

Facility Name & ID Number PARK RIDGE TERRACE

0037291 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,710	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	54	TOTALS	54	19,710	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					8
9	SNF/PED					9
10	ICF	12,435	1,245		13,680	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,435	1,245		13,680	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.41%

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

_____ (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 08/01/91

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

YES Date 08/01/91 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

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 PARK RIDGE TERRACE # 0037291 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	83,166	3,789	4,586	91,541		91,541		91,541		1
2	Food Purchase		61,487		61,487	(6,358)	55,129	(267)	54,862		2
3	Housekeeping	26,787	9,251		36,038		36,038		36,038		3
4	Laundry	17,317	6,280		23,597		23,597		23,597		4
5	Heat and Other Utilities			51,126	51,126		51,126	536	51,662		5
6	Maintenance	24,065	11,678	10,348	46,091		46,091	(4,558)	41,533		6
7	Other (specify):*			3,197	3,197		3,197	86	3,283		7
8	TOTAL General Services	151,335	92,485	69,257	313,077	(6,358)	306,719	(4,203)	302,516		8
	B. Health Care and Programs										
9	Medical Director			7,000	7,000		7,000		7,000		9
10	Nursing and Medical Records	498,081	10,476	8,546	517,103		517,103	3,957	521,060		10
10a	Therapy										10a
11	Activities	7,390	820	3,300	11,510		11,510	(3,300)	8,210		11
12	Social Services	45,583			45,583		45,583		45,583		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	551,054	11,296	18,846	581,196		581,196	657	581,853		16
	C. General Administration										
17	Administrative	59,808			59,808		59,808	6,392	66,200		17
18	Directors Fees										18
19	Professional Services			78,990	78,990		78,990	(51,582)	27,408		19
20	Dues, Fees, Subscriptions & Promotions			8,445	8,445		8,445	(1,206)	7,239		20
21	Clerical & General Office Expenses	40,013	4,524	19,479	64,016		64,016	13,221	77,237		21
22	Employee Benefits & Payroll Taxes			126,600	126,600	6,358	132,958		132,958		22
23	Inservice Training & Education			854	854		854	202	1,056		23
24	Travel and Seminar							3,427	3,427		24
25	Other Admin. Staff Transportation			8,063	8,063		8,063	3,098	11,161		25
26	Insurance-Prop.Liab.Malpractice			8,000	8,000		8,000		8,000		26
27	Other (specify):*			4,057	4,057		4,057	2,593	6,650		27
28	TOTAL General Administration	99,821	4,524	254,488	358,833	6,358	365,191	(23,855)	341,336		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	802,210	108,305	342,591	1,253,106		1,253,106	(27,401)	1,225,705		29

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

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

Facility Name & ID Number **PARK RIDGE TERRACE**

#0037291

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

12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			11,374	11,374		11,374	5,619	16,993			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			208	208		208	103,767	103,975			32
33	Real Estate Taxes			12,380	12,380		12,380		12,380			33
34	Rent-Facility & Grounds			123,852	123,852		123,852	(108,465)	15,387			34
35	Rent-Equipment & Vehicles			10,730	10,730		10,730	2,530	13,260			35
36	Other (specify):*											36
37	TOTAL Ownership			158,544	158,544		158,544	3,451	161,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,565	29,565		29,565		29,565			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			29,565	29,565		29,565		29,565			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	802,210	108,305	530,700	1,441,215		1,441,215	(23,950)	1,417,265			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 PARK RIDGE TERRACE

0037291

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,546)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(267)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(3,678)	21		18
19	Entertainment		20		19
20	Contributions	(810)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,057)	27		24
25	Fund Raising, Advertising and Promotional	(565)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule <u>SEE ATTACHED</u>	(3,128)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,051)		\$	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)	(9,899)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (9,899)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (23,950)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

PARK RIDGE TERRACE

ID# 0037291

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING SALARY	\$ (3,128)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				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	Total	(3,128)		48
49				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **PARK RIDGE TERRACE**# **0037291**

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	(267)	0	0	0	0	0	0	0	0	0	0	(267)	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	536	0	0	0	0	0	0	0	0	0	536	5
6	Maintenance	0	(4,558)	0	0	0	0	0	0	0	0	0	(4,558)	6
7	Other (specify):*	0	86	0	0	0	0	0	0	0	0	0	86	7
8	TOTAL General Services	(267)	(3,936)	0	(4,203)	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	3,957	0	0	0	0	0	0	0	0	0	3,957	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,300)	0	0	0	0	0	0	0	0	0	(3,300)	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	657	0	657	16								
	C. General Administration													
17	Administrative	0	6,392	0	0	0	0	0	0	0	0	0	6,392	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(51,582)	0	0	0	0	0	0	0	0	0	(51,582)	19
20	Fees, Subscriptions & Promotions	(1,375)	169	0	0	0	0	0	0	0	0	0	(1,206)	20
21	Clerical & General Office Expenses	(6,806)	0	20,027	0	0	0	0	0	0	0	0	13,221	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	202	0	0	0	0	0	0	0	0	202	23
24	Travel and Seminar	0	0	3,427	0	0	0	0	0	0	0	0	3,427	24
25	Other Admin. Staff Transportation	0	0	3,098	0	0	0	0	0	0	0	0	3,098	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,057)	0	6,650	0	0	0	0	0	0	0	0	2,593	27
28	TOTAL General Administration	(12,238)	(45,021)	33,404	0	(23,855)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(12,505)	(48,300)	33,404	0	(27,401)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK RIDGE TERRACE# 0037291

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	(1,546)	0	203	6,962	0	0	0	0	0	0	0	5,619 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	50	103,717	0	0	0	0	0	0	0	103,767 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	3,387	(111,852)	0	0	0	0	0	0	0	(108,465) 34
35	Rent-Equipment & Vehicles	0	0	2,530	0	0	0	0	0	0	0	0	2,530 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(1,546)	0	6,170	(1,173)	0	3,451 37						
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(14,051)	(48,300)	39,574	(1,173)	0	(23,950) 45						

Facility Name & ID Number PARK RIDGE TERRACE

0037291

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
SEE ATTACHED LIST		LITCHFIELD TERRACE	LITCHFIELD	MAVIN	SKOKIE, IL	COUNSULTING
		ARC OF JACKSONVILLE	JACKSONVILLE	ENTERPRISES, LTD.		BOOKKEEPING
		PARKVIEW TERRACE	EAST MOLINE			
		SKYVIEW TERRACE	JACKSONVILLE	MAVIN NURSING	SKOKIE, IL	REAL ESTATE
		SPRINGFIELD TERRACE	SPRINGFIELD	ASSOC LTD		
		VANDALIA TERRACE	VANDALIA			

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 MAINTENANCE CONSULTAN	\$ 9,000			\$	\$ (9,000)	1
2	V	10 PSYCHO-SOCIAL CONSULTANT	3,000				(3,000)	2
3	V	11 ACTIVITIES CONSULTANT	3,300				(3,300)	3
4	V	19 ADMIN. /BKPP. FEES	36,750				(36,750)	4
5	V	19 ADMIN. /CONSULT. FEES	16,038				(16,038)	5
6	V							6
7	V	5 ELECTRICITY/GAS				536	536	7
8	V	6 MAINTENANCE				4,442	4,442	8
9	V	7 SCAVENGER				86	86	9
10	V	10 PSYCH-SOCIAL & NURSING CONSULT				6,957	6,957	10
11	V	17 ADMINISTRATIVE SALARIES				6,392	6,392	11
12	V	19 PROFESSIONAL FEES				1,206	1,206	12
13	V	20 ADVERTISING				169	169	13
14	Total		\$ 68,088			\$ 19,788	\$ * (48,300)	14

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

Facility Name & ID Number PARK RIDGE TERRACE

0037291

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	\$	MAVIN ENTERPRISES, LTD.		\$ 20,027	\$ 20,027	15
16	V	23	SEMINARS				202	202	16
17	V	24	TRAVEL				3,427	3,427	17
18	V	25	TRANSPORTATION				3,098	3,098	18
19	V	27	EMPLOYEE BENEFITS				6,650	6,650	19
20	V	30	DEPRECIATION (SL)				203	203	20
21	V	32	INTEREST				50	50	21
22	V	34	OFFICE RENT				3,387	3,387	22
23	V	35	EQUIPMENT RENT				2,530	2,530	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			\$			\$ 39,574	\$ * 39,574	39

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

Facility Name & ID Number PARK RIDGE TERRACE

0037291

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 111,852	MAVIN NURSING ASSOC. LTD. PARTNERSHIP		\$	(111,852)	15
16	V	30	DEPRECIATION				6,962	6,962	16
17	V	32	INTEREST				103,717	103,717	17
18	V								18
19	V								19
20	V								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			\$ 111,852			\$ 110,679	\$ * (1,173)	39

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

Facility Name & ID Number PARK RIDGE TERRACE # 0037291 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									\$		1	
2											2	
3											3	
4											4	
5											5	
6											6	
7			SEE ATTACHED SCHEDULE									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 PARK RIDGE TERRACE

0037291 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization MAVIN ENTERPRISES, LTD.
 Street Address 3845 OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-0100
 Fax Number (847) 679-0647

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	5	ELECTRICITY/GAS	PATIENT DAYS	154,308	7	\$ 6,048	\$ 13,680	\$ 536	1
2	6	MAINTENANCE	PATIENT DAYS	154,308	7	50,100	13,680	4,442	2
3	7	SCAVENGER	PATIENT DAYS	154,308	7	966	13,680	86	3
4	10	PSYCH-SOCIAL & NURSING	PATIENT DAYS	154,308	7	78,470	13,680	6,957	4
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	154,308	7	72,100	13,680	6,392	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	154,308	7	13,601	13,680	1,206	6
7	20	ADVERTISING	PATIENT DAYS	154,308	7	1,910	13,680	169	7
8	21	TOTAL OFFICE	PATIENT DAYS	154,308	7	225,899	174,769	20,027	8
9	23	SEMINARS	PATIENT DAYS	154,308	7	2,280	13,680	202	9
10	24	TRAVEL	PATIENT DAYS	154,308	7	38,655	13,680	3,427	10
11	25	TRANSPORTATION	PATIENT DAYS	154,308	7	34,943	13,680	3,098	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	154,308	7	75,013	13,680	6,650	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	154,308	7	2,285	13,680	203	13
14	32	INTEREST	PATIENT DAYS	154,308	7	566	13,680	50	14
15	34	OFFICE RENT	PATIENT DAYS	154,308	7	38,200	13,680	3,387	15
16	35	EQUIPMENT RENT	PATIENT DAYS	154,308	7	28,543	13,680	2,530	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 669,579	\$ 246,869		\$ 59,362	25

Facility Name & ID Number PARK RIDGE TERRACE

0037291 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 MAVIN NURSING ASSOCIATES LTD.
 Street Address 3845 OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-0100
 Fax Number (847) 679-0647

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	RELATED PARTY						\$	\$			\$	1					
2	MAVIN NURSING ASSOC LTD											2					
3	GRAND NATIONAL BANK		X	MORTGAGE	DEMAND	12/99	1,250,000	1,200,635	12/14/04	8.5600	103,717	3					
4												4					
5	MGMT CO ALLOCATION										50	5					
Working Capital																	
6	A.I. CREDIT CORPORATION		X	INSURANCE FINANCE							208	6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 1,250,000	\$ 1,200,635			\$ 103,975	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 1,250,000	\$ 1,200,635			\$ 103,975	15					

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

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

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

Facility Name & ID Number PARK RIDGE TERRACE# 0037291 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	26,296	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.)			\$	19,147	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(7,149)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	19,529	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.			\$	12,380	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
1997	<u>17,010</u>	<u>8</u>			
1998	<u>17,678</u>	<u>9</u>			
1999	<u>17,768</u>	<u>10</u>			
2000	<u>18,954</u>	<u>11</u>			
2001	<u>19,147</u>	<u>12</u>			
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL.					
THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.					
			FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

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

IMPORTANT NOTICE

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

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

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

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARK RIDGE TERRACE COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0037291

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cos

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-01-252-012</u>	<u>NURSING HOME</u>	\$ <u>18,285.00</u>	\$ <u>18,285.00</u>
2. <u>11-01-177-016</u>	<u>NURSING HOME</u>	\$ <u>862.00</u>	\$ <u>862.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>19,147.00</u>	\$ <u>19,147.00</u>

B. Real Estate Tax Cost Allocation:

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

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

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number PARK RIDGE TERRACE

0037291 Report Period Beginning:

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				\$	1
2	<u>MAVIN NURSING</u>			<u>45,219</u>	2
3	TOTALS			\$ 45,219	3

Facility Name & ID Number **PARK RIDGE TERRACE**

0037291

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	54		1991		\$ 219,321	\$ 6,962	31.5	\$ 6,962	\$	\$ 78,950	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1992		5,735	199	20	287	88	2,240	9
10	VARIOUS		1993		13,400	344	20	667	323	5,277	10
11	VARIOUS		1994		1,854	48	20	93	45	784	11
12	VARIOUS		1995		4,453	114	20	223	109	1,636	12
13	FLOORING/CARPET		1996		1,791	46	20	90	44	630	13
14	HOT WATER HEATER		1996		1,009	26	20	50	24	350	14
15	VINYL TILE		1996		875	22	20	44	22	293	15
16	VINYL TILE		1996		1,309	34	20	65	31	428	16
17	COMPRESSOR		1996		1,422	36	20	71	35	450	17
18	ROOF REPAIRS		1996		2,000	51	20	100	49	608	18
19	WALL COVERING		1996		608	16	20	30	14	197	19
20	ROOF-SITTING ROOM		1997		9,193	196	20	460	264	2,683	20
21	FLOOR TILE		1997		2,256	58	20	113	55	631	21
22	NURSING CALL SYSTEM REPAIRS		1997		1,834	47	20	92	45	483	22
23	NURSING CALL SYSTEM REPAIRS		1997		3,265	84	20	163	79	869	23
24	NURSING CALL SYSTEM REPAIRS		1997		1,845	47	20	92	45	483	24
25	NURSING CALL SYSTEM REPAIRS		1997		1,140	29	20	57	28	299	25
26	NURSING CALL SYSTEM REPAIRS		1997		1,410	36	20	71	35	373	26
27	NURSING CALL SYSTEM REPAIRS		1997		1,230	32	20	62	30	326	27
28	NURSING CALL SYSTEM REPAIRS		1997		2,082	53	20	104	51	544	28
29	ROOF		1999		5,000	128	20	250	122	1,000	29
30	INSTALLED OF NEW DURO-LAST ROOF		2000		70,200	2,553	27.5	2,553		7,233	30
31	BACK FLOW PREVENTER FOR MAIN WATER LINE		2000		2,750	100	27.5	100		250	31
32	INSTALLED NEW HEAT EXCHANGE & CYCLED UNIT		2000		1,871	68	27.5	68		170	32
33	COMMERCIAL SECURITY SYSTEM		2000		6,315	230	27.5	230		575	33
34	INSTALLATION OF THE CCTV SYSTEM		2001		3,881	141	27.5	141		211	34
35	FLOORING-BATHROOMS, RESIDENT ROOMS		2001		4,448	162	27.5	162		243	35
36	NEW SIDEWALK		2002		11,846	233	27.5	233		233	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number **PARK RIDGE TERRACE**

0037291

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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 384,343	\$ 12,095		\$ 13,633	\$ 1,538	\$ 108,449	70

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

Facility Name & ID Number PARK RIDGE TERRACE # 0037291 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	\$ 27,599	\$ 4,040	\$ 2,607	\$ (1,433)	8-10 YR	\$ 13,245	71
72	Current Year Purchases	11,003	2,201	550	(1,651)	10 YR	550	72
73	Fully Depreciated Assets		203	203				73
74	<u>MGMT CO ALLOCATION</u>							74
75	TOTALS	\$ 38,602	\$ 6,444	\$ 3,360	\$ (3,084)		\$ 13,795	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	<u>FACILITY BUSINESS</u>	<u>VEHICLE REHAB</u>	1994	\$ 6,539	\$	\$	\$		\$ 6,539	76
77										77
78										78
79										79
80	TOTALS			\$ 6,539	\$	\$	\$		\$ 6,539	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)	\$ 474,703	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,539	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 16,993	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,546)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 128,783	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 2,081

Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>ADMINISTRATIVE</u>	<u>2002 NISSAN ALTIMA</u>	\$ <u>640.00</u>	\$ <u>8,649</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 640.00	\$ 8,649	21

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

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

Facility Name & ID Number PARK RIDGE TERRACE # 0037291 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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits			N/A				6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$	\$		\$	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 **PARK RIDGE TERRACE**

0037291

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

Ending:

12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2002** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 6,195	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	272,904		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,394		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	777,875		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,071,368	\$	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	165,022		15
16	Equipment, at Historical Cost	45,141		16
17	Accumulated Depreciation (book methods)	(49,550)		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): DEPOSITS	4,498		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 165,111	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,236,479	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 315,414	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,073		28
29	Short-Term Notes Payable	980,638		29
30	Accrued Salaries Payable	26,882		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,480		31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,529		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,389,016	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,389,016	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (152,537)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,236,479	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 117,548	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	32	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 117,580	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(270,117)	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)	\$ (270,117)	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)	\$ (152,537)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **PARK RIDGE TERRACE**

0037291

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

Ending: **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	\$ 1,171,098	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,171,098	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		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			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,171,098	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	313,077	31
32	Health Care	581,196	32
33	General Administration	358,833	33
B. Capital Expense			
34	Ownership	158,544	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	29,565	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,441,215	40
41	Income before Income Taxes (line 30 minus line 40)**	(270,117)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (270,117)	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 **PARK RIDGE TERRACE**

0037291

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	2,032	2,210	\$ 56,316	\$ 25.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	452	505	11,045	21.87	3
4	Licensed Practical Nurses	8,847	9,356	178,791	19.11	4
5	Nurse Aides & Orderlies	23,286	25,052	227,971	9.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,186	1,230	7,390	6.01	10
11	Social Service Workers	3,632	3,697	45,583	12.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,693	10,044	83,166	8.28	15
16	Dishwashers					16
17	Maintenance Workers	2,135	2,232	24,065	10.78	17
18	Housekeepers	4,041	4,272	26,787	6.27	18
19	Laundry	2,749	2,825	17,317	6.13	19
20	Administrator	1,807	2,054	59,808	29.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,199	3,486	36,885	10.58	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(specify)					32
33	Other(specify) SEE ATTACHED	1,424	1,440	27,086	18.81	33
34	TOTAL (lines 1 - 33)	64,483	68,403	\$ 802,210 *	\$ 11.73	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	M	\$ 4,586	1-3	35
36	Medical Director	O	7,000	9-3	36
37	Medical Records Consultant	N	2,008	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	520	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	3,300	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47	PSYCHO SOCIAL CONSULTANT	S	3,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,414		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	93	2,850	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	93	\$ 2,850		53

Facility Name & ID Number PARK RIDGE TERRACE**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$2439
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 29,565
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. \$ 6,358 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	4,586
	REPAIRS & MAINTENANCE	0
		0
		4,586
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	17,269
	ELECTRICITY	18,550
	WATER	14,904
	CABLE TV - LOBBY	403
		0
		51,126
6	MAINTENANCE	
	GROUNDS MAINTENANCE	13
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE CONSULTANT	9,000
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,220
	FIRE SERVICE	115
		0
		0
		0
		10,348
7	OTHER	
	SCAVENGER	2,717
	SECURITY SERVICE	480
		3,197
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	7,000
		7,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	2,850
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	3,000
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,008
	PHARMACY CONSULTANT XVIII B 39-2	520
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	168
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		8,546
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,300
		0
		3,300
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	6,559
	ADMINISTRATIVE CONSULTANTS XIX C	16,038
	PROFESSIONAL FEES XIX C	19,643
	BOOKKEEPING/ADMINISTRATIVE SERVICES	36,750
20	FEES,SUBSCRIPTIONS,PROMOTIONS	78,990
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	565
	EMPLOYEE WANT ADS XIX F	3,817
	CONTRIBUTIONS VI 20 XIX F	330
	DUES & SUBSCRIPTIONS XIX F	2,549
	LICENSES & PERMITS XIX F	704
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	480
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
21	CLERICAL & GENERAL OFFICE EXPENSES	8,445
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,850
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	3,678
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,840
	MESSENGER SERVICE	111
		0
		19,479

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	63,914
	UNEMPLOYMENT COMPENSATION XIX D	16,096
	WORKERS COMPENSATION INSURANC XIX D	32,400
	HOSPITALIZATION INSURANCE XIX D	10,293
	EMPLOYEE BENEFITS - OTHER XIX D	3,897
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
23	INSERVICE TRAINING & EDUCATION	126,600
	EDUCATION & SEMINARS	854
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,063
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	8,000
27	OTHER	
	BAD DEBTS VI 24	4,057
		0
		4,057

GRAND TOTAL COLUMN 3 OTHER

342,591

PARK RIDGE TERRACE
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2002

TOTAL FOOD PURCHASE	61,487	PATIENT MEALS	41040
LESS SALES TAX	(267)	ADD EMPLOYEE MEALS	4745
	-----		-----
NET FOOD	61,220	TOTAL MEALS/YEAR	45785
TOTAL PATIENT CENSUS	13,680	NET FOOD	61220
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	45785

TOTAL PATIENT MEALS	41040	COST PER MEAL	1.34
		TIME EMPLOYEE MEALS	4745
ADD # EMPLOYEE MEALS/DAY	13		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	6358
	-----		=====
TOTAL EMPLOYEE MEALS	4745		