

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0040816</u></p> <p><b>Facility Name:</b> <u>EMERALD PARK HEALTH CARE CENTER</u></p> <p><b>Address:</b> <u>9125 SOUTH PULASKI RD.</u> <u>EVERGREEN PARK</u> <u>60642</u>          Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>(708) 425-3400</u> Fax # <u>(708) 425-5086</u></p> <p><b>IDPA ID Number:</b> <u>363473443001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>02/11/1987</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>          </u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other <u>          </u></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other <u>          </u></td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>          </u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u>          </u>		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u>          </u>		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE        ILLINOIS DEPARTMENT OF PUBLIC AID        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____		(Title) _____	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>
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Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER

# 0040816 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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	163	Skilled (SNF)	163	59,495	1
2		Skilled Pediatric (SNF/PED)			2
3	86	Intermediate (ICF)	86	31,390	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	249	TOTALS	249	90,885	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	8,251	279	2,065	10,595	8
9	SNF/PED					9
10	ICF	74,187	1,435	357	75,979	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	82,438	1,714	2,422	86,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.26%

D. How many bed-hold days during this year were paid by Public Aid? 1,367 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 02/11/1987

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 01/01/1996 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 32 and days of care provided 1,996

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

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

Facility Name & ID Number **EMERALD PARK HEALTH CARE CENTE** # **0040816** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

**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
	<b>A. General Services</b>										
1	Dietary	216,198	27,001	20,805	264,004		264,004		264,004		1
2	Food Purchase		305,082		305,082	(23,652)	281,430	(953)	280,477		2
3	Housekeeping	290,686	42,127		332,813		332,813		332,813		3
4	Laundry	82,176	21,036	3,068	106,280		106,280		106,280		4
5	Heat and Other Utilities			110,561	110,561		110,561		110,561		5
6	Maintenance	51,320	67,233	53,040	171,593		171,593	(6,720)	164,873		6
7	Other (specify):*			37,744	37,744		37,744	50	37,794		7
8	<b>TOTAL General Services</b>	<b>640,380</b>	<b>462,479</b>	<b>225,218</b>	<b>1,328,077</b>	<b>(23,652)</b>	<b>1,304,425</b>	<b>(7,623)</b>	<b>1,296,802</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,500	7,500		7,500		7,500		9
10	Nursing and Medical Records	2,382,853	83,238	12,864	2,478,955		2,478,955		2,478,955		10
10a	Therapy	65,214	518	5,759	71,491		71,491		71,491		10a
11	Activities	46,063	16,404	2,553	65,020		65,020		65,020		11
12	Social Services	183,084		7,627	190,711		190,711		190,711		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,677,214</b>	<b>100,160</b>	<b>36,303</b>	<b>2,813,677</b>		<b>2,813,677</b>		<b>2,813,677</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	59,578		177,634	237,212		237,212	19,314	256,526		17
18	Directors Fees										18
19	Professional Services			139,863	139,863		139,863	11,274	151,137		19
20	Dues, Fees, Subscriptions & Promotions			38,347	38,347		38,347	(8,315)	30,032		20
21	Clerical & General Office Expenses	126,204	15,424	43,633	185,261		185,261	695	185,956		21
22	Employee Benefits & Payroll Taxes			659,338	659,338	23,652	682,990		682,990		22
23	Inservice Training & Education							48	48		23
24	Travel and Seminar			1,648	1,648		1,648		1,648		24
25	Other Admin. Staff Transportation			6,899	6,899		6,899	907	7,806		25
26	Insurance-Prop.Liab.Malpractice			107,688	107,688		107,688	1,069	108,757		26
27	Other (specify):*			1,010,269	1,010,269		1,010,269	(1,002,304)	7,965		27
28	<b>TOTAL General Administration</b>	<b>185,782</b>	<b>15,424</b>	<b>2,185,319</b>	<b>2,386,525</b>	<b>23,652</b>	<b>2,410,177</b>	<b>(977,312)</b>	<b>1,432,865</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,503,376</b>	<b>578,063</b>	<b>2,446,840</b>	<b>6,528,279</b>		<b>6,528,279</b>	<b>(984,935)</b>	<b>5,543,344</b>		<b>29</b>

\*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 PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	9,960
	REPAIRS & MAINTENANCE	10,845
		0
		20,805
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	3,068
		0
		3,068
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	42,205
	ELECTRICITY	40,138
	WATER	28,218
	CABLE TV - LOBBY	0
		0
		110,561
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	1,629
	PAINTING & DECORATING	11,677
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	16,122
	ELEVATOR MAINTENANCE & REPAIR	7,604
	OUTSIDE LABOR	3,376
	EXTERMINATING SERVICE	5,338
	FIRE SERVICE	7,294
		0
		0
		0
		53,040
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	13,096
	SECURITY SERVICE	24,648
		0
		37,744
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	7,500
		0
		7,500

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	220
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	3,908
	PHARMACY CONSULTANT XVIII B 39-2	5,136
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	3,600
		0
		12,864
<b>10a</b>	<b>THERAPY</b>	
	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	1,439
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	2,020
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	2,300
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		5,759
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,553
		0
		2,553
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	7,627
	SOCIAL WORKER XVIII B 45-2	0
		0
		7,627
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	177,634
<b>18</b>	<b>DIRECTORS FEES</b>	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	11,701
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	128,162
		0
		139,863
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	829
	CONTRIBUTIONS VI 20 XIX F	5,600
	DUES & SUBSCRIPTIONS XIX F	8,003
	LICENSES & PERMITS XIX F	19,616
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	200
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,274
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	825
		38,347
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,719
	EQUIPMENT REPAIR & MAINTENANCE	574
	OUTSIDE CLERICAL SERVICES	8,000
	PENALTIES / OVERDRAFT CHARGES VI 18	2,950
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,057
	MESSENGER SERVICE	515
	STAFF DEVELOPMENT	10,818
		43,633

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	275,025
	UNEMPLOYMENT COMPENSATION XIX D	71,027
	WORKERS COMPENSATION INSURANCE XIX D	180,913
	HOSPITALIZATION INSURANCE XIX D	88,958
	EMPLOYEE BENEFITS - OTHER XIX D	4,443
	EMPLOYEE PHYSICAL EXAMS XIX D	233
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	UNION PENSION XIX D	38,739
	CHICAGO HEAD TAX XIX D	0
		659,338
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	1,648
	TRAVEL XIX G	0
		0
		0
		1,648
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	6,899
		6,899
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	107,688
		107,688
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	1,010,269
		0
		1,010,269

GRAND TOTAL COLUMN 3 OTHER

2,446,840

Facility Name &amp; ID Number

EMERALD PARK HEALTH CARE CENTER

#0040816

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## 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	
	<b>D. Ownership</b>											
30	Depreciation			154,863	154,863		154,863	178,718	333,581			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,610	2,610		2,610	473,974	476,584			32
33	Real Estate Taxes							382,601	382,601			33
34	Rent-Facility & Grounds			976,406	976,406		976,406	(976,406)				34
35	Rent-Equipment & Vehicles			8,783	8,783		8,783	6,599	15,382			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,142,662	1,142,662		1,142,662	65,486	1,208,148			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,817	101,357	150,174		150,174		150,174			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,327	136,327		136,327		136,327			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		48,817	237,684	286,501		286,501		286,501			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,503,376	626,880	3,827,186	7,957,442		7,957,442	(919,449)	7,037,993			45

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

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	14,224	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	(953)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties	(2,950)	21		18
19	Entertainment		20		19
20	Contributions	(8,874)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,010,269)	27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(38,793)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,047,815)		\$	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)	128,366		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 128,366		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (919,449)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

STATE OF ILLINOIS  
 EMERALD PARK HEALTH CARE CENTER

ID# 0040816

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (9,731)	6	1
2	MARKETING SALARIES	(18,244)	21	2
3	STAFF DEVELOPMENT	(10,818)	21	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	<b>Total</b>	(38,793)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER# 0040816 Report Period Beginning:

01/01/2003

Ending: 12/31/2003

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(953)	0	0	0	0	0	0	0	0	0	0	(953)	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	(9,731)	3,011	0	0	0	0	0	0	0	0	0	(6,720)	6
7	Other (specify):*	0	50	0	0	0	0	0	0	0	0	0	50	7
8	<b>TOTAL General Services</b>	<b>(10,684)</b>	<b>3,061</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,623)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	9,211	10,103	0	0	0	0	0	0	0	0	19,314	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,041	233	0	0	0	0	0	0	0	0	11,274	19
20	Fees, Subscriptions & Promotions	(9,074)	759	0	0	0	0	0	0	0	0	0	(8,315)	20
21	Clerical & General Office Expenses	(32,012)	23,055	9,652	0	0	0	0	0	0	0	0	695	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	48	0	0	0	0	0	0	0	0	0	48	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	629	278	0	0	0	0	0	0	0	0	907	25
26	Insurance-Prop.Liab.Malpractice	0	853	216	0	0	0	0	0	0	0	0	1,069	26
27	Other (specify):*	(1,010,269)	4,888	3,077	0	0	0	0	0	0	0	0	(1,002,304)	27
28	<b>TOTAL General Administration</b>	<b>(1,051,355)</b>	<b>50,484</b>	<b>23,559</b>	<b>0</b>	<b>(977,312)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(1,062,039)</b>	<b>53,545</b>	<b>23,559</b>	<b>0</b>	<b>(984,935)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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	14,224	334	0	164,160	0	0	0	0	0	0	0	178,718	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	473,974	0	0	0	0	0	0	0	473,974	32
33	Real Estate Taxes	0	0	0	382,601	0	0	0	0	0	0	0	382,601	33
34	Rent-Facility & Grounds	0	0	0	(976,406)	0	0	0	0	0	0	0	(976,406)	34
35	Rent-Equipment & Vehicles	0	5,255	1,344	0	0	0	0	0	0	0	0	6,599	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>14,224</b>	<b>5,589</b>	<b>1,344</b>	<b>44,329</b>	<b>0</b>	<b>65,486</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(1,047,815)</b>	<b>59,134</b>	<b>24,903</b>	<b>44,329</b>	<b>0</b>	<b>(919,449)</b>	<b>45</b>						

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
MARVIN MERMELSTEIN	24.50	SEE ATTACHED SCHEDULE		EKS MANAGEMENT	LINCOLNWOOD	MANAGEMENT
DORREN MERMELSTEIN	24.50			EMI ENTERPRISES	LINCOLNWOOD	CONSULTANT
MORRIS ESFORMES	51.00			M. MERMELSTEIN		
				PARTNERSHIP	LINCOLNWOOD	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	21 OUTSIDE CLERICAL	\$ 8,000	EKS MANAGEMENT, INC		\$	(8,000)	1	
2	V	6 PAINTERS SALARIES				3,011	3,011	2	
3	V	7 SCAVENGER				50	50	3	
4	V	17 CFO SALARY				9,211	9,211	4	
5	V	19 PROFESSIONAL FEES				11,041	11,041	5	
6	V	20 WANT ADS/BACKGR CKS				759	759	6	
7	V	21 TOTAL OFFICE				31,055	31,055	7	
8	V	23 SEMINARS				48	48	8	
9	V	25 TRANSPORTATION				629	629	9	
10	V	26 INSURANCE				853	853	10	
11	V	27 EMPLOYEE BENEFITS				4,888	4,888	11	
12	V	30 DEPRECIATION ( SL )				334	334	12	
13	V	35 EQUIPMENT RENT				5,255	5,255	13	
14	Total		\$ 8,000			\$ 67,134	\$ *	59,134	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 8,000	EMI ENTERPRISES, INC		\$	(8,000)
16	V	17 OFFICERS SALARY				18,103	18,103
17	V	19 ACCOUNTING FEES				233	233
18	V	21 TOTAL OFFICE				9,652	9,652
19	V	25 TRANSPORTATION				278	278
20	V	26 INSURANCE				216	216
21	V	27 EMPLOYEE BENEFITS				3,077	3,077
22	V	35 AUTO LEASE				1,344	1,344
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 8,000			\$ 32,903	\$ * 24,903

\* 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	34 RENT	\$ 976,406	M. MERMELSTEIN PARTNERSHIP		\$	\$ (976,406)
16	V	30 SL DERPESATION				164,160	164,160
17	V	32 INTEREST				473,974	473,974
18	V	33 REAL ESTATE TAXES				382,601	382,601
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 976,406			\$ 1,020,735	\$ * 44,329

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

Facility Name & ID Number EMERALD PARK HEALTH CARE CENT # 0040816 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## 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	MARVIN MERMELSTEIN		ADMINISTRATIV	24.50	SEE ATTACHED			MGMT FEES	\$ 65,000	17-3	1
2	MORRIS ESFORMES		ADMINISTRATIV	51.00				MGMT FEES	65,000	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 130,000		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 EMERALD PARK HEALTH CARE CENTER

# 0040816

Report Period Beginning:

01/01/2003

Ending: 2/31/2003

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 EKS MANAGEMENT, INC  
 Street Address 6865 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847 ) 674-5795  
 Fax Number ( 847) 674-5794

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	6	PAINTERS SALARIES	PATIENT DAYS	884,739	14	\$ 30,769	\$ 30,769	86,574	\$ 3,011	1
2	7	SCAVENGER	PATIENT DAYS	884,739	14	510		86,574	50	2
3	17	CFO SALARY	PATIENT DAYS	884,739	14	94,128	94,128	86,574	9,211	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	884,739	14	112,835	83,281	86,574	11,041	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	884,739	14	7,759		86,574	759	5
6	21	TOTAL OFFICE	PATIENT DAYS	884,739	14	317,364	228,335	86,574	31,055	6
7	23	SEMINARS	PATIENT DAYS	884,739	14	490		86,574	48	7
8	25	TRANSPORTATION	PATIENT DAYS	884,739	14	6,427		86,574	629	8
9	26	INSURANCE	PATIENT DAYS	884,739	14	8,715		86,574	853	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	49,951		86,574	4,888	10
11	30	DEPRECIATION ( SL )	PATIENT DAYS	884,739	14	3,418		86,574	334	11
12	35	EQUIPMENT RENT	PATIENT DAYS	884,739	14	53,700		86,574	5,255	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					\$ 686,066	\$ 436,513		\$ 67,134	25

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER

# 0040816

Report Period Beginning:

01/01/2003

Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization EMI ENTERPRISES, INC  
 Street Address 6865 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847) 674-5795  
 Fax Number ( 847) 674-5794

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	17	OFFICERS SALARY	PATIENT DAYS	884,739	14	\$ 185000	\$ 185,000	86,574	\$ 18,103	1
2	19	ACCOUNTING FEES	PATIENT DAYS	884,739	14	2381	86,574	233		2
3	21	TOTAL OFFICE	PATIENT DAYS	884,739	14	98637	86,574	9,652		3
4	25	TRANSPORTATION	PATIENT DAYS	884,739	14	2845	86,574	278		4
5	26	INSURANCE	PATIENT DAYS	884,739	14	2209	86,574	216		5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	31442	86,574	3,077		6
7	35	AUTO LEASE	PATIENT DAYS	884,739	14	13730	86,574	1,344		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					\$ 336,244	\$ 261,255		\$ 32,903	25

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTE

# 0040816

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

**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		7	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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	COLE TAYLOR BANK		X	MORTGAGE	\$84,627.75	01/21/02	\$ 7,300,000	\$ 7,115,941	02/05/07	7.1250	\$ 473,974	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	PARKWAY BANK		X	WORKING CAPITAL	DEMAND	01/08/02	263,000			PRIME+	2,610	6						
7												7						
8												8						
9	TOTAL Facility Related				\$84,627.75		\$ 7,563,000	\$ 7,115,941			\$ 476,584	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 7,563,000	\$ 7,115,941			\$ 476,584	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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	\$	<b>291,599</b>	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.)	\$	<b>337,100</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>45,501</b>	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>337,100</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>382,601</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	<b>259,589</b>	8
	1999	<b>266,222</b>	9
	2000	<b>273,716</b>	10
	2001	<b>283,073</b>	11
	2002	<b>337,100</b>	12

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.**

<b>FOR OHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2002	\$	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:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 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 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME EMERALD PARK HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040816

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(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>24-02-300-046-0000</u>	<u>NURSING HOME</u>	\$ <u>35,005.20</u>	\$ <u>35,005.20</u>
2. <u>24-02-300-047-0000</u>	<u>NURSING HOME</u>	\$ <u>201,396.84</u>	\$ <u>201,396.84</u>
3. <u>24-02-300-048-0000</u>	<u>NURSING HOME</u>	\$ <u>100,698.33</u>	\$ <u>100,698.33</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>337,100.37</u>	\$ <u>337,100.37</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER

# 0040816

Report Period Beginning:

01/01/2003 Ending:

12/31/2003

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 68,246 B. General Construction Type: Exterior BRICK Frame STEEL 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).

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RESIDENT CARE</u>		<u>1996</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 50,000</b>	<b>3</b>

Facility Name &amp; ID Number EMERALD PARK HEALTH CARE CENTER

# 0040816

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	249	1996	1976	\$ 6,402,500	\$ 164,160	30	\$ 213,417	\$ 49,257	\$ 1,551,370	4
5				(359,068)						5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	BUILDING IMPROVEMENTS		1987	65,253		20	3,263	3,263	54,481	9
10	BUILDING IMPROVEMENTS		1987	16,408		19	864	864	6,047	10
11	BUILDING IMPROVEMENTS		1987	1,924		15			1,924	11
12	BUILDING IMPROVEMENTS		1987	7,771		5			7,771	12
13	BUILDING IMPROVEMENTS		1988	9,570		20	479	479	7,040	13
14	BUILDING IMPROVEMENTS		1988	6,960		19	366	366	5,714	14
15	BUILDING IMPROVEMENTS		1989	7,955		20	398	398	3,111	15
16	BUILDING IMPROVEMENTS		1989	5,500		15	367	367	5,311	16
17	BUILDING IMPROVEMENTS		1990	34,570		20	1,729	1,729	23,661	17
18	ELECTRICAL		1991	1,658		31.5	53	53	673	18
19	ELEVATOR		1991	75,000		31.5	2,381	2,381	26,571	19
20	REMODELING		1991	3,668		31.5	116	116	1,397	20
21	ALARM DETECTION		1992	2,700		31.5	86	86	411	21
22	CURTAINS & TRACKS		1992	16,416		31.5	521	521	5,926	22
23	BUILDING IMPROVEMENTS		1993	63,956		39	1,640	1,640	18,297	23
24	BUILDING IMPROVEMENTS		1994	3,221		39	83	83	788	24
25	BUILDING IMPROVEMENTS		1994	3,500		39	90	90	855	25
26	HOT WATER HEATER		1994	1,985		39	51	51	484	26
27	BUILDING IMPROVEMENTS		1995	9,054	357	39	232	(125)	1,972	27
28	REPLACE FLOORS IN ENTIRE FACILITY		1996	63,110	1,618	30	2,104	486	15,780	28
29	WALLPAPERING		1996	3,646	93	30	122	29	915	29
30	DRAPERY & CURTAINS		1996	12,244	314	30	408	94	3,060	30
31	PAVEMENT - DRIVEWAY		1996	6,600	169	30	220	51	1,650	31
32	REMODELING SHOWER ROOMS, BATHROOM & REHAB ROOMS		1996	171,960	4,410	30	5,732	1,322	41,668	32
33	NEW LOBBIES & NURSING STATION		1997	69,250	1,776	39	1,776		11,211	33
34	KITCHEN ELECTRICAL		1997	3,578	92	7	511	419	3,112	34
35	FIRE DOOR		1997	520	13	7	74	61	451	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.

Facility Name &amp; ID Number EMERALD PARK HEALTH CARE CENTER

# 0040816

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

## 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	AIR CONDITIONER	1997	\$ 2,205	\$ 57	39	\$ 57	\$	\$ 370	37
38	TIME CLOCK SYSTEM	1998	4,958	127	39	127		699	38
39	PLUMBING	1998	5,398	138	39	138		759	39
40	AIR CONDITIONING	1998	4,239	109	39	109		599	40
41	ROOF	1998	1,562	40	39	40		220	41
42	TUCKPOINTING	1999	1,917	49	39	49		221	42
43	FIRE ALARM	1999	1,420	36	39	36		162	43
44	FENCE	1999	3,367	86	39	86		387	44
45	WINDOWS	1999	4,677	120	39	120		540	45
46	HVAC WORK	1999	2,946	76	7	76		342	46
47	PAINTING	1999	42,104	3,760	7	6,015	2,255	27,067	47
48	WALLPAPER	1999	4,804	429	7	686	257	3,087	48
49	CUBICLE CURTAINS	1999	17,937	1,602	7	2,562	960	11,529	49
50	DRAPES	1999	2,436	218	7	348	130	1,566	50
51	CARPETING	1999	2,788	249	7	398	149	1,791	51
52	FIRE DAMPERS	2001	1,190	31	39	31		62	52
53	ROOFING	2001	2,838	73	39	73		146	53
54	FLOORING	2001	5,320	137	39	137		273	54
55	EXTERIOR BRICK	2001	300	8	39	8		16	55
56	DISCHARGE VENTS	2001	6,948	176	39	176		354	56
57	WINDOWS	2001	1,680	43	39	43		86	57
58	WINDOWS	2001	1,550	40	39	40		80	58
59	ELEVATOR	2001	5,972	153	39	153		306	59
60	WIRING & PIPES	2001	8,766	225	39	225		450	60
61	ELECTRICAL	2001	158	4	39	4		8	61
62	SPRINCLER SYSTEM	2001	1,424	37	39	37		74	62
63	ROOFING	2001	566	15	39	15		30	63
64	CARPET	2001	1,683	294	39	43	(251)	254	64
65	CARPET	2001	434	76	39	11	(65)	65	65
66	HANDRAIL	2001	23,600	4,128	39	605	(3,523)	3,570	66
67	NURSING STATION	2001	6,000	1,049	39	154	(895)	908	67
68	HANDRAIL	2001	16,800	2,938	39	431	(2,507)	2,002	68
69	FRONT HALLWAY	2001	2,400	420	39	62	(358)	664	69
70	TOTAL (lines 4 thru 69)		\$ 6,901,796	\$ 189,945		\$ 250,178	\$ 60,233	\$ 1,860,338	70

\*\*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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,901,796	\$ 189,945		\$ 250,178	\$ 60,233	\$ 1,860,338	1
2	FRONT RECEPTION	2001	4,800	840	39	123	(717)	726	2
3	ELEVATOR	2001	3,900	682	39	100	(582)	590	3
4	HANDRAIL	2001	11,800	2,064	39	303	(1,761)	1,786	4
5	EMPLOYEE KITCHEN	2001	1,900	332	39	49	(283)	288	5
6	NURSING STATION	2001	10,000	1,749	39	256	(1,493)	812	6
7	ELEVATOR IMPROVEMENTS	2002	2,422	62	39	62		119	7
8	ROOFING	2002	2,838	73	39	73		134	8
9	FLOOR REMODELING	2002	4,756	122	39	122		234	9
10	FLOOR REMODELING	2002	3,807	98	39	98		180	10
11	FLOOR REMODELING	2002	11,296	290	39	290		556	11
12	ALARM SYSTEM-INSTALL SEVEN KEYPAD	2003	4,181	70	27.5	70		70	12
13	FLOOR REMODELING-2RD & 2ND FLOOR BEDROOMS	2003	44,266	604	27.5	604		604	13
14	ELEVATOR-REPLACEMENT CYLINDER	2003	36,057	383	27.5	383		383	14
15	PARKING LOT-SEALCOATING, PRAVACY FENCE & GATE	2003	7,147	79	15	79		79	15
16	REPLACE OLD CUBICLE RODS, MINI BLINDS	2003	8,012	1,602	20	401	(1,201)	401	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,058,978	\$ 198,995		\$ 253,191	\$ 54,196	\$ 1,867,300	34

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

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	\$ 957,207	\$ 89,932	\$ 72,010	\$ (17,922)	8-10	\$ 659,726	71
72	Current Year Purchases	46,718	23,936	2,546	(21,390)	8-10	2,546	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY ALLOCATION</b>		334	334				74
75	<b>TOTALS</b>	\$ 1,003,925	\$ 114,202	\$ 74,890	\$ (39,312)		\$ 662,272	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			2002	\$ 27,499	\$ 6,160	\$ 5,500	\$ (660)	5	\$ 11,000	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 27,499	\$ 6,160	\$ 5,500	\$ (660)		\$ 11,000	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)	\$ 8,140,402	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 319,357	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 333,581	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,224	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,540,572	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	<b>TOTALS</b>	\$	\$	\$	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?  YES  NO

If NO, see instructions.

		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: \$ 5,441 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2002 BUIC PARK AVENUE	\$ 568.00	\$ 568	17
18	PAINTERS	2003 CHEVY ASTRO VAN	645.00	1,291	18
19	ADMINISTRATIVE	2002 VOLVO	742.00	1,483	19
20					20
21	TOTAL		\$ #####	\$ 3,342	21

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. \_\_\_\_\_ /2004 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2005 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2006 \$ \_\_\_\_\_

\* 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.

**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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
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**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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	\$		\$ 66,854	\$		\$ 66,854	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			119			119	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			34,384			34,384	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 prescrpts				34,994		34,994	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY, LAB, OTHER SERVICES Other (specify): MEDICAL SUPPLIES	39-2 39-2					8,288 5,535		8,288 5,535	13
14	TOTAL			\$		\$ 101,357	\$ 48,817		\$ 150,174	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 EMERALD PARK HEALTH CARE CENTER

# 0040816

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 54,494	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,250,124		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,289		6
7	Other Prepaid Expenses	122,331		7
8	Accounts Receivable (owners or related parties)	902,506		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,420,744	\$	10
	<b>B. Long-Term Assets</b>			
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	951,497		15
16	Equipment, at Historical Cost	1,095,473		16
17	Accumulated Depreciation (book methods)	(1,077,894)		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): <b>GOODWILL</b>	244,323		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,213,399	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,634,143	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 245,852	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	920,361		29
30	Accrued Salaries Payable	142,118		30
31	Accrued Taxes Payable (excluding real estate taxes)	38,740		31
32	Accrued Real Estate Taxes(Sch.IX-B)	337,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,684,171	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,684,171	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,949,972	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,634,143	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,524,534</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>PRIOR YEAR ADJUSTMENT</b>	<b>95,959</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,620,493</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>344,479</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(15,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>329,479</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,949,972</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,273,022	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,273,022	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	24,793	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 24,793	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,906	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,906	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING COMMISSIONS</b>	200	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 200	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,301,921	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,328,077	31
32	Health Care	2,813,677	32
33	General Administration	2,386,525	33
<b>B. Capital Expense</b>			
34	Ownership	1,142,662	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	150,174	35
36	Provider Participation Fee	136,327	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,957,442	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	344,479	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 344,479	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 **EMERALD PARK HEALTH CARE CENTER**

# **0040816**

Report Period Beginning: **01/01/2003**

Ending:

**12/31/2003**

**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	3,500	3,630	\$ 104,941	\$ 28.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,601	8,733	198,477	22.73	3
4	Licensed Practical Nurses	57,480	58,417	1,094,254	18.73	4
5	Nurse Aides & Orderlies	114,337	116,502	900,442	7.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,363	3,363	65,214	19.39	8
9	Activity Director					9
10	Activity Assistants	6,194	6,294	46,063	7.32	10
11	Social Service Workers	19,588	20,033	183,084	9.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,296	30,980	216,198	6.98	15
16	Dishwashers					16
17	Maintenance Workers	5,101	5,463	51,320	9.39	17
18	Housekeepers	39,472	40,116	290,686	7.25	18
19	Laundry	10,487	10,713	82,176	7.67	19
20	Administrator	2,132	2,161	59,578	27.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,630	10,712	107,960	10.08	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	240	240	4,654	19.39	31
32	Other Health Care(specify)					32
33	Other(specify) <u>SEE ATTACHED</u>	10,264	10,447	98,329	9.41	33
34	TOTAL (lines 1 - 33)	321,685	327,804	\$ 3,503,376 *	\$ 10.69	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	\$ 9,960	1-3	35
36	Medical Director	7,500	9-3	36
37	Medical Records Consultant	3,908	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	5,136	10-3	39
40	Physical Therapy Consultant	1,439	10a-3	40
41	Occupational Therapy Consultant	2,020	10a-3	41
42	Respiratory Therapy Consultant	2,300	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	2,553	11-3	44
45	Social Service Consultant	7,627	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 42,443		49

**C. CONTRACT NURSES**

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



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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING	07/03	\$ 11,677	3 YR	\$	\$	\$	\$ 1,946	\$ 3,893	\$ 3,892	\$ 1,946	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 11,677		\$	\$	\$	\$ 1,946	\$ 3,893	\$ 3,892	\$ 1,946	\$	\$

Facility Name &amp; ID Number EMERALD PARK HEALTH CARE CENTER

# 0040816

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

**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-\$8003
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 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 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. \$ 136,327  
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. \$ #REF! Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees