

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER# 0042671 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	<u>74</u>	Skilled (SNF)	<u>74</u>	<u>27,010</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>52</u>	Intermediate (ICF)	<u>52</u>	<u>18,980</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>126</u>	TOTALS	<u>126</u>	<u>45,990</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	<u>31</u>		<u>2,444</u>	<u>2,475</u>	8
9	SNF/PED					9
10	ICF	<u>24,262</u>	<u>3,946</u>		<u>28,208</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,293</u>	<u>3,946</u>	<u>2,444</u>	<u>30,683</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.72%

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

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)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 05/01/97

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

YES Date 05/01/97 NO

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

YES NO If YES, enter number of beds certified 18 and days of care provided 2,444Medicare Intermediary ADMINISTAR

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 PRAIRIE VILLAGE HEALTHCARE CEN] # 0042671 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	122,701	11,035	7,652	141,388		141,388		141,388		1
2	Food Purchase		116,477		116,477	(12,374)	104,103	(546)	103,557		2
3	Housekeeping	86,575	20,190		106,765		106,765		106,765		3
4	Laundry	36,741	11,106		47,847		47,847		47,847		4
5	Heat and Other Utilities			71,887	71,887		71,887	259	72,146		5
6	Maintenance	17,709	31,474	8,462	57,645		57,645	6,974	64,619		6
7	Other (specify):*			5,998	5,998		5,998		5,998		7
8	TOTAL General Services	263,726	190,282	93,999	548,007	(12,374)	535,633	6,687	542,320		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	729,561	43,823	1,713	775,097		775,097	20,067	795,164		10
10a	Therapy	70,178	3,956	29,307	103,441		103,441	1,506	104,947		10a
11	Activities	29,730	4,562		34,292		34,292		34,292		11
12	Social Services	17,302		4,330	21,632		21,632		21,632		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	846,771	52,341	37,750	936,862		936,862	21,573	958,435		16
	C. General Administration										
17	Administrative	82,307		108,000	190,307		190,307	(62,929)	127,378		17
18	Directors Fees										18
19	Professional Services			61,564	61,564		61,564	(7,340)	54,224		19
20	Dues, Fees, Subscriptions & Promotions			37,083	37,083		37,083	(26,167)	10,916		20
21	Clerical & General Office Expenses	75,443	9,372	107,520	192,335		192,335	(50,234)	142,101		21
22	Employee Benefits & Payroll Taxes			162,053	162,053	12,374	174,427		174,427		22
23	Inservice Training & Education			3,644	3,644		3,644	626	4,270		23
24	Travel and Seminar			1,849	1,849		1,849	251	2,100		24
25	Other Admin. Staff Transportation			4,451	4,451		4,451	1,769	6,220		25
26	Insurance-Prop.Liab.Malpractice			74,617	74,617		74,617	2,661	77,278		26
27	Other (specify):*							24,578	24,578		27
28	TOTAL General Administration	157,750	9,372	560,781	727,903	12,374	740,277	(116,785)	623,492		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,268,247	251,995	692,530	2,212,772		2,212,772	(88,525)	2,124,247		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			19,934	19,934		19,934	58,173	78,107			30
31	Amortization of Pre-Op. & Org.			1,597	1,597		1,597		1,597			31
32	Interest			2,107	2,107		2,107	205,535	207,642			32
33	Real Estate Taxes			23,977	23,977		23,977		23,977			33
34	Rent-Facility & Grounds			402,166	402,166		402,166	(396,893)	5,273			34
35	Rent-Equipment & Vehicles			30,612	30,612		30,612	(4,610)	26,002			35
36	Other (specify):*											36
37	TOTAL Ownership			480,393	480,393		480,393	(137,795)	342,598			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		60,392	136,657	197,049		197,049	(18,599)	178,450			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,985	68,985		68,985		68,985			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		60,392	205,642	266,034		266,034	(18,599)	247,435			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,268,247	312,387	1,378,565	2,959,199		2,959,199	(244,919)	2,714,280			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 PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

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	(5,329)	30		9
10	Interest and Other Investment Income	(20,208)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(546)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(250)	20		17
18	Fines and Penalties	(8,120)	21		18
19	Entertainment				19
20	Contributions	(400)	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	(27,061)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>MARKETING SALARY</u>	(17,861)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (79,775)		\$	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)	(165,144)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (165,144)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (244,919)		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
PRAIRIE VILLAGE HEALTHCARE CENTER

ID# 0042671

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2	MARKETING SALARY	(17,861)	21	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	(17,861)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

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	(546)	0	0	0	0	0	0	0	0	0	0	(546)	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	259	0	0	0	0	0	0	0	0	0	259	5
6	Maintenance	0	6,974	0	0	0	0	0	0	0	0	0	6,974	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(546)	7,233	0	0	0	0	0	0	0	0	0	6,687	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	20,067	0	0	0	0	0	0	0	0	0	20,067	10
10a	Therapy	0	5,495	(3,989)	0	0	0	0	0	0	0	0	1,506	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	25,562	(3,989)	0	21,573	16							
	C. General Administration													
17	Administrative	0	(62,929)	0	0	0	0	0	0	0	0	0	(62,929)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(7,340)	0	0	0	0	0	0	0	0	0	(7,340)	19
20	Fees, Subscriptions & Promotions	(27,711)	0	1,544	0	0	0	0	0	0	0	0	(26,167)	20
21	Clerical & General Office Expenses	(25,981)	(75,600)	51,347	0	0	0	0	0	0	0	0	(50,234)	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	626	0	0	0	0	0	0	0	0	626	23
24	Travel and Seminar	0	0	251	0	0	0	0	0	0	0	0	251	24
25	Other Admin. Staff Transportation	0	0	1,769	0	0	0	0	0	0	0	0	1,769	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,661	0	0	0	0	0	0	0	0	2,661	26
27	Other (specify):*	0	0	24,578	0	0	0	0	0	0	0	0	24,578	27
28	TOTAL General Administration	(53,692)	(145,869)	82,776	0	(116,785)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,238)	(113,074)	78,787	0	(88,525)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

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	(5,329)	0	63,502	0	0	0	0	0	0	0	0	58,173	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20,208)	0	225,743	0	0	0	0	0	0	0	0	205,535	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(396,893)	0	0	0	0	0	0	0	0	(396,893)	34
35	Rent-Equipment & Vehicles	0	(9,494)	4,884	0	0	0	0	0	0	0	0	(4,610)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(25,537)	(9,494)	(102,764)	0	(137,795)	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	(18,599)	0	0	0	0	0	0	0	0	(18,599)	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	(18,599)	0	(18,599)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(79,775)	(122,568)	(42,576)	0	(244,919)	45							

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

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
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					NILES	THERAPY
				PRAIRIE VILLAGE HEALTHCARE CENTER LLC		
					NILES	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17	MANAGEMENT FEES	\$ 96,000	CAREPLUS MGMT INC		\$ (96,000)
2	V	35	COMPUTER LEASE	9,494	" "		(9,494)
3	V	19	DATA PROCESSING FEES	12,000	" "		(12,000)
4	V	21	CLERICAL FEES	75,600	" "		(75,600)
5	V			" "			
6	V			" "			
7	V	5	ELECTRICITY			259	259
8	V	6	REPAIRS			616	616
9	V	6	MAINTENANCE SALARIES			6,358	6,358
10	V	10	NURSING			20,067	20,067
11	V	10a	THERAPY SALARIES			5,495	5,495
12	V	17	ADMIN SALARIES			33,071	33,071
13	V	19	PROFESSIONAL FEES			4,660	4,660
14	Total		\$ 193,094			\$ 70,526	\$ * (122,568)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20 DUES/LICENSES/WANT ADS	\$	CAREPLUS MGMT INC		\$ 1,544	\$ 1,544	15
16	V	21 OFFICE SALARIES/EXPENSES		" "		51,347	51,347	16
17	V	23 SEMINARS		" "		626	626	17
18	V	24 TRAVEL		" "		251	251	18
19	V	25 TRANSPORTATION		" "		1,769	1,769	19
20	V	26 INSURANCE		" "		2,661	2,661	20
21	V	27 EMPLOYEE BENEFITS		" "		24,578	24,578	21
22	V	30 SL DEPRECIATION		" "		8,363	8,363	22
23	V	32 INTEREST		" "		20,520	20,520	23
24	V	34 OFFICE RENT		" "		5,273	5,273	24
25	V	35 EQUIP RENT/AUTO LEASE		" "		4,884	4,884	25
26	V							26
27	V							27
28	V							28
29	V	10a THERAPY SERVICES	29,307	CAREPLUS REHABILITATIVE SERVICES		25,318	(3,989)	29
30	V	39 ANCILLARY THERAPY	136,656	" "		118,057	(18,599)	30
31	V							31
32	V							32
33	V							33
34	V	34 RENT	402,166	PRAIRIE VILLAGE HEALTHCARE CENTER LLC			(402,166)	34
35	V	30 SL DEPRECIATION		" "		55,139	55,139	35
36	V	32 INTEREST		" "		205,223	205,223	36
37	V							37
38	V							38
39	Total		\$ 568,129			\$ 525,553	\$ * (42,576)	39

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CEN # 0042671 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	CAREPLUS MGMT ALLOCATIONS:								\$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	31.88	SEE ATTACHED	3.2	5.29	SALARY	9,791	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	31.88	SCHEDULES	3.2	5.29	" "	9,791	17-7	3
4	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	2.17	" "	3.2	5.29	" "	5,743	17-7	4
5	JOE ZIMMERMAN	CFO	CLERICAL	2.17	" "	3.2	5.29	" "	6,317	21-7	5
6											6
7											7
8											8
9											9
10											10
11	ERIC ROTHNER (HUNTER MGMT LLC)		CONSULTING	31.90	" "			MGMT FEES	12,000	17-3	11
12											12
13								TOTAL	\$ 43,642		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 PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 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 CAREPLUS MANAGEMENT INC
 Street Address 5940 W TOUHY
 City / State / Zip Code NILES 60714
 Phone Number (847) 647-1717
 Fax Number (847) 647-0222

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	459,177	9 FACILITIES	\$ 75,722	\$ 0	\$ 0	1
2	5	ELECTRICITY	" "	579,760	13 FACILITIES	4,894	30,683	259	2
3	6	REPAIRS	" "	579,760	13 FACILITIES	11,630	30,683	616	3
4	6	MAINTENANCE SALARIES	" "	579,760	13 FACILITIES	120,135	30,683	6,358	4
5	10	NURSING	" "	579,760	13 FACILITIES	379,168	30,683	20,067	5
6	10a	THERAPY SALARIES	" "	579,760	13 FACILITIES	103,831	30,683	5,495	6
7	17	ADMIN SALARIES	" "	579,760	13 FACILITIES	624,886	30,683	33,071	7
8	19	PROFESSIONAL FEES	" "	579,760	13 FACILITIES	88,050	30,683	4,660	8
9	20	DUES/LICENSES/WANT ADS	" "	579,760	13 FACILITIES	29,166	30,683	1,544	9
10	21	OFFICE SALARIES/EXPENSES	" "	579,760	13 FACILITIES	970,207	30,683	51,347	10
11	23	SEMINARS	" "	579,760	13 FACILITIES	11,834	30,683	626	11
12	24	TRAVEL	" "	579,760	13 FACILITIES	4,741	30,683	251	12
13	25	TRANSPORTATION	" "	579,760	13 FACILITIES	33,424	30,683	1,769	13
14	26	INSURANCE	" "	579,760	13 FACILITIES	50,288	30,683	2,661	14
15	27	EMPLOYEE BENEFITS	" "	579,760	13 FACILITIES	464,414	30,683	24,578	15
16	30	SL DEPRECIATION	" "	579,760	13 FACILITIES	158,032	30,683	8,363	16
17	32	INTEREST	" "	579,760	13 FACILITIES	387,734	30,683	20,520	17
18	34	OFFICE RENT	" "	579,760	13 FACILITIES	99,626	30,683	5,273	18
19	35	EQUIP RENT/AUTO LEASE	" "	579,760	13 FACILITIES	92,291	30,683	4,884	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,710,073	\$ 1,326,621	\$ 192,342	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC				\$	\$				1										
2	CIB BANK	X	CAPITAL IMPROVEMENTS	\$16,113.80	02/01	765,000	507,798	02/06	PRIME+	47,778										
3	LOAN COSTS	X	LOAN COSTS	W/O OVER LOAN	02/01	3,825	2,422			765										
4	CIB BANK	X	MORTGAGE	\$17,387.00	12/98	2,100,000		12/04	7.7500	151,384										
5	LOAN COSTS	X	LOAN COSTS	W/O OVER LOAN	09/97	30,174	7,239			5,296										
Working Capital																				
6	INSURANCE FINANCING	X	INSUR. FINANCE							2,107										
7	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC									20,520										
8																				
9	TOTAL Facility Related			\$33,500.80		\$ 2,898,999	\$ 517,459			\$ 227,850										
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$	\$			\$										
15	TOTALS (line 9+line14)					\$ 2,898,999	\$ 517,459			\$ 227,850										

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 PRAIRIE VILLAGE HEALTHCARE CENTER# 0042671 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.	\$	22,930	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	23,337	2
3. Under or (over) accrual (line 2 minus line 1).			\$	407	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	23,570	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	23,977	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	23,179	8	
		1998	22,743	9	
		1999	22,519	10	
		2000	22,702	11	
		2001	23,337	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 PRAIRIE VILLAGE HEALTHCARE CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0042671

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>09-17-100-012</u>	<u>NURSING HOME</u>	\$ <u>23,337.22</u>	\$ <u>23,337.22</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>23,337.22</u>	\$ <u>23,337.22</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 PRAIRIE VILLAGE HEALTHCARE CENTER

0042671 Report Period Beginning:

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,028 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1 + BASEMENT

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: 7,983 2. Number of Years Over Which it is Being Amortized: 5 YEARS
3. Current Period Amortization: 1,597 4. Dates Incurred: 5/97

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>RELATED PARTY:PRAIRIE VILLAGE HEALTHCARE CENTER LI</u>			\$	1
2	<u>NURSING HOME: ACRES</u>	<u>8.686</u>	<u>1997</u>	<u>170,000</u>	2
3	TOTALS			\$ 170,000	3

Facility Name & ID Number **PRAIRIE VILLAGE HEALTHCARE CENTER**

0042671

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC:			\$	\$		\$	\$	\$	4
5	126		1997		1,114,539	28,577	39	28,577		156,004	5
6											6
7											7
8											8
		Improvement Type**									
9		ELECTRIC PANEL IN BOILER ROOM		1997	1,192	31	39	31		172	9
10		NURSE CALL SYSTEM		1997	17,863	458	39	458		2,480	10
11		40 TON A/C AND GAS LINE		1997	114,953	2,947	39	2,947		15,596	11
12		NEW ROOF		1997	35,981	923	39	923		4,807	12
13		CUBICLE TRACK/ PAINTING/ HAND & BUMPER RAILS		1997	18,875	484	39	484		2,521	13
14		CEILING TILE/ LIGHT FIXTURES/ CUBICLE TRACK		1997	44,010	1,128	39	1,128		5,781	14
15		MECHANICAL, PLUMBING, HVAC & ELECTRICAL OVERHAUL		1997	165,706	4,249	39	4,249		21,777	15
16		FLOOR TILE		1997	35,928	921	39	921		4,643	16
17		REMODELLING/ PAINTING/ WALLCOVERINGS/ BUMPER RAIL		1997	52,605	1,349	39	1,349		6,801	17
18		REMODELLING/ WALLCOVERINGS/ RAILS/ WINDOW TREATM		1998	58,466	1,500	39	1,500		7,112	18
19		TILING/ FLOORING/ DOORS		1998	36,939	948	39	948		4,425	19
20		ELECTRICAL/ ELEVATOR/ PLUMBING REPAIRS		1998	69,378	1,778	39	1,778		8,221	20
21		GENERATOR		1998	21,049	540	39	540		2,453	21
22		JFK CONTEMPORARY DESIGNS		1999	3,549	91	39	91		277	22
23		CANOPY/BARRIERS/CORNER GUARDS/KICKPLATES		2000	9,164	333	27.5	333		770	23
24				2001	54,531	1,982	27.5	1,983	1	3,520	24
25		CONCRETE WORK/ DRYWALL/ DOORS		2002	4,490	24	27.5	24		24	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34		RELATED PARTY ALLOCATION - CAREPLUS MGMT				62		62			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 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)		\$ 1,859,218	\$ 48,325		\$ 48,326	\$ 1	\$ 247,384	70

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 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	\$ 191,888	\$ 18,618	\$ 14,482	\$ (4,136)	8-15 YRS	\$ 72,266	71
72	Current Year Purchases	2,936	1,292	98	(1,194)	15 YRS	98	72
73	Fully Depreciated Assets							73
74	** RELATED PARTY - SL DEPN: CAREPLUS MGMT, 8,301 / PRAIRIE VILLAGE LLC, 6,900		15,201	15,201				74
75	TOTALS	\$ 194,824	\$ 35,111	\$ 29,781	\$ (5,330)		\$ 72,364	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)	\$ 2,224,042	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 83,436	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 78,107	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,329)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 319,748	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

**

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: \$ 23,211

Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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. 2003 \$ _____

13. 2004 \$ _____

14. 2005 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>FACILITY VAN</u>		\$ <u>668.94</u>	\$ <u>7,401</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>668.94</u>	\$ <u>7,401</u>	21

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

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 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	39-3	hrs	\$		\$ 75,807	\$		\$ 75,807	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,589			6,589	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			54,261			54,261	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				59,332		59,332	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2					801		801	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					259		259	13
14	TOTAL			\$		\$ 136,657	\$ 60,392		\$ 197,049	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 **PRAIRIE VILLAGE HEALTHCARE CENTER**# **0042671**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	\$ (2,117)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>25,000</u>)	916,726		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	275,000		5
6	Prepaid Insurance	41,287		6
7	Other Prepaid Expenses	1,523		7
8	Accounts Receivable (owners or related parties)	62,603		8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,295,022	\$	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	7,051		15
16	Equipment, at Historical Cost	190,263		16
17	Accumulated Depreciation (book methods)	(156,816)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): <u>SECURITY DEPOSITS</u>	4,137		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 44,635	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,339,657	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 389,650	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,565		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,410		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,570		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)	\$ 474,195	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>DUE TO LLC</u>	167,218		43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 167,218	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 641,413	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 698,244	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,339,657	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 688,230	1
2	Restatements (describe):		2
3	POST-CLOSING ALLOWANCE FOR BAD DEBTS	(25,000)	3
4	ROUNDING	3	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 663,233	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	35,011	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)	\$ 35,011	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)	\$ 698,244	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 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	\$ 2,969,525	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,969,525	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	4,954	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,954	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***	20,208	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,208	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)	\$ 2,994,687	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	548,007	31
32	Health Care	936,862	32
33	General Administration	727,903	33
B. Capital Expense			
34	Ownership	480,393	34
C. Ancillary Expense			
35	Special Cost Centers	197,049	35
36	Provider Participation Fee	68,985	36
D. Other Expenses (specify):			
37	LEGAL SETTLEMENT	477	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,959,676	40
41	Income before Income Taxes (line 30 minus line 40)**	35,011	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 35,011	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

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	2,204	2,288	\$ 41,092	\$ 17.96	1
2	Assistant Director of Nursing	181	194	2,720	14.02	2
3	Registered Nurses	4,675	4,900	82,602	16.86	3
4	Licensed Practical Nurses	14,459	15,157	195,329	12.89	4
5	Nurse Aides & Orderlies	43,050	44,249	385,187	8.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,458	6,926	70,178	10.13	8
9	Activity Director					9
10	Activity Assistants	4,365	4,571	29,730	6.50	10
11	Social Service Workers	2,035	2,125	17,302	8.14	11
12	Dietician					12
13	Food Service Supervisor	2,046	2,168	27,230	12.56	13
14	Head Cook	5,946	6,147	45,149	7.34	14
15	Cook Helpers/Assistants	7,248	7,824	50,322	6.43	15
16	Dishwashers					16
17	Maintenance Workers	1,999	2,043	17,709	8.67	17
18	Housekeepers	13,310	13,670	86,575	6.33	18
19	Laundry	5,557	5,754	36,741	6.39	19
20	Administrator	1,934	2,104	45,005	21.39	20
21	Assistant Administrator	2,001	2,088	37,302	17.86	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,052	4,472	57,582	12.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,912	2,039	22,631	11.10	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MARKETING</u>	1,315	1,363	17,861	13.10	33
34	TOTAL (lines 1 - 33)	124,747	130,082	\$ 1,268,247 *	\$ 9.75	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	\$ 7,355	1-3	35
36	Medical Director	O	2,400	9-3	36
37	Medical Records Consultant	N	163	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	550	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	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	4,330	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHIATRIC</u>		1,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,598		49

C. CONTRACT NURSES

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

Facility Name & ID Number **PRAIRIE VILLAGE HEALTHCARE CENTER**

0042671

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

Ending: **12/31/2002**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DIANNA BLACKKETTER	ADMIN	0	\$ 45,005	Workers' Compensation Insurance	\$ 35,404	IDPH License Fee	\$ 1,433	
PAM BROWN	ASST ADMIN	0	37,302	Unemployment Compensation Insurance	12,406	Advertising: Employee Recruitment	1,433	
				FICA Taxes	95,831	Health Care Worker Background Check	0	
				Employee Health Insurance	14,920	(Indicate # of checks performed)		
				Employee Meals	12,374	MARKETING/ADV/PROMO	27,061	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	650	
				EMPLOYEE BENEFITS - OTHER	3,290	LICENSES & PERMITS	350	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	7,589	
				PENSION/PROFIT SHARING PLANS	202	MGMT CO ALLOCATION	1,544	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(650)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(27,061)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 82,307	TOTAL (agree to Schedule V, line 22, col.8)	\$ 174,427	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,916	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
CAREPLUS MGMT	MANAGEMENT FEES		\$ 96,000				Out-of-State Travel	\$
HUNTER MGMT	MANAGEMENT FEES		12,000					
							In-State Travel	
							TRAVEL	1,849
							MGMT CO ALLOCATION	251
							Seminar Expense	0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 108,000	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,100
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
CAREPLUS MGMT	DATA PROC		\$ 12,000					
AMERICAN DATA	DATA PROC		3,695					
NATIONAL DATACARE	DATA PROC		1,137					
RICHARD PEELO	M/C COST REPORT		3,750					
KBKB	ACCT		30,500					
MEYER MAGENCE	LEGAL		12,434					
SACHNOFF WEAVER	LEGAL		605					
PERSONNEL PLANNERS	UNEMPL CONSULT		1,993					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 66,114					
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

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? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$7,204
- (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? 15 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 68,985
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. \$ 12,374 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	7,355
	REPAIRS & MAINTENANCE	297
		0
		7,652
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	25,234
	ELECTRICITY	31,928
	WATER	11,515
	CABLE TV - LOBBY	3,210
		0
		71,887
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,785
	PAINTING & DECORATING	0
	BUILDING REPAIRS	2,052
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,444
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,045
	FIRE SERVICE	2,136
		0
		0
		0
		8,462
7	OTHER	
	SCAVENGER	5,998
	SECURITY SERVICE	0
		5,998
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,400
		2,400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	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	163
	PHARMACY CONSULTANT XVIII B 39-2	550
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B 47-2	1,000
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		1,713
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	2,626
	SPEECH THERAPY SERVICES	216
	OCCUPATIONAL THERAPY SERVICES	2,925
	THERAPY CONTRACT SERVICES	12,740
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		29,307
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,330
		0
		4,330
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	108,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,832
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	44,732
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	61,564
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	27,061
	EMPLOYEE WANT ADS XIX F	1,433
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	7,589
	LICENSES & PERMITS XIX F	350
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	250
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	400
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
21	CLERICAL & GENERAL OFFICE EXPENSES	37,083
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,211
	EQUIPMENT REPAIR & MAINTENANCE	7,371
	OUTSIDE CLERICAL SERVICES	75,600
	PENALTIES / OVERDRAFT CHARGES VI 18	8,120
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	14,000
	MESSENGER SERVICE	1,218
		0
		107,520

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	95,831
	UNEMPLOYMENT COMPENSATION XIX D	12,406
	WORKERS COMPENSATION INSURANC XIX D	35,404
	HOSPITALIZATION INSURANCE XIX D	14,920
	EMPLOYEE BENEFITS - OTHER XIX D	3,290
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	202
	CHICAGO HEAD TAX XIX D	0
		162,053
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,644
		3,644
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	1,849
		0
		0
		1,849
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,451
		4,451
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	74,617
		74,617
27	OTHER	
	BAD DEBTS VI 24	0
		0
		0

GRAND TOTAL COLUMN 3 OTHER

692,530

PRAIRIE VILLAGE HEALTHCARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2002

TOTAL FOOD PURCHASE	116,477	PATIENT MEALS	92049
LESS SALES TAX	(546)	ADD EMPLOYEE MEALS	10950
	-----		-----
NET FOOD	115,931	TOTAL MEALS/YEAR	102999
TOTAL PATIENT CENSUS	30,683	NET FOOD	115931
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	102999

TOTAL PATIENT MEALS	92049	COST PER MEAL	1.13
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	12374
	-----		=====
TOTAL EMPLOYEE MEALS	10950		

PRAIRIE VILLAGE HEALTHCARE CENTER
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S									3,011,349	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	936,862	162,053	242,295	47,847	257,865	565,850	68,985	480,393		1,268,247
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	3,083		9,754			17,775		(30,612)		
CABLE TV			(3,210)			3,210				
CONTRACT NURSING										
INTEREST INCOME							(8)	(20,200)		
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(108,000)		108,000		
O2 INCOME							(4,954)			
BAD DEBTS						0	0			
DISCOUNTS LOST							0			
ANCILLARIES	197,049							0		
SETTLEMENT INTEREST						477				
RECLASSIFIED SALARIES	(22,631)	0	0	0	0	22,631	0	0		
PROFIT SHARING	0	0	0	0	0	0	41,824	0		
PRIOR EXPENSES	0	0	0	0	0	0	0	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	1,114,363	162,053	248,839	47,847	257,865	501,943	105,847	537,581	2,976,338	1,268,247
PER FINANCIAL STATEMENTS	1,114,363	162,053	248,839	47,847	257,865	501,943	105,847	537,581	35,011	1,268,247
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									35,011	

PRAIRIE VILLAGE HEALTHCARE CENTER - COMPARISONS - 12/31/2002

ref.	12/31/2002			12/31/2001			DIFF	12/31/2000			
CAPACITY DAYS	45,990			45,990			0	46116			
CENSUS DAYS	30,683			31,459			(776)	33085			
OCCUPANCY %	66.72%			68.40%				71.74%			
SALARIES											
TOTAL General Services	8-1	263,726	9.72%	8.60	255246	9.00%	8.11	8,480	275260	10.67%	8.32
Social Services	12-1	17,302	0.64%	0.56	4939	0.17%	0.16	12,363	1573	0.06%	0.05
TOTAL Health Care and Programs	16-1	846,771	31.20%	27.60	841611	29.67%	26.75	5,160	788209	30.55%	23.82
Clerical & General Office Expenses	21-1	75,443	2.78%	2.46	79734	2.81%	2.53	(4,291)	85235	3.30%	2.58
TOTAL General Administration	28-1	157,750	5.81%	5.14	158320	5.58%	5.03	(570)	159595	6.19%	4.82
TOTAL Operation Expense	29-1	1,268,247	46.72%	41.33	1255177	44.25%	39.90	13,070	1223064	47.40%	36.97
ADJUSTED TOTALS											
Food	2-8	103,557	3.82%	3.38	111312	3.92%	3.54	(7,755)	106306	4.12%	3.21
Heat and Other Utilities	5-8	72,146	2.66%	2.35	77792	2.74%	2.47	(5,646)	75962	2.94%	2.30
Maintenance	6-8	64,619	2.38%	2.11	81923	2.89%	2.60	(17,304)	85634	3.32%	2.59
TOTAL General Services	8-8	542,320	19.98%	17.67	557203	19.64%	17.71	(14,883)	565145	21.90%	17.08
Administrative	17-8	127,378	4.69%	4.15	146609	5.17%	4.66	(19,231)	143352	5.56%	4.33
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	54,224	2.00%	1.77	88864	3.13%	2.82	(34,640)	74012	2.87%	2.24
Fees, Subscriptions, Promotions	20-8	10,916	0.40%	0.36	25293	0.89%	0.80	(14,377)	14260	0.55%	0.43
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
License Fee-Other	Pg21	350	0.01%	0.01	200	0.01%	0.01	150	400	0.02%	0.01
Clerical & General Office Expenses	21-8	142,101	5.24%	4.63	151403	5.34%	4.81	(9,302)	143989	5.58%	4.35
Employee Benefits & Payroll Taxes	22-8	174,427	6.43%	5.68	173016	6.10%	5.50	1,411	174295	6.75%	5.27
Payroll Taxes	Pg21	108,237	3.99%	3.53	107516	3.79%	3.42	721	108773	4.22%	3.29
W/C Insurance	Pg21	35,404	1.30%	1.15	35606	1.26%	1.13	(202)	33408	1.29%	1.01
Health Insurance	Pg21	14,920	0.55%	0.49	11644	0.41%	0.37	3,276	13293	0.52%	0.40
Inservice Training & Education	23-8	4,270	0.16%	0.14	3657	0.13%	0.12	613	3450	0.13%	0.10
Travel and Seminar	24-8	2,100	0.08%	0.07	1517	0.05%	0.05	583	2663	0.10%	0.08
Other Admin. Staff Transportation	25-8	6,220	0.23%	0.20	5194	0.18%	0.17	1,026	3023	0.12%	0.09
Insurance-Prop.Liab.Malpractice	26-8	77,278	2.85%	2.52	101479	3.58%	3.23	(24,201)	55006	2.13%	1.66
Other (specify):*	27-8	24,578	0.91%	0.80	24080	0.85%	0.77	498	16733	0.65%	0.51
TOTAL General Administration	28-8	623,492	22.97%	20.32	721112	25.42%	22.92	(97,620)	630783	24.45%	19.07
TOTAL Operation Expense	29-8	2,124,247	78.26%	69.23	2219468	78.25%	70.55	(95,221)	2072980	80.34%	62.66
Real Estate Taxes	33-3	23,977	0.88%	0.78	22892	0.81%	0.73	1,085	22289	0.86%	0.67
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	2,714,280	100.00%	88.46	2836466	100.00%	90.16	(122,186)	2580320	100.00%	77.99
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1049352.3	38.66%	34.20	1162305.7	40.98%	36.95	(112,953)	1083602.8	41.99%	32.75

PRAIRIE VILLAGE HEALTHCARE CENTER - 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!

NO DEFERRED MAINT

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=-225743

RELATED PARTY 225743

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

Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.

Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-63502

RELATED PARTY 63502

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.

N/A - RELATED PARTY

Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.

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 DOES NOT EQUAL 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 = Page 21-G.