

Facility Name & ID Number PEDIATRIC REHABILITATION INSTITUTE# 0042788 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	<u>150</u>	Skilled Pediatric (SNF/PED)	<u>150</u>	<u>54,750</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,750</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	<u>21,372</u>		<u>824</u>	<u>22,196</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,372</u>		<u>824</u>	<u>22,196</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.54%

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

497 (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)

NONEF. 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 09/30/97

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

YES Date 09/30/97 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 PEDIATRIC REHABILITATION INSTITU # 0042788 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	142,123	13,734	12,024	167,881		167,881		167,881		1
2	Food Purchase		144,635		144,635	(14,235)	130,400	(335)	130,065		2
3	Housekeeping	106,821	14,094		120,915		120,915		120,915		3
4	Laundry	38,434	7,578	3,405	49,417		49,417		49,417		4
5	Heat and Other Utilities			99,044	99,044		99,044		99,044		5
6	Maintenance	56,650	7,650	29,681	93,981		93,981		93,981		6
7	Other (specify):*			5,204	5,204		5,204		5,204		7
8	TOTAL General Services	344,028	187,691	149,358	681,077	(14,235)	666,842	(335)	666,507		8
	B. Health Care and Programs										
9	Medical Director			29,400	29,400		29,400		29,400		9
10	Nursing and Medical Records	1,687,209	211,168	569,578	2,467,955		2,467,955		2,467,955		10
10a	Therapy	344,947	758		345,705		345,705		345,705		10a
11	Activities	37,110	7,023		44,133		44,133		44,133		11
12	Social Services										12
13	Nurse Aide Training										13
14	Program Transportation			954	954		954		954		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,069,266	218,949	599,932	2,888,147		2,888,147		2,888,147		16
	C. General Administration										
17	Administrative	186,924		300,000	486,924		486,924		486,924		17
18	Directors Fees										18
19	Professional Services			57,826	57,826		57,826		57,826		19
20	Dues, Fees, Subscriptions & Promotions			45,169	45,169		45,169	(37,802)	7,367		20
21	Clerical & General Office Expenses	94,374	12,311	35,852	142,537		142,537	(4,373)	138,164		21
22	Employee Benefits & Payroll Taxes			424,064	424,064	14,235	438,299		438,299		22
23	Inservice Training & Education			589	589		589		589		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			22,333	22,333		22,333		22,333		25
26	Insurance-Prop.Liab.Malpractice			10,514	10,514		10,514		10,514		26
27	Other (specify):*										27
28	TOTAL General Administration	281,298	12,311	896,347	1,189,956	14,235	1,204,191	(42,175)	1,162,016		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,694,592	418,951	1,645,637	4,759,180		4,759,180	(42,510)	4,716,670		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			60,048	60,048		60,048	172,163	232,211			30
31	Amortization of Pre-Op. & Org.			190	190		190		190			31
32	Interest			60,730	60,730		60,730	287,660	348,390			32
33	Real Estate Taxes			112,868	112,868		112,868		112,868			33
34	Rent-Facility & Grounds			230,437	230,437		230,437	(230,437)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			464,273	464,273		464,273	229,386	693,659			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,826	141,532	214,358		214,358		214,358			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			287,566	287,566		287,566		287,566			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		72,826	429,098	501,924		501,924		501,924			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,694,592	491,777	2,539,008	5,725,377		5,725,377	186,876	5,912,253			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 PEDIATRIC REHABILITATION INSTITUTE

0042788

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	19,950	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	(335)	2		13
14	Non-Care Related Interest	(233)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(900)	20		17
18	Fines and Penalties	(4,373)	21		18
19	Entertainment				19
20	Contributions	(270)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,356)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(27,276)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,793)		\$	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)	209,669		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 209,669		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 186,876		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

STATE OF ILLINOIS
PEDIATRIC REHABILITATION INSTITUTE

ID# 0042788

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PEDIATRIC REHABILITATION INSTITUTE

0042788

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	(335)	0	0	0	0	0	0	0	0	0	0	(335)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(335)	0	0	0	0	0	0	0	0	0	0	(335)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(37,802)	0	0	0	0	0	0	0	0	0	0	(37,802)	20
21	Clerical & General Office Expenses	(4,373)	0	0	0	0	0	0	0	0	0	0	(4,373)	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(42,175)	0	0	0	0	0	0	0	0	0	0	(42,175)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,510)	0	0	0	0	0	0	0	0	0	0	(42,510)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PEDIATRIC REHABILITATION INSTITUTE

0042788

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	19,950	152,213	0	0	0	0	0	0	0	0	0	172,163	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(233)	287,893	0	0	0	0	0	0	0	0	0	287,660	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(230,437)	0	0	0	0	0	0	0	0	0	(230,437)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	19,717	209,669	0	229,386	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)	(22,793)	209,669	0	186,876	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
CHARLOTTE KOHN	50	BIRCHWOOD PLAZA/DOBSON PLAZA	CHGO/EVANSTON	CDS LLC	MORTON GROVE	REAL ESTATE
DAVID FRIEDMAN	10					RENTAL
SUSAN FRIEDMAN	30					
JUDITH FRIEDMAN	10					

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	34 RENT	\$ 230,437	CDS LLC		\$	\$ (230,437)	1
2	V	30 SL DEPRECIATION		" "		152,213	152,213	2
3	V	32 INTEREST		" "		287,893	287,893	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 230,437			\$ 440,106	\$ * 209,669	14

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

Facility Name & ID Number PEDIATRIC REHABILITATION INSTITU # 0042788 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	CHARLOTTE KOHN	MANAGEMENT	MANAGEMENT	50.00	394,849	10	15.00	MGMT FEES	\$ 300,000	17-3	1
2	ASHER KOHN	ASST. ADMIN.	ADMIN.	0.00	0	40	100.00	SALARY	79,533	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 379,533		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 PEDIATRIC REHABILITATION INSTITUTE # 0042788 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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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 - CDS LLC:						\$	\$			\$	1					
2	MIDWEST BANK		X	MORTGAGE	\$27,156.00	11/98	3,750,000	3,597,630	11/03	7.76	284,418	2					
3	LOAN COSTS		X	LOAN COSTS 5 YRS AMORT		11/98	17,375	2,896	11/03		3,475	3					
4												4					
5												5					
Working Capital																	
6	MIDWEST BANK		X	LINE OF CREDIT		5/1/99	1,035,000	1,035,000	6/5/00	9.5	60,375	6					
7	INSURANCE FINANCING		X	INSURANCE FINANCING							122	7					
8												8					
9	TOTAL Facility Related				\$27,156.00		\$ 4,802,375	\$ 4,635,526			\$ 348,390	9					
B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES							233	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 233	14					
15	TOTALS (line 9+line14)						\$ 4,802,375	\$ 4,635,526			\$ 348,623	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 PEDIATRIC REHABILITATION INSTITUTE# 0042788 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.	\$	108,330	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.)			\$	110,048	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,718	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	111,150	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.			\$	112,868	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	58,030	8	
		1998	119,630	9	
		1999	88,738	10	
		2000	107,258	11	
		2001	110,048	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% 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 PEDIATRIC REHABILITATION INSTITUTE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042788

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>11-29-302-016-0000</u>	<u>NURSING HOME</u>	\$ <u>6,851.34</u>	\$ <u>6,851.34</u>
2. <u>11-29-302-017-0000</u>	<u>NURSING HOME</u>	\$ <u>6,599.58</u>	\$ <u>6,599.58</u>
3. <u>11-29-302-018-0000</u>	<u>NURSING HOME</u>	\$ <u>10,364.35</u>	\$ <u>10,364.35</u>
4. <u>11-29-302-019-0000</u>	<u>NURSING HOME</u>	\$ <u>19,715.52</u>	\$ <u>19,715.52</u>
5. <u>11-29-302-020-0000</u>	<u>NURSING HOME</u>	\$ <u>19,092.54</u>	\$ <u>19,092.54</u>
6. <u>11-29-302-022-0000</u>	<u>NURSING HOME</u>	\$ <u>47,425.03</u>	\$ <u>47,425.03</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>110,048.36</u>	\$ <u>110,048.36</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 PEDIATRIC REHABILITATION INSTITUTE

0042788 Report Period Beginning:

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,316 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

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: 2,868 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 190 4. Dates Incurred: 1997

Nature of Costs: ORGANIZATION EXPENSE
(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	<u>RELATED PARTY - CDS LTD</u>			\$	1
2	<u>NURSING HOME</u>		<u>1997</u>	<u>139,000</u>	2
3	TOTALS			\$ 139,000	3

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		RELATED PARTY - CDS LLC:			\$	\$		\$	\$	\$	4
5	150		1997	1969	3,769,250	125,642	30	125,642		837,612	5
6											6
7											7
8											8
		Improvement Type**									
9		TILING	1997		70,845	2,576	15	4,723	2,147	25,976	9
10		HEATING & COOLING TOWER	1997		14,806	538	15	987	449	5,429	10
11		CONSTRUCTION	1997		38,860	1,413	15	2,591	1,178	14,250	11
12		SPRINKLERS	1997		7,081	257	15	472	215	2,596	12
13		DROP CEILING	1997		8,250	300	15	550	250	3,025	13
14		FIRE DOORS	1997		5,726	208	15	382	174	2,101	14
15		TECHNO HYDRO	1997		4,035	147	15	269	122	1,480	15
16		CDS COMMUNI	1998		1,456	53	15	97	44	437	16
17		WOOD PRODUCTS - 1ST FLOOR	1998		5,000	182	15	333	151	1,499	17
18		AIR CONDITIONER	1998		106,087	3,857	10	10,609	6,752	47,740	18
19		IMOROVEMENTS	1998		3,600	131	15	240	109	1,080	19
20		WOOD PRODUCTS	1998		12,370	450	15	825	375	3,712	20
21		NURSE STATION - 2ND & 3RD FLOOR	1998		9,165	333	15	611	278	2,750	21
22		DAMPER EQUIPMENT	1998		6,048	220	15	403	183	1,814	22
23		FIRE PLACE	1998		1,346	49	15	90	41	405	23
24		DAMPER EQUIPMENT	1998		898	33	15	60	27	270	24
25		PLUMBING FIXTURES	1998		403	15	15	27	12	121	25
26		GENERATOR TANK	1998		6,062	220	15	404	184	1,818	26
27		WALL REPLACEMENT	1998		265	10	15	18	8	81	27
28		FIRE ALARM SYSTEM	1998		75,690	2,752	15	5,046	2,294	22,707	28
29		FIRE DOORS/PLUMBING REPAIRS/CUBICLE TRACK	1999		7,520	273	27.5	273		927	29
30		AIR CONDITIONER	1999		33,277	1,210	27.5	1,210		4,790	30
31		ELEVATOR DOORS	1999		6,400	233	27.5	233		709	31
32		CABINETRY & CUBICLE CURTAINS	2000		5,563	202	27.5	202		581	32
33		WALK-IN FREEZER/REFRIGERATOR	2000		7,395	269	27.5	269		706	33
34		CARPETING	2001		5,376	195	27.5	195		290	34
35											35
36											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.

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
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)	\$	\$		\$	\$	\$	70
		4,212,774	141,768		156,761	14,993	984,906	

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

Facility Name & ID Number PEDIATRIC REHABILITATION INSTITUTE # 0042788 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	\$ 455,249	\$ 43,922	\$ 48,879	\$ 4,957	5-15 YRS	\$ 359,556	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	2,280					2,280	73
74	SL DEPN - RELATED PARTY - CDS LLC	186,000	26,571	26,571		5 YRS	178,406	74
75	TOTALS	\$ 643,529	\$ 70,493	\$ 75,450	\$ 4,957		\$ 540,242	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)	\$ 4,995,303	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 212,261	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 232,211	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,950	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,525,148	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: \$ _____ 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

* 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 PEDIATRIC REHABILITATION INSTITUTE # 0042788 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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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	39-3	visits			253			253	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	39-2 / 39-3				141,279	72,826		214,105	12
13	Other (specify):					RESP ST & PT	O2 & EQP REN			13
14	TOTAL			\$		\$ 141,532	\$ 72,826		\$ 214,358	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 **PEDIATRIC REHABILITATION INSTITUTE**# **0042788**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	\$ (135,649)	\$ (129,649)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,399,568	1,399,568	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,036	25,036	6
7	Other Prepaid Expenses	24,628	24,628	7
8	Accounts Receivable (owners or related parties)	750,680	750,680	8
9	Other(specify): R.E.TAX ESCROW			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,064,263	\$ 2,070,263	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		139,000	13
14	Buildings, at Historical Cost		3,769,250	14
15	Leasehold Improvements, at Historical Cost	443,523	443,523	15
16	Equipment, at Historical Cost	457,530	643,530	16
17	Accumulated Depreciation (book methods)	(456,240)	(1,388,310)	17
18	Deferred Charges		2,896	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 444,813	\$ 3,609,889	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,509,076	\$ 5,680,152	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 458,497	\$ 458,497	26
27	Officer's Accounts Payable	1,700,000	1,700,000	27
28	Accounts Payable-Patient Deposits	4,594	4,594	28
29	Short-Term Notes Payable	1,035,000	1,035,000	29
30	Accrued Salaries Payable	101,657	101,657	30
31	Accrued Taxes Payable (excluding real estate taxes)	39,118	39,118	31
32	Accrued Real Estate Taxes(Sch.IX-B)		111,150	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	DUE TO CDS LLC	394,150		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,733,016	\$ 3,450,016	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,597,630	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)	\$	\$ 3,597,630	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,733,016	\$ 7,047,646	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,223,940)	\$ (1,367,494)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,509,076	\$ 5,680,152	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,323,977)	1
2	Restatements (describe):		2
3	POST-CLOSING MEMBERS CONTRIBUTIONS	45,000	3
4	ROUNDING	3	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,278,974)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,094,966)	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) MEMBERS CONTRIBUTIONS	1,150,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 55,034	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)	\$ (1,223,940)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,632,389	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,632,389	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	PARKING FEES	4,688	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,688	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,637,077	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	681,077	31
32	Health Care	2,888,147	32
33	General Administration	1,189,956	33
B. Capital Expense			
34	Ownership	464,273	34
C. Ancillary Expense			
35	Special Cost Centers	214,358	35
36	Provider Participation Fee	287,566	36
D. Other Expenses (specify):			
37	WAGE SETTLEMENT	6,666	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,732,043	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,094,966)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,094,966)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 **PEDIATRIC REHABILITATION INSTITUTE**

0042788

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	2,104	2,224	\$ 80,746	\$ 36.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,029	23,391	661,893	28.30	3
4	Licensed Practical Nurses	4,486	4,839	115,423	23.85	4
5	Nurse Aides & Orderlies	70,209	74,098	796,971	10.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,580	17,985	344,947	19.18	8
9	Activity Director					9
10	Activity Assistants	3,948	4,172	37,110	8.90	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,902	2,998	53,775	17.94	13
14	Head Cook	4,037	4,345	37,012	8.52	14
15	Cook Helpers/Assistants	7,169	7,498	51,336	6.85	15
16	Dishwashers					16
17	Maintenance Workers	4,143	4,827	56,650	11.74	17
18	Housekeepers	13,676	14,435	106,821	7.40	18
19	Laundry	5,200	5,598	38,434	6.87	19
20	Administrator	2,080	2,240	71,050	31.72	20
21	Assistant Administrator	3,840	4,116	115,874	28.15	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,499	6,932	94,374	13.61	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 Ca <u>ADMITTING</u>	1,836	2,114	32,176	15.22	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,738	181,812	\$ 2,694,592 *	\$ 14.82	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	\$ 10,205	1-3	35
36	Medical Director	O	29,400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,236	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	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	<u>NEUROLOGIST</u>		10,249	10-3	47
48	<u>MR/DD CONSULTANT</u>		28,120	10-3	48
49	TOTAL (lines 35 - 48)		\$ 83,210		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	12,396	\$ 272,713	10-3	50
51	Licensed Practical Nurses	4,731	85,153	10-3	51
52	Nurse Aides	20,852	168,107	10-3	52
53	TOTAL (lines 50 - 52)	37,978	\$ 525,973		53

Facility Name & ID Number PEDIATRIC REHABILITATION INSTITUTE

0042788

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (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? _____
- (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 _____ 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. \$ 287,566
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. \$ 14,235 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. \$ _____
- (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	10,205
	REPAIRS & MAINTENANCE	1,819
		0
		12,024
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,405
		0
		3,405
5	HEAT & OTHER UTILITIES	
	GAS HEAT	31,238
	ELECTRICITY	60,475
	WATER	7,331
	CABLE TV - LOBBY	0
		0
		99,044
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,935
	PAINTING & DECORATING	421
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	850
	ELEVATOR MAINTENANCE & REPAIR	15,807
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,430
	FIRE SERVICE	6,238
		0
		0
		0
		29,681
7	OTHER	
	SCAVENGER	5,204
	SECURITY SERVICE	0
		5,204
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	29,400
		29,400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	525,973
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	5,236
	UTILIZATION REVIEW FEES XVIII B -2	0
	NEUROLOGIST XVIII B 47-2	10,249
	MR/DD CONSULTANT XVIII B 48-2	28,120
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		569,578
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
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
	CLERGY	0
		0
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	954
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	300,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	2,924
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	54,902
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	57,826
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	9,356
	EMPLOYEE WANT ADS XIX F	4,291
	CONTRIBUTIONS VI 20 XIX F	150
	DUES & SUBSCRIPTIONS XIX F	60
	LICENSES & PERMITS XIX F	2,882
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	27,276
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	900
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	120
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	134
21	CLERICAL & GENERAL OFFICE EXPENSES	45,169
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	215
	EQUIPMENT REPAIR & MAINTENANCE	4,662
	OUTSIDE CLERICAL SERVICES	
	PENALTIES / OVERDRAFT CHARGES VI 18	4,373
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	300
	TELEPHONE	26,302
	MESSENGER SERVICE	0
		0
		35,852

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	206,071
	UNEMPLOYMENT COMPENSATION XIX D	20,359
	WORKERS COMPENSATION INSURANC XIX D	52,774
	HOSPITALIZATION INSURANCE XIX D	128,024
	EMPLOYEE BENEFITS - OTHER XIX D	2,885
	EMPLOYEE PHYSICAL EXAMS XIX D	50
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	9,297
	CHICAGO HEAD TAX XIX D	4,604
		424,064
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	589
		589
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	22,333
		22,333
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	10,514
		10,514
27	OTHER	
	BAD DEBTS VI 24	0
		0
		0

GRAND TOTAL COLUMN 3 OTHER

1,645,637

PEDIATRIC REHABILITATION INSTITUTE
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2002

TOTAL FOOD PURCHASE	144,635	PATIENT MEALS	66588
LESS SALES TAX	(335)	ADD EMPLOYEE MEALS	7300
	-----		-----
NET FOOD	144,300	TOTAL MEALS/YEAR	73888
TOTAL PATIENT CENSUS	22,196	NET FOOD	144300
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	73888

TOTAL PATIENT MEALS	66588	COST PER MEAL	1.95
		TIME EMPLOYEE MEALS	7300
ADD # EMPLOYEE MEALS/DAY	20		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	14235
	-----		=====
TOTAL EMPLOYEE MEALS	7300		

PEDIATRIC REHABILITATION INSTITUTE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S									4,616,040	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	2,888,147	424,064	319,144	49,417	312,516	765,892	287,566	464,273		2,694,592
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	0		0			0		0		
CABLE TV			0			0				
CONTRACT NURSING										525,973
INTEREST INCOME							0			
PARKING							(4,688)			
EMPLOYEE PHYSICAL EXAMS		(50)				50				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(300,000)		300,000		
O2 INCOME										
BAD DEBTS						0	0			
DISCOUNTS LOST							0			
ANCILLARIES	214,358							0		
SETTLEMENT						6,666				
RECLASSIFIED SALARIES	(32,176)	0	0	0	0	32,176	0	0		
PROFIT SHARING	0	(9,297)	0	0	0	0	9,297	0		
PRIOR EXPENSES	0	0	0	0	0	0	(16,349)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	3,070,329	414,717	319,144	49,417	312,516	504,784	275,826	764,273	5,711,006	3,220,565
PER FINANCIAL STATEMENTS	3,070,329	414,717	319,144	49,417	312,516	504,784	275,826	764,273	(1,094,966)	3,220,565
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									(1,094,966)	

PEDIATRIC REHABILITATION INSTITUTE - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		54,750			54750		0	54900			
CENSUS DAYS		22,196			22770		(574)	22409			
OCCUPANCY %		40.54%			41.59%			40.82%			
SALARIES											
TOTAL General Services	8-1	344,028	5.82%	15.50	339285	5.85%	14.90	4,743	280822	5.19%	12.53
Social Services	12-1	0	0.00%	0.00	134029	2.31%	5.89	(134,029)	135398	2.50%	6.04
TOTAL Health Care and Programs	16-1	2,069,266	35.00%	93.23	1601714	27.60%	70.34	467,552	1258409	23.25%	56.16
Clerical & General Office Expenses	21-1	94,374	1.60%	4.25	119408	2.06%	5.24	(25,034)	105154	1.94%	4.69
TOTAL General Administration	28-1	281,298	4.76%	12.67	323731	5.58%	14.22	(42,433)	292149	5.40%	13.04
TOTAL Operation Expense	29-1	2,694,592	45.58%	121.40	2264730	39.02%	99.46	429,862	1831380	33.84%	81.73
ADJUSTED TOTALS											
Food	2-8	130,065	2.20%	5.86	135362	2.33%	5.94	(5,297)	71669	1.32%	3.20
Heat and Other Utilities	5-8	99,044	1.68%	4.46	100390	1.73%	4.41	(1,346)	103021	1.90%	4.60
Maintenance	6-8	93,981	1.59%	4.23	102423	1.76%	4.50	(8,442)	117421	2.17%	5.24
TOTAL General Services	8-8	666,507	11.27%	30.03	678030	11.68%	29.78	(11,523)	565087	10.44%	25.22
Administrative	17-8	486,924	8.24%	21.94	504323	8.69%	22.15	(17,399)	486995	9.00%	21.73
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	57,826	0.98%	2.61	197523	3.40%	8.67	(139,697)	55745	1.03%	2.49
Fees, Subscriptions, Promotions	20-8	7,367	0.12%	0.33	20433	0.35%	0.90	(13,066)	35763	0.66%	1.60
License Fee-IDPA	Pg21	400	0.01%	0.02	0	0.00%	0.00	400	0	0.00%	0.00
License Fee-Other	Pg21	2,482	0.04%	0.11	0	0.00%	0.00	2,482	3904	0.07%	0.17
Clerical & General Office Expenses	21-8	138,164	2.34%	6.22	152785	2.63%	6.71	(14,621)	155537	2.87%	6.94
Employee Benefits & Payroll Taxes	22-8	438,299	7.41%	19.75	344853	5.94%	15.15	93,446	302662	5.59%	13.51
Payroll Taxes	Pg21	226,430	3.83%	10.20	185756	3.20%	8.16	40,674	152641	2.82%	6.81
W/C Insurance	Pg21	52,774	0.89%	2.38	14478	0.25%	0.64	38,296	45902	0.85%	2.05
Health Insurance	Pg21	128,024	2.17%	5.77	114102	1.97%	5.01	13,922	84016	1.55%	3.75
Inservice Training & Education	23-8	589	0.01%	0.03	1405	0.02%	0.06	(816)	390	0.01%	0.02
Travel and Seminar	24-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Other Admin. Staff Transportation	25-8	22,333	0.38%	1.01	28498	0.49%	1.25	(6,165)	28954	0.54%	1.29
Insurance-Prop.Liab.Malpractice	26-8	10,514	0.18%	0.47	61932	1.07%	2.72	(51,418)	87147	1.61%	3.89
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
TOTAL General Administration	28-8	1,162,016	19.65%	52.35	1311752	22.60%	57.61	(149,736)	1153193	21.31%	51.46
TOTAL Operation Expense	29-8	4,716,670	79.78%	212.50	4597193	79.21%	201.90	119,477	4074453	75.29%	181.82
Real Estate Taxes	33-3	112,868	1.91%	5.09	73391	1.26%	3.22	39,477	144797	2.68%	6.46
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	5,912,253	100.00%	266.37	5803799	100.00%	254.89	108,454	5411353	100.00%	241.48
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1491938.8	25.23%	67.22	1745887.2	30.08%	76.67	(253,948)	1510309.7	27.91%	67.40

PEDIATRIC REHABILITATION INSTITUTE - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

#VALUE!

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-287893

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.

Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-152213

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.

#VALUE!

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 = Page 21-B.

Professional fees on Page 3 Line 19-3 = Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 DO NOT EQUAL Page 21-G.

NO DEFERRED MAINT

RELATED PARTY 3475

RELATED PARTY

RELATED PARTY 152213

RELATED PARTY

NO EQUIP RENTAL

NO TRAVEL