

		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>I. IDPH Facility ID Number: <u>0024463</u></p> <p>Facility Name: <u>Peterson Park Health Care Center</u></p> <p>Address: <u>6141 N. Pulaski</u> <u>Chicago</u> <u>60646</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 478-2000</u> Fax # <u>(773) 478-8408</u></p> <p>IDPA ID Number: <u>36-2999153</u></p> <p>Date of Initial License for Current Owners: <u>01/01/78</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Bob Kagda</u> Telephone Number: <u>(847)-675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 722">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 722 1281 828"></td> <td data-bbox="1281 722 1921 766">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1144 766 1281 828"></td> <td data-bbox="1281 766 1921 810">(Title) _____</td> </tr> <tr> <td data-bbox="1144 828 1281 1042">Paid Preparer</td> <td data-bbox="1281 828 1921 888">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 888 1281 1042"></td> <td data-bbox="1281 888 1921 932">(Print Name and Title) <u>Bob Kagda Partner</u></td> </tr> <tr> <td data-bbox="1144 932 1281 1042"></td> <td data-bbox="1281 932 1921 1011">(Firm Name & Address) <u>Krupnick, Bokor, Kagda & Brooks, Ltd. 3750 W. Devon Ave. Lincolnwood, IL 60712-1124</u></td> </tr> <tr> <td data-bbox="1144 1011 1281 1042"></td> <td data-bbox="1281 1011 1921 1042">(Telephone) <u>(847)-675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p>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>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) <u>Bob Kagda Partner</u>		(Firm Name & Address) <u>Krupnick, Bokor, Kagda & Brooks, Ltd. 3750 W. Devon Ave. Lincolnwood, IL 60712-1124</u>		(Telephone) <u>(847)-675-3585</u> Fax # <u>(847) 675-5777</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name & ID Number Peterson Park Health Care Center

0024463 Report Period Beginning: 01/01/03 Ending: 12/31/03

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>93</u>	Skilled (SNF)	<u>93</u>	<u>33,945</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>95</u>	Intermediate (ICF)	<u>95</u>	<u>34,675</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>188</u>	TOTALS	<u>188</u>	<u>68,620</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	<u>10,249</u>	<u>1,432</u>	<u>4,247</u>	<u>15,928</u>	8
9	SNF/PED					9
10	ICF	<u>43,682</u>	<u>1,612</u>	<u>32</u>	<u>45,326</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>53,931</u>	<u>3,044</u>	<u>4,279</u>	<u>61,254</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.27%

D. How many bed-hold days during this year were paid by Public Aid? 982 (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) _____

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/78

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/86 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 17 and days of care provided 4,247

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/03 Fiscal Year: 12/31/03

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

STATE OF ILLINOIS

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	296,378	40,182	21,038	357,598	(41,749)	315,849	(170)	315,679		1
2	Food Purchase		369,032		369,032		369,032		369,032		2
3	Housekeeping	104,117	33,106		137,223		137,223		137,223		3
4	Laundry	75,402	5,105		80,507		80,507		80,507		4
5	Heat and Other Utilities			150,980	150,980		150,980	4,527	155,507		5
6	Maintenance	92,158		45,779	137,937		137,937	9,543	147,480		6
7	Other (specify):*										7
8	TOTAL General Services	568,055	447,425	217,797	1,233,277	(41,749)	1,191,528	13,900	1,205,428		8
B. Health Care and Programs											
9	Medical Director			12,900	12,900		12,900	(11,650)	1,250		9
10	Nursing and Medical Records	2,406,793	137,072	49,065	2,592,930		2,592,930		2,592,930		10
10a	Therapy		67	12,295	12,362		12,362		12,362		10a
11	Activities	180,756	19,586	8,140	208,482		208,482		208,482		11
12	Social Services	242,800		5,407	248,207		248,207		248,207		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,830,349	156,725	87,807	3,074,881		3,074,881	(11,650)	3,063,231		16
C. General Administration											
17	Administrative	129,628		513,492	643,120		643,120	(413,017)	230,103		17
18	Directors Fees										18
19	Professional Services			34,891	34,891	(1,109)	33,782	6,693	40,475		19
20	Dues, Fees, Subscriptions & Promotions			35,071	35,071		35,071	(17,016)	18,055		20
21	Clerical & General Office Expenses	102,261	41,473	192,060	335,794		335,794	54,959	390,753		21
22	Employee Benefits & Payroll Taxes			560,836	560,836	41,749	602,585	27,967	630,552		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,624	2,624		2,624		2,624		24
25	Other Admin. Staff Transportation			7,351	7,351		7,351	2,373	9,724		25
26	Insurance-Prop.Liab.Malpractice			164,500	164,500		164,500	2,051	166,551		26
27	Other (specify):*							5,128	5,128		27
28	TOTAL General Administration	231,889	41,473	1,510,825	1,784,187	40,640	1,824,827	(330,862)	1,493,965		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,630,293	645,623	1,816,429	6,092,345	(1,109)	6,091,236	(328,612)	5,762,624		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.

Peterson Park Health Care Center
0024463
COST REPORT RECLASSIFICATIONS
01/01/03
12/31/03

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	<u>41,749</u>	
2	FOOD		<u>41,749</u>

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	<u>1,109</u>	
19	PROFESSIONAL FEES		<u>1,109</u>

To reclass cost of appealing real estate taxes

Facility Name & ID Number

Peterson Park Health Care Center

#0024463

Report Period Beginning:

01/01/03

Ending:

12/31/03

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							229,306	229,306			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,471	45,471		45,471	255,214	300,685			32
33	Real Estate Taxes			(5,251)	(5,251)	1,109	(4,142)	246,008	241,866			33
34	Rent-Facility & Grounds			702,996	702,996		702,996	(702,996)				34
35	Rent-Equipment & Vehicles			1,233	1,233		1,233	2,318	3,551			35
36	Other (specify):*							2,289	2,289			36
37	TOTAL Ownership			744,449	744,449	1,109	745,558	32,139	777,697			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	89,350	166,651	31,374	287,375		287,375		287,375			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	89,350	166,651	134,304	390,305		390,305		390,305			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,719,643	812,274	2,695,182	7,227,099		7,227,099	(296,473)	6,930,626			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 Peterson Park Health Care Center

0024463

Report Period Beginning: 01/01/03

Ending: 12/31/03

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	24,314	30		9
10	Interest and Other Investment Income	(35,469)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(170)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,792)	21		18
19	Entertainment				19
20	Contributions	(320)	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	(147,722)	21		24
25	Fund Raising, Advertising and Promotional	(16,735)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,128)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(14,356)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (196,378)		\$	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)	(100,095)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (100,095)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (296,473)		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

Peterson Park Health Care Center

ID# 0024463

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Bank Charges	\$ (1)	21	1
2	Prior Period Adjustments:			2
3	Class Advertising	(469)	20	3
4	Medical Director	(11,650)	9	4
5	Related Party Adjustments (Paage 6)			5
6	Trust Fees	(300)	21	6
7	Bank Charges	(734)	21	7
8	State Replacemnt Tax	(1,200)	21	8
9	Round off adjustment	(2)	30	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	(14,356)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	(170)	0	0	0	0	0	0	0	0	0	0	(170)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4,527	0	0	0	0	0	0	0	0	4,527	5
6	Maintenance	0	0	9,543	0	0	0	0	0	0	0	0	9,543	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(170)	0	14,070	0	0	0	0	0	0	0	0	13,900	8
	B. Health Care and Programs													
9	Medical Director	(11,650)	0	0	0	0	0	0	0	0	0	0	(11,650)	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(11,650)	0	0	0	0	0	0	0	0	0	0	(11,650)	16
	C. General Administration													
17	Administrative	0	0	(363,612)	(49,405)	0	0	0	0	0	0	0	(413,017)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,513	4,180	0	0	0	0	0	0	0	0	6,693	19
20	Fees, Subscriptions & Promotions	(17,524)	200	308	0	0	0	0	0	0	0	0	(17,016)	20
21	Clerical & General Office Expenses	(155,877)	2,390	208,446	0	0	0	0	0	0	0	0	54,959	21
22	Employee Benefits & Payroll Taxes	0	0	27,967	0	0	0	0	0	0	0	0	27,967	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	2,373	0	0	0	0	0	0	0	0	2,373	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,051	0	0	0	0	0	0	0	0	2,051	26
27	Other (specify):*	0	0	0	5,128	0	0	0	0	0	0	0	5,128	27
28	TOTAL General Administration	(173,401)	5,103	(118,287)	(44,277)	0	(330,862)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(185,221)	5,103	(104,217)	(44,277)	0	(328,612)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Peterson Park Health Care Center# 0024463

Report Period Beginning:

01/01/03

Ending:

12/31/03

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	24,312	190,645	14,349	0	0	0	0	0	0	0	0	229,306 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(35,469)	278,407	12,276	0	0	0	0	0	0	0	0	255,214 32
33	Real Estate Taxes	0	237,374	8,634	0	0	0	0	0	0	0	0	246,008 33
34	Rent-Facility & Grounds	0	(702,996)	0	0	0	0	0	0	0	0	0	(702,996) 34
35	Rent-Equipment & Vehicles	0	0	2,318	0	0	0	0	0	0	0	0	2,318 35
36	Other (specify):*	0	2,289	0	0	0	0	0	0	0	0	0	2,289 36
37	TOTAL Ownership	(11,157)	5,719	37,577	0	0	0	0	0	0	0	0	32,139 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(196,378)	10,822	(66,640)	(44,277)	0	(296,473) 45						

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning:

01/01/03

Ending:

12/31/03

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
Schedule attached		Courtyard Terrace (Endee)	Rockford			
		Embassy Care Cener	Wilmington			
		Peterson Park Health Care	Chicago			

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	34 Rent	\$ 702,996	Peterson Park Realty		\$	\$ (702,996) 1
2	V	32 Interest Expense		Peterson Park Realty		278,407	278,407 2
3	V	20 License and Fees		Peterson Park Realty		200	200 3
4	V	30 Depreciation		Peterson Park Realty		190,645	190,645 4
5	V	21 Bank Charges		Peterson Park Realty		734	734 5
6	V	21 Trust Fees		Peterson Park Realty		300	300 6
7	V	21 Office Expense		Peterson Park Realty		156	156 7
8	V	36 Amort of Mtge Costs		Peterson Park Realty		2,289	2,289 8
9	V	19 Accounting		Peterson Park Realty		2,513	2,513 9
10	V	33 RE Tax Expense		Peterson Park Realty		237,374	237,374 10
11	V	21 State Replacement Tax		Peterson Park Realty		1,200	1,200 11
12	V						
13	V						
14	Total		\$ 702,996			\$ 713,818	\$ * 10,822 14

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

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning: 01/01/03

Ending: 12/31/03

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	\$ 513,492	Future Associates		\$	\$ (513,492) 15
16	V	5 Utilities		Future Associates		4,527	4,527 16
17	V	6 Maintenance		Future Associates		9,543	9,543 17
18	V	17 Administrative		Future Associates		149,880	149,880 18
19	V	19 Professional Fees		Future Associates		4,180	4,180 19
20	V	21 Clerical and General		Future Associates		208,446	208,446 20
21	V	22 Employee Benefits		Future Associates		27,967	27,967 21
22	V	25 Auto Expense		Future Associates		2,373	2,373 22
23	V	26 Insurance Expense		Future Associates		2,051	2,051 23
24	V	30 Depreciation		Future Associates		14,349	14,349 24
25	V	32 Interest Expense		Future Associates		12,276	12,276 25
26	V	33 Real Estate Taxes		Future Associates		8,634	8,634 26
27	V	35 Equipment Rental		Future Associates		2,318	2,318 27
28	V	20 License, Dues, Fees		Future Associates		308	308 28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$ 513,492			\$ 446,852	\$ * (66,640) 39

* 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 Salary Ron Shabat	\$	Shabat & Associates	100.00%	\$ 94,595	\$ 94,595
16	V	27 Payroll Taxes		Shabat & Associates	100.00%	5,128	5,128
17	V	17 Management Fees (from Future)	144,000				(144,000)
18	V						
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		\$ 144,000			\$ 99,723	\$ * (44,277)

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	Ronald Shabat	Director	Administrative	43.09		25	67.57	Salary	\$ 39,000	17-1	1
2	Ronald Shabat	Director	Administrative	43.09	179,000	25	67.57	Allocated	94,595	17-7	2
3	Menachem Shabat	Administrator	Administrative	6.38		60	100.00	Salary	81,024	17-1	3
4	Nachshon Draiman	Director	Administrative	35.64							4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 214,619		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 Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 Future Associates
 Street Address 7514 N. Skokie Blvd
 City / State / Zip Code Skokie, IL
 Phone Number (847)982-1195
 Fax Number (847)982-0992

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	1,083,202	4	\$ 9,550	\$ 513,492	\$ 4,527	1
2	6	Maintenance	Management Fees	1,083,202	4	20,131	513,492	9,543	2
3	17	Administrative	Direct allocation		4	261,600		149,880	3
4	19	Professional Fees	Management Fees	1,083,202	4	8,817	513,492	4,180	4
5	21	Clerical and General	Management Fees	1,083,202	4	380,592	310,233	180,420	5
6	22	Employee Benefits	Management Fees	1,083,202	4	54,245	513,492	25,715	6
7	25	Auto Expense	Management Fees	1,083,202	4	5,005	513,492	2,373	7
8	26	Insurance Expense	Management Fees	1,083,202	4	4,326	513,492	2,051	8
9	30	Depreciation	Management Fees	1,083,202	4	30,268	513,492	14,349	9
10	32	Interest Expense	Management Fees	1,083,202	4	25,895	513,492	12,276	10
11	33	Real Estate Taxes	Management Fees	1,083,202	4	18,214	513,492	8,634	11
12	35	Equipment Rental	Management Fees	1,083,202	4	18,214	513,492	2,318	12
13	20	License, Dues, Fees	Management Fees	1,083,202	4	649	513,492	308	13
14	21	Clerical and General	Direct allocation		3	46,710	46,710	28,026	14
15	22	Employee Benefits	Direct allocation		3	3,753		2,252	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 887,969	\$ 356,943	\$ 446,852	25

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 Shabat & Associates
 Street Address 7514 N Skokie Blvd
 City / State / Zip Code Chicago, IL 60077
 Phone Number (847)982-1195
 Fax Number (847)982-0992

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	Salary R Shabat	Avg Hrs Wkd	37	3	\$ 140,000	\$ 140,000	25	\$ 94,595	1
2	27	Payroll Taxes	Avg Hrs Wkd	37	3	7,590	25	5,128		2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 147,590	\$ 140,000		\$ 99,723	25

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/03 Ending: 12/31/03

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										
										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	BankFinancial, F.S.B.		X	Mortgage	\$35,075.41	08/20/02	\$ 6,000,000	\$ 5,810,502	9/10/07	Var	\$ 278,407	1							
2												2							
3	Allocation from Future											3							
4												4							
5												5							
Working Capital																			
6	Bank Financial		X	Line of Credit		Various		818,411		Var	32,866	6							
7	Insurance		X							Var	3,610	7							
8	Illinois Provider Asses		X							Var	8,995	8							
9	TOTAL Facility Related				\$35,075.41		\$ 6,000,000	\$ 6,628,913			\$ 336,154	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13	Interest Income											13							
14	TOTAL Non-Facility Related						\$	\$			\$ (35,469)	14							
15	TOTALS (line 9+line14)						\$ 6,000,000	\$ 6,628,913			\$ 300,685	15							

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

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

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

Facility Name & ID Number **Peterson Park Health Care Center**# **0024463** Report Period Beginning: **01/01/03** Ending: **12/31/03****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.			\$	240,000	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.)			\$	240,757	2																			
3.	Under or (over) accrual (line 2 minus line 1).			\$	757	3																			
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	240,000	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.)			\$	1,109	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.			\$	241,866	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		1998	291,699	8	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY			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
FOR OHF USE ONLY																									
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																						
		1999	230,523	9																					
		2000	223,731	10																					
		2001	229,549	11																					
		2002	232,123	12																					
	<u>Estimate based on 2002 bill</u>	240000																							
	<u>Allocation from Future</u>	8634																							

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 Peterson Park Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0024463

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>13-02-115-052-0000</u>	<u>Facility</u>	\$ <u>232,123.00</u>	\$ <u>232,123.00</u>
2. <u>10-28-408-025</u>	<u>Management Office</u>	\$ <u>17,915.80</u>	\$ <u>2,413.00</u>
3. <u>10-28-408-026</u>	<u>Management Office</u>	\$ <u>8,751.07</u>	\$ <u>1,179.00</u>
4. <u>10-28-408-027</u>	<u>Management Office</u>	\$ <u>8,751.07</u>	\$ <u>1,179.00</u>
5. <u>10-28-408-028</u>	<u>Management Office</u>	\$ <u>12,701.72</u>	\$ <u>1,711.00</u>
6. <u>10-28-408-029</u>	<u>Management Office</u>	\$ <u>12,701.72</u>	\$ <u>1,711.00</u>
7. <u>10-28-408-030</u>	<u>Management Office</u>	\$ <u>1,522.14</u>	\$ <u>205.00</u>
8. <u>10-28-408-031</u>	<u>Management Office</u>	\$ <u>1,522.14</u>	\$ <u>205.00</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>295,988.66</u>	\$ <u>240,726.00</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 Peterson Park Health Care Center# 0024463 Report Period Beginning:01/01/03 Ending:12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,900 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1986	\$ 283,071	1
2					2
3	TOTALS			\$ 283,071	3

XL 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	188	1986		\$ 2,548,850	\$ 107,051	35	\$ 72,825	\$ (34,226)	\$ 1,244,078	4
5	Alloc LCF	1986		103,029	4,327	30	3,434	(893)	58,669	5
6	Alloc LCF	1987		2,472	79	31.5	79		789	6
7										7
8										8
Improvement Type**										
9	Various		1979	4,800					4,800	9
10	Various		1981	57,728					57,728	10
11	Various		1982	11,967					11,967	11
12	Various		1983	3,440					3,440	12
13	Various		1984	12,700					12,700	13
14	Various		1985	98,707		19	1,477	1,477	97,846	14
15	Various		1986	42,087	237	19	2,217	1,980	38,885	15
16	Various		1987	17,729	563	31	572	9	9,586	16
17	Various		1988	35,577	1,130	31	1,147	17	17,584	17
18	Various		1989	14,591	463	31	470	7	6,767	18
19	Various		1990	27,693	879	31	894	15	11,969	19
20	Various		1991	62,352	1,979	20	3,117	1,138	38,227	20
21	Various		1992	10,152	323	20	507	184	6,095	21
22	Various		1993	21,815	246	20	1,090	844	11,582	22
23	Various		1994	264,384	5,870	20	13,219	7,349	122,437	23
24	Various		1995	103,507	2,756	20	5,179	2,423	43,759	24
25	Various		1996	35,086	958	20	1,753	795	13,288	25
26	Various		1997	62,950	1,614	20	3,147	1,533	20,157	26
27	Various		1998	49,698	1,275	20	2,484	1,209	14,220	27
28	Various		1999	87,532	2,483	20	4,377	1,894	21,133	28
29	Dual pres. control		1/31/2000	703	18	20	35	17	140	29
30	Rehung Door closers		1/31/2000	1,183	31	20	59	28	236	30
31	Det Heat 194F		1/31/2000	1,121	28	20	56	28	224	31
32	Enviormnt testing		2/28/2000	1,445	37	20	73	36	283	32
33	1 inch Valves		2/28/2000	556	15	20	28	13	110	33
34	Door Hldr Ball bear		3/31/2000	1,130	29	20	56	27	218	34
35	Valves ovrrhd pipe		3/31/2000	1,997	51	20	100	49	383	35
36	3 grease traps		3/31/2000	7,345	189	20	368	179	1408	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning:

01/01/03

Ending:

12/31/03

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		
37	Repair oven doors	3/31/2000	\$ 691	\$ 17	20	\$ 34	\$ 17	\$ 133	37
38	Fire suppression sys	4/30/2000	2,058	53	20	103	50	386	38
39	A/C thermostadt	4/30/2000	4,604	118	20	230	112	863	39
40	Repair rehang door	4/30/2000	1,578	41	20	79	38	296	40
41	Air conditioneers	5/31/2000	3,646	94	20	183	89	668	41
42	SS Panel	6/6/2000	372	9	20	18	9	67	42
43	New gas line	6/11/2000	875	23	20	44	21	158	43
44	Light fixtures	6/27/2000	22,067	566	20	1,104	538	3,953	44
45	Flooring Wallcover	6/27/2000	63,063	1,617	20	3,153	1,536	11,298	45
46	Repair doors	6/30/2000	2,184	56	20	109	53	391	46
47	New Ceiling Fixture	7/1/2000	6,205	159	20	311	152	1,086	47
48	Door closers	7/31/2000	1,435	37	20	72	35	252	48
49	Air conditioneers	8/31/2000	4,311	110	20	215	105	737	49
50	Vinyl floor tile	8/31/2000	566	14	20	29	15	97	50
51	New elect pipe wire	8/31/2000	1,300	34	20	65	31	222	51
52	Repair A/C lines	8/31/2000	2,023	52	20	101	49	439	52
53	Templer sprink.syst	8/31/2000	1,609	42	20	81	39	274	53
54	Install door frames	9/9/2000	4,150	107	20	207	100	692	54
55	Ceiling Dining room	9/26/2000	20,041	514	20	1,002	488	3,340	55
56	Rebult lift assemb	9/30/2000	557	15	20	28	13	93	56
57	Repair dining door	9/30/2000	481	13	20	24	11	80	57
58	Replace shower fauct	10/30/2000	2,800	72	20	140	68	455	58
59	Wallpaper	10/30/2000	683	17	20	34	17	111	59
60	Lobby baseboard	10/31/2000	1,437	37	20	72	35	234	60
61	New ceilings	10/31/2000	11,027	282	20	552	270	1,854	61
62	Wall - Employee DR	11/2/2000	2,411	62	20	120	58	382	62
63	Door closures	11/30/2000	1,213	31	20	60	29	192	63
64	Kitchen exhaust fan	11/30/2000	772	20	20	38	18	123	64
65	Probes for tank	12/31/2000	567	14	20	29	15	87	65
66	Borders Resident rm	12/31/2000	7,600	195	20	380	185	1,172	66
67	Borders resident rm	12/31/2000	637	17	20	32	15	99	67
68	WALLPAPER	1/1/2001	7,508	192	20	376	184	1,126	68
69	WATER HEATER	1/4/2001	5,240	135	20	262	127	786	69
70	TOTAL (lines 4 thru 69)		\$ 3,880,037	\$ 137,396		\$ 128,050	\$ (9,346)	\$ 1,902,854	70

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

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	Totals from Page 12A, Carried Forward		\$ 3,880,037	\$ 137,396		\$ 128,050	\$ (9,346)	\$ 1,902,854	1
2	HOT WATER HTR	1/12/2001	1,100	28	20	55	27	165	2
3	Floor tile	2/13/2001	2,290	58	20	114	56	334	3
4	Wallcoverings	2/27/2001	3,160	81	20	158	77	461	4
5	KEY & CYLINDERS	3/6/2001	1,348	34	20	68	34	191	5
6	WALLCOVERINGS	3/19/2001	11,626	298	20	582	284	1,647	6
7	VALVES PUMP A/C	3/22/2001	1,218	31	20	61	30	173	7
8	TILES	3/26/2001	1,788	46	20	90	44	253	8
9	BATH TUB FAUCETS	4/3/2001	3,450	89	20	172	83	475	9
10	DOOR CLOSE	4/4/2001	607	15	20	31	16	84	10
11	WINDOW TREATMENT	4/11/2001	1,536	40	20	77	37	212	11
12	HANDLE STOPPER	4/16/2001	625	16	20	32	16	86	12
13	ALARM CONTROL	5/25/2001	1,880	48	20	94	46	251	13
14	NEW LAV FAUCETS	5/29/2001	625	16	20	32	16	84	14
15	BROKEN SEWER LINE	6/5/2001	1,400	36	20	70	34	181	15
16	AIR COND	6/11/2001	3,743	96	20	187	91	483	16
17	AIR COND	6/14/2001	3,027	77	20	152	75	391	17
18	AIR COND	6/29/2001	3,324	85	20	166	81	429	18
19	WALKWAY RETAIN WALL	7/5/2001	2,590	67	20	129	62	324	19
20	CCTV system repair	8/10/2001	2,967	76	20	149	73	359	20
21	CCTV repairs	8/29/2001	952	25	20	47	22	115	21
22	Tile	9/14/2001	513	13	20	25	12	60	22
23	Roofing	9/19/2001	895	23	20	45	22	105	23
24	CCTV-reception desk	10/15/2001	1,560	40	20	78	38	176	24
25	Repair 6inc.sew.line	11/13/2001	1,250	32	20	62	30	136	25
26	STOREROOM LOCK	11/16/2001	937	24	20	47	23	102	26
27	PILOT SAFETY CONTROL	12/6/2001	1,514	39	20	75	36	157	27
28	ENERGY MGMT CONTROL	12/6/2001	1,975	50	20	99	49	206	28
29	REPAIR NSE CALL SYS	12/14/2001	715	19	20	36	17	75	29
30	EXHAUST FAN	12/20/2001	1,675	43	20	84	41	175	30
31	NEW ROOFTOP KIT. FAN	12/24/2001	880	22	20	44	22	92	31
32	Electric line and outlets	1/16/2002	3,380	87	20	169	82	253	32
33	Nurse call system	2/15/2002	767	20	20	39	19	58	33
34	TOTAL (lines 1 thru 33)		\$ 3,945,354	\$ 139,070		\$ 131,319	\$ (7,751)	\$ 1,911,147	34

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

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	Totals from Page 12B, Carried Forward		\$ 3,945,354	\$ 139,070		\$ 131,319	\$ (7,751)	\$ 1,911,147	1
2	Solenoid lock w/ magnet	2/15/2002	885	23	20	44	21	66	2
3	Nurs call system 2 south	3/25/2002	728	18	20	37	19	55	3
4	Nurs call system 1 north	3/25/2002	741	19	20	37	18	56	4
5	Remove old ceiling	5/8/2002	82,615	2,118	20	4,131	2,013	6,196	5
6	Exhaust Fan	5/13/2002	1,875	48	20	94	46	141	6
7	7 Air conditioneers	5/13/2002	4,485	115	20	224	109	336	7
8	Exhaust Fan	5/14/2002	3,865	99	20	193	94	290	8
9	Plastic anchors	5/28/2002	1,098	28	20	55	27	82	9
10	Nurse station	5/30/2002	53,692	1,377	20	2,685	1,308	4,027	10
11	New stainless steel sdink	6/3/2002	540	13	20	26	13	40	11
12	New crown moldings dayrooms	6/3/2002	4,170	107	20	209	102	313	12
13	Remove install handrail bumpers	6/12/2002	6,060	156	20	303	147	454	13
14	Repair 2 broken floor drains	6/12/2002	550	14	20	27	13	41	14
15	Window and new light	6/14/2002	808	21	20	41	20	61	15
16	Remove install floor d/r	6/17/2002	22,784	585	20	1,139	554	1,709	16
17	Front door alarm	6/19/2002	1,114	29	20	56	27	84	17
18	Wall covering	6/20/2002	55,100	1,413	20	2,754	1,341	4,132	18
19	Remove and install d/r lighting	6/20/2002	43,005	1,103	20	2,150	1,047	3,225	19
20	Paint remove walls paint wall coverings	6/20/2002	1,488	38	20	75	37	112	20
21	Modified bitumen roof install	7/2/2002	1,100	28	20	55	27	83	21
22	Handrails, bumpers & soffits	7/12/2002	9,031	232	20	451	219	677	22
23	Room signage, end caps window trtmnt	8/2/2002	5,023	129	20	251	122	377	23
24	Install 8inch+D29 inline duct fan	8/9/2002	875	23	20	44	21	66	24
25	PA System	8/12/2002	2,939	76	20	147	71	220	25
26	Architect per retainer	8/31/2002	3,000	77	20	150	73	225	26
27	Architect -Remodeling and addition	9/8/2002	970	25	20	49	24	73	27
28	Modified bitumen roof install	9/20/2002	1,480	38	20	74	36	111	28
29	Paint Moldings	9/27/2002	700	18	20	35	17	53	29
30	Install security hardware	10/2/2002	545	14	20	27	13	41	30
31	CCTV System 1 north day room	10/28/2002	1,037	26	20	52	26	78	31
32	CCTV System 1 south D/R	10/28/2002	1,037	26	20	52	26	78	32
33	Install latching alarm system	10/28/2002	1,266	32	20	63	31	95	33
34	TOTAL (lines 1 thru 33)		\$ 4,259,960	\$ 147,138		\$ 147,049	\$ (89)	\$ 1,934,744	34

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

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	Totals from Page 12C, Carried Forward		\$ 4,259,960	\$ 147,138		\$ 147,049	\$ (89)	\$ 1,934,744	1
2	Rebuild And clean bathroom exhaust fans	10/31/2002	1,225	31	20	61	30	92	2
3	2 new firex smoke alarms/detectors	11/13/2002	1,755	45	20	88	43	132	3
4	CCTV System 2nd Floor South D/R	12/10/2002	1,137	29	20	57	28	85	4
5	CCTV System 2nd Floor North D/R	12/10/2002	1,137	29	20	57	28	85	5
6	Ceramic wall tile	12/11/2002	4,801	123	20	240	117	360	6
7	Fire rated exit device	12/11/2002	4,281	109	20	214	105	321	7
8	Window treatments	12/20/2002	10,010	256	20	501	245	751	8
9	15 bathroom remodeling	12/23/2002	7,000	180	20	350	170	525	9
10	Heat & A/C Motor	1/2/2003	1,274	31	20	32	1	32	10
11	New fan, 26 blade"	1/2/2003	652	16	20	16		16	11
12	New smoke detector assembly	1/26/2003	865	21	20	22	1	22	12
13	Bathroom remodeling	1/29/2003	4,595	113	20	115	2	115	13
14	Roof repairs	2/3/2003	715	16	20	18	2	18	14
15	Installed CCTV for lobby	2/7/2003	1,447	32	20	36	4	36	15
16	Three compmnt. sink w/drains	2/7/2003	950	21	20	24	3	24	16
17	Install CCTV main dining room	2/7/2003	1,237	28	20	31	3	31	17
18	Two pipe freezing unit	2/11/2003	946	21	20	24	3	24	18
19	B7G motor assembly	2/17/2003	2,360	53	20	59	6	59	19
20	Recirculating pump on storage tank	2/21/2003	750	17	20	19	2	19	20
21	Nurses call system	3/1/2003	765	16	20	19	3	19	21
22	Install CCTV o/s delivery door	3/28/2003	1,286	26	20	32	6	32	22
23	Install CCTV basement	3/28/2003	1,382	28	20	35	7	35	23
24	Roof repairs	4/10/2003	660	12	20	17	5	17	24
25	Defrost clock walk in freezer	4/16/2003	573	10	20	14	4	14	25
26	Leak in baseboard	4/29/2003	1,161	21	20	29	8	29	26
27	Cedar fencing	5/8/2003	2,800	45	20	70	25	70	27
28	Nurses station 2nd floor	5/16/2003	550	9	20	14	5	14	28
29	Stockade fencing	6/4/2003	1,880	26	20	47	21	47	29
30	Elevator communication system	6/12/2003	887	12	20	22	10	22	30
31	Electrical svce basement, cctv panel	6/12/2003	532	7	20	13	6	13	31
32	Electrical svce in kitchen	6/12/2003	813	11	20	20	9	20	32
33	Telephone svce, outlets, lines	6/12/2003	716	10	20	18	8	18	33
34	TOTAL (lines 1 thru 33)		\$ 4,321,102	\$ 148,542		\$ 149,363	\$ 821	\$ 1,937,841	34

**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	Totals from Page 12D, Carried Forward	\$ 4,321,102	\$ 148,542		\$ 149,363	\$ 821	\$ 1,937,841		1
2	Montiring system for CCTV	6/12/2003 1,044	15	20	26	11	26		2
3	Elevator repairs	6/30/2003 10,591	147	20	265	118	265		3
4	Verical sewerage pump	7/11/2003 5,813	68	20	145	77	145		4
5	Patio door	7/29/2003 5,774	68	20	144	76	144		5
6	Circuit breakers elect svce	8/25/2003 942	9	20	24	15	24		6
7	Nurses call system 2nd floor	8/25/2003 817	8	20	31	23	31		7
8	B&G circulating pump	8/25/2003 3,845	37	20	96	59	96		8
9	Parking lot repaving	9/12/2003 5,100	38	20	128	90	128		9
10	Pump motor	9/12/2003 829	6	20	21	15	21		10
11	Johnson controls	10/21/2003 1,146	6	20	29	23	29		11
12	Walk in cooler leaks & short cycles	10/29/2003 941	5	20	24	19	24		12
13	Telephone svce, in basement	11/28/2003 800	3	20	20	17	20		13
14	Duct control panel	12/30/2003 10,800	12	20	270	258	270		14
15									15
16	Alloc from LCF	1987 14,180	450	31.5	450		7,314		16
17	Alloc from LCF	1988 796	25	31.5	25		388		17
18	Alloc from LCF	1989 296	9	31.5	9		134		18
19	Alloc from LCF	1993 8,236	211	39	211		2,189		19
20	Alloc from LCF	1994 12,559	322	39	322		3,044		20
21	Alloc from LCF-Air Cond.; Roof Repairs	2001 3,498	90	39	90		223		21
22	Alloc from LCF-5 Ton Trane A/C	2002 857	22	39	22		30		22
23	Alloc from LCF-Office Remodeling	2003 269							23
24	Alloc fro Future Associates	1987 44,687	1,418	31.5	1,441	23	24,341		24
25	Alloc fro Future Associates	1994 13,070	177	Var	793	616	7,840		25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,467,992	\$ 151,688		\$ 153,949	\$ 2,261	\$ 1,984,567		34

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

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	\$ 593,522	\$ 43,763	\$ 65,425	\$ 21,662	10	\$ 367,216	71
72	Current Year Purchases	42,071	6,408	2,187	(4,221)	10	2,187	72
73	Fully Depreciated Assets	499,582		4,612	4,612	10	499,582	73
74								74
75	TOTALS	\$ 1,135,175	\$ 50,171	\$ 72,224	\$ 22,053		\$ 868,985	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	Allocation from Future			\$ 91,479	\$ 3,133	\$ 3,133	\$	5	\$ 54,360	76
77										77
78										78
79										79
80	TOTALS			\$ 91,479	\$ 3,133	\$ 3,133	\$		\$ 54,360	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)	\$ 5,977,717	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 204,992	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 229,306	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24,314	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,907,912	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
 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

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 1,233 Description: Pitney Bowes postage machine

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocation from Future</u>		\$	\$ <u>2,318</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>2,318</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.

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>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>
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B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39-1;39-3	hrs	\$ 22,841		\$		\$		\$	22,841		1	
2	Licensed Speech and Language Development Therapist	39-3	hrs				5,070						5,070	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	39-1; 39-3	hrs	66,509			3,000						69,509	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						120,814				120,814	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):	39-2;39-3					23,304		45,837				69,141	13
14	TOTAL			\$ 89,350		\$ 31,374		\$ 166,651		\$ 287,375				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.

PETERSON PARK HEALTH CARE CENTER
Page16 Supplemnt

0024463

01/01/03 to

12/31/03

Special Services - Supplies - (Column 6 -Other)

1 Med Tube : Ent., & Urol

39-2

21668

2 Equipment Rental

39-2

24169

Total

45837

Outside Therapies (Column 5- Other)

1 Respiratory Therapy

39-3

13717

2 Lab & XRay

39-3

9587

Total

23304

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 480	\$ 671	1
2	Cash-Patient Deposits	97,948	97,948	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	1,757,428	1,757,428	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,332	87,332	6
7	Other Prepaid Expenses	1,276	1,276	7
8	Accounts Receivable (owners or related parties)	(453,891)	4,708,271	8
9	Other(specify):	21,680	133,872	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,512,253	\$ 6,786,798	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		102,484	13
14	Buildings, at Historical Cost		2,548,850	14
15	Leasehold Improvements, at Historical Cost		1,573,428	15
16	Equipment, at Historical Cost		1,207,500	16
17	Accumulated Depreciation (book methods)		(3,799,598)	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):	6,180		22
23	Other(specify):		60,542	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,180	\$ 1,693,206	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,518,433	\$ 8,480,004	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 535,189	\$ 668,734	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	93,075	93,075	28
29	Short-Term Notes Payable	818,411	818,411	29
30	Accrued Salaries Payable	506,096	506,096	30
31	Accrued Taxes Payable (excluding real estate taxes)	116,532	116,532	31
32	Accrued Real Estate Taxes(Sch.IX-B)		240,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Schedule attached</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,069,303	\$ 2,442,848	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,810,502	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Schedule attached</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,810,502	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,069,303	\$ 8,253,350	46
47	TOTAL EQUITY(page 18, line 24)	\$ (550,870)	\$ 226,654	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,518,433	\$ 8,480,004	48

*(See instructions.)

OTHER CURRENT ASSETS:	<u>Amount</u>	<u>Amount</u>
Real Estate Tax Escrow		112,192
Employee Advances	21,680	21,680
	<u>21,680</u>	<u>133,872</u>

OTHER CURRENT LIABILITIES:	<u>Amount</u>	<u>Amount</u>
Accrued Expenses		
	<u> </u>	<u> </u>

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		54,362
Exchange	6,180	6,180
	<u>6,180</u>	<u>60,542</u>

OTHER NON CURRENT LIABILITIES:		
	<u> </u>	<u> </u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 823,570	1
2	Restatements (describe):		2
3	Transfer Equity to PP Realty	(1,719,809)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (896,239)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	345,368	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)	\$ 345,368	17
B. Transfers (Itemize):			
18	Round off adj	1	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (550,870)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Nur Peterson Park Health Care Cent# 0024463 Report Period Beginning: 01/01/03 Ending: 12/31/03

Balance per General Ledger (747,874)

Adjustments:

Transfer fro PP Realty to Equity 1,719,809

-

-

Round Off Adj

Total adjustments 1,719,809

Balance - Beginning of Year 971,935

Equity(Deficit) from Page 17 Col 1 (550,870)

Related Party

Equity(Deficit) 0

Income 0

-

Combined Equity - End of Year (550,870)

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning: 01/01/03

Ending:

12/31/03

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	\$ 7,171,481	1
2	Discounts and Allowances for all Levels	(138,035)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,033,446	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	294,961	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 294,961	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	121,991	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	21,139	20
21	Other Medical Services	51,080	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 194,210	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	35,469	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 35,469	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Prior Year Expenses</u>	14,381	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,381	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,572,467	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,233,277	31
32	Health Care	3,074,881	32
33	General Administration	1,784,187	33
B. Capital Expense			
34	Ownership	744,449	34
C. Ancillary Expense			
35	Special Cost Centers	287,375	35
36	Provider Participation Fee	102,930	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,227,099	40
41	Income before Income Taxes (line 30 minus line 40)**	345,368	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 345,368	43

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

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

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

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

Facility Name & ID Number Peterson Park Health Care Center# 0024463

Report Period Beginning:

01/01/03

Ending:

12/31/03SUPPLEMENTAL SCHEDULE OF REVENUES

12/31/03

<u>DESCRIPTION</u>	<u>AMOUNT</u>
1 Vending Commissions	
2 Adj of Prior period Expenses	
3 Class Advert Adj on Page 5	(469)
4 Advertising	(2,282)
5 Medical Director Adj on Page 5	(11,650)
6 Sales Tax	20
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u><u>(14,381)</u></u>

Facility Name & ID Number Peterson Park Health Care Center

0024463

Report Period Beginning: 01/01/03

Ending:

12/31/03

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	2,120	2,219	\$ 86,759	\$ 39.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,892	39,162	1,006,061	25.69	3
4	Licensed Practical Nurses	7,342	7,968	156,413	19.63	4
5	Nurse Aides & Orderlies	107,924	115,912	1,127,824	9.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	17,853	19,027	180,756	9.50	10
11	Social Service Workers	16,420	17,999	242,800	13.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	23,185	25,668	296,378	11.55	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,604	8,310	92,158	11.09	17
18	Housekeepers	12,222	13,452	104,117	7.74	18
19	Laundry	6,858	7,718	75,402	9.77	19
20	Administrator	4,494	4,494	129,628	28.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,576	6,332	102,261	16.15	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	1,704	2,051	29,736	14.50	31
32	Other Health Care(specify)					32
33	Other(specify)	2,616	2,828	89,350	31.59	33
34	TOTAL (lines 1 - 33)	249,810	273,140	\$ 3,719,643 *	\$ 13.62	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	435	\$ 17,654	1-3	35
36	Medical Director	Monthly	12,900	3-9	36
37	Medical Records Consultant	94	5,317	3-10	37
38	Nurse Consultant	47	3,308	3-10	38
39	Pharmacist Consultant	Monthly	3,564	3-10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	86	12,295	3-10a	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	63	2,750	3-11	44
45	Social Service Consultant	126	5,407	3-12	45
46	Other(specify) Rehab Cons	119	36,876	3-10	46
47	Purchasing Cons	Monthly	3,384	1-3	47
48	Religious Service	As Required	5,390	3-11	48
49	TOTAL (lines 35 - 48)	970	\$ 108,845		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

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
PT Salaries	1,904	2,101	\$ 66,509	\$ 31.66
OT Salaries	712	727	22,841	31.42
	<u>2,616</u>	<u>2,828</u>	<u>\$ 89,350</u>	<u>\$ 31.59</u>

Peterson Park Health Care Center

01/01/03 to 12/31/03

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Page 21 SUPP

Page 21- Professional Services:

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