oxygen	45,661	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 390,348	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	15,770	13
14	Non-Patient Meals	183	14
15	Telephone, Television and Radio	7,020	15
16	Rental of Facility Space		16
17	Sale of Drugs	70,731	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,606	19
20	Radiology and X-Ray		20
21	Other Medical Services	32,095	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 168,405	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Receipts</u>	(652)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (652)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,896,373	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	610,044	31
32	Health Care	1,652,919	32
33	General Administration	726,842	33
B. Capital Expense			
34	Ownership	4,308,136	34
C. Ancillary Expense			
35	Special Cost Centers	45,732	35
36	Provider Participation Fee	55,297	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,398,970	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,502,597)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,502,597)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

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

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

Facility Name & ID Number LaSalle HealthCare Center

0045740

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,967	2,142	\$ 49,852	\$ 23.27	1
2	Assistant Director of Nursing	2,029	2,210	42,310	19.14	2
3	Registered Nurses	13,346	14,534	279,504	19.23	3
4	Licensed Practical Nurses	12,586	13,707	238,325	17.39	4
5	Nurse Aides & Orderlies	68,030	74,087	713,847	9.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,336	2,573	54,891	21.33	7
8	Rehab/Therapy Aides	1,774	1,953	34,317	17.57	8
9	Activity Director	1,941	2,076	22,587	10.88	9
10	Activity Assistants	4,479	4,791	33,709	7.04	10
11	Social Service Workers	3,359	3,631	31,247	8.61	11
12	Dietician					12
13	Food Service Supervisor	1,891	2,026	31,399	15.50	13
14	Head Cook	7,113	7,619	59,627	7.83	14
15	Cook Helpers/Assistants	7,497	8,031	52,999	6.60	15
16	Dishwashers					16
17	Maintenance Workers	3,945	4,313	38,842	9.01	17
18	Housekeepers	10,391	11,468	75,842	6.61	18
19	Laundry	6,722	7,670	59,199	7.72	19
20	Administrator	1,925	2,092	61,140	29.23	20
21	Assistant Administrator					21
22	Other Administrative	1,881	2,044	31,877	15.60	22
23	Office Manager					23
24	Clerical	3,917	4,257	48,308	11.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,935	2,116	18,294	8.65	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Rounding</u>			(3)		33
34	TOTAL (lines 1 - 33)	159,064	173,340	\$ 1,978,113 *	\$ 11.41	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	150	\$ 5,923	1 - 3	35
36	Medical Director	96	9,000	9 - 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	336	15,300	10 - 7	38
39	Pharmacist Consultant	127	5,454	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	2,695	11 - 3	44
45	Social Service Consultant	45	2,612	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	799	\$ 40,984		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number LaSalle HealthCare Center# 0045740Report Period Beginning: 01/01/2002Ending: 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. Illinois HealthCare Association - \$4,055
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,001 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.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 55,297
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 223
- (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? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
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.

STATE OF ILLINOIS

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

Facility Name & ID Number LaSalle HealthCare Center # 0037671

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7

Amount

Infectious Waste Disposal <> Default <> Nursing Admin/Supv	8,039
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service <> Default <> Physical Plant	8,344
	<u>16,383</u>

Health Care Program - Line 15

Amount

N/A

	<u>0</u>
--	----------

General & Administrative - Line 27

Amount

N/A

	<u>0</u>
--	----------

Inservice Education - Line 23 Column 3 (over \$2,000)

Amount

N/A

	<u>0</u>
--	----------

STATE OF ILLINOIS

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

Facility Name & ID Number LaSalle HealthCare Center # 0045740

Meals - adjustment

36,011 Days (Total Patient days)

3 Mult (3 meals a day)

108033 Sub total

193 meals to employess (reported by facility)

108226 Add Sub

125,131 Divide -Pg 3, line 2, column 2

1.16 Cost per day

1.16 Cost per day

193 mult - meal to employees

223 = adjust for pg 2, line 2, column2

STATE OF ILLINOIS

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

Facility Name & ID Number LaSalle HealthCare Center # 0037671

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

<u>Ownership - Line 36</u>	<u>Amount</u>
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	3,806,261
Home office -Depreciation	8,935
	3,815,196
	3,815,196

<u>Ancillary Expenses - Line 43 -Column 2</u>	<u>Amount</u>
Ancillary Supplies <> Default <> Laboratory	109
	109
	109

<u>Ancillary Expenses - Line 43 -Column 3</u>	<u>Amount</u>
Contract Svcs - Chgbl <> Default <> Laboratory	1,243
Contract Svcs - Chgbl <> Default <> X/Ray	0
Professional Services Chgble <> Default <> X/Ray	0
Professional Services Chgble <> General / Other <> X/Ray	0
	1,243
	1,243

STATE OF ILLINOIS

Report Period:

Beginning: 01/01/2002

Page -6.1

Facility Name & ID Number: LaSalle HealthCare Center

0045740

Ending: 12/31/2002

**Related Illinois Nursing Homes
as of
12/31/2002**

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	Dixon HealthCare Center LaSalle Health & Rehabilitation Center Litchfield HeathCare Center Montebello HeathCare Center Nature Trail HealthCare Center Odin HeathCare Center Parkway HealthCare Center Mariner Health of Westchester	0040865 0037671 0037689 0031468 0039586 0039503 0040857 0042374

STATE OF ILLINOIS

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

Facility Name & ID Number LaSalle HealthCare Center # 0037671

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIIES

<u>OTHER CURRENT ASSETS:</u>	<u>AMOUNT</u>	
	Total	0
		Difference
Reconcile with schedule XV, line 9:	0	0

<u>OTHER NON-CURRENT ASSETS:</u>		
Excess Reorganized Value <>Excess Reorg Value <> Default	2,259,000	
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	208	
	Total	2,259,208
		Difference
Reconcile with schedule XV, line 23:	2,259,208	0

<u>OTHER CURRENT LIABILITIES:</u>	<u>AMOUNT</u>	
Misc Dedctns - Employee <> Other Decductions <> Default	(77)	
Accruals - Insurance <> Self Funded Ins Accr <> Default	(67,412)	
Accruals - Insurance <> Basic Life <> Default	(785)	
Accruals - Insurance <> Lt Dsbly <> Default	(294)	
Accruals - Insurance <> Executive Supp Life <> Default	(144)	
Accruals - Insurance <> Short Term Disability <> Default	(479)	
Accruals - Insurance <> Dependent Life <> Default-Dept	(15)	
Accruals - Insurance <> Accidental Death Dismemberment <> Defa	(1)	
Accruals - Insurance <> NES Insurance <> Default-Dept	(5,845)	
	Total	(75,052)
		Difference
Reconcile with schedule XV, line 36:	(75,052)	(0)

<u>OTHER NON-CURRENT LIABILITIES::</u>		
Intercompany - Revolver <> Default <> Default	190,569	
	Total	190,569
		Difference
Reconcile with schedule XV, line 43:	190,569	0

STATE OF ILLINOIS

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

Facility Name & ID Number LaSalle HealthCare Center # 0037671

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Personal Purchase Receipts <> Default <> Vending	0

Total 0 Difference

Reconcile with schedule XVII, line 28: 0 0

DESCRIPTIONS

Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	-
Personal Purchase Expense <> Default <> Patient Personal Purchase	652
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-

Total 652 Difference

Reconcile with schedule XVII, line 28a: 652 0