

		FOR OHF USE					

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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>0035642</u></p> <p>Facility Name: <u>NEW BEGINNINGS CARE CENTRE</u></p> <p>Address: <u>1000 DIXON AVENUE</u> <u>ROCKFALL</u> <u>61071</u> <small>Number City Zip Code</small></p> <p>County: <u>WHITESIDE</u></p> <p>Telephone Number: <u>(815) 625-8510</u> Fax # <u>(815) 625-8443</u></p> <p>IDPA ID Number: <u>36-3651790</u></p> <p>Date of Initial License for Current Owners: <u>07/01/89</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></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 type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" 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>01/01/2001</u> to <u>12/31/2001</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date)</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>ROBERT HEDGES</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>PRESIDENT</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date)</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(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>	Officer or Administrator of Provider	(Signed) _____ (Date)		(Type or Print Name) <u>ROBERT HEDGES</u>		(Title) <u>PRESIDENT</u>	Paid Preparer	(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 & 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 NEW BEGINNINGS CARE CENTRE# 0035642 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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>55</u>	Skilled (SNF)	<u>55</u>	<u>20,075</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>55</u>	TOTALS	<u>55</u>	<u>20,075</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>389</u>	<u>389</u>	8
9	SNF/PED					9
10	ICF	<u>13,396</u>	<u>583</u>		<u>13,979</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,396</u>	<u>583</u>	<u>389</u>	<u>14,368</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.57%

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

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 7/01/89

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

YES Date 7/01/89 NO

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

YES NO If YES, enter number of beds certified 55 and days of care provided 389Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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	100,830	6,405	4,374	111,609		111,609	0	111,609		1
2	Food Purchase		73,904		73,904	(2,975)	70,929	(484)	70,445		2
3	Housekeeping	69,412	11,054	0	80,466		80,466	0	80,466		3
4	Laundry	24,903	5,656	263	30,822		30,822	0	30,822		4
5	Heat and Other Utilities			34,452	34,452		34,452	420	34,872		5
6	Maintenance	30,258	4,731	17,843	52,832		52,832	6,834	59,666		6
7	Other (specify):* scavenger			2,083	2,083		2,083	20	2,103		7
8	TOTAL General Services	225,403	101,750	59,015	386,168	(2,975)	383,193	6,790	389,983		8
	B. Health Care and Programs										
9	Medical Director	0		4,100	4,100		4,100	0	4,100		9
10	Nursing and Medical Records	452,228	44,513	177,993	674,734	(19,783)	654,951	0	654,951		10
10a	Therapy	25,938	1,788	3,836	31,562		31,562	0	31,562		10a
11	Activities	48,251	2,132	0	50,383		50,383	0	50,383		11
12	Social Services	0		2,024	2,024		2,024	0	2,024		12
13	Nurse Aide Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	526,417	48,433	187,953	762,803	(19,783)	743,020	0	743,020		16
	C. General Administration										
17	Administrative	48,481		0	48,481		48,481	25,743	74,224		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			32,581	32,581		32,581	700	33,281		19
20	Dues, Fees, Subscriptions & Promotions			14,904	14,904		14,904	(8,294)	6,610		20
21	Clerical & General Office Expenses	44,562	7,279	18,340	70,181		70,181	6,525	76,706		21
22	Employee Benefits & Payroll Taxes			109,695	109,695	2,975	112,670	0	112,670		22
23	Inservice Training & Education			1,242	1,242		1,242	0	1,242		23
24	Travel and Seminar			0	0		0	1,046	1,046		24
25	Other Admin. Staff Transportation			1,047	1,047		1,047	0	1,047		25
26	Insurance-Prop.Liab.Malpractice			26,658	26,658		26,658	0	26,658		26
27	Other (specify):*			6,597	6,597		6,597	1,002	7,599		27
28	TOTAL General Administration	93,043	7,279	211,064	311,386	2,975	314,361	26,722	341,083		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	844,863	157,462	458,032	1,460,357	(19,783)	1,440,574	33,512	1,474,086		29

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

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

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

#0035642

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

12/31/2001

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			14,125	14,125		14,125	20,142	34,267			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			24,581	24,581		24,581	61,155	85,736			32
33	Real Estate Taxes			15,066	15,066		15,066	0	15,066			33
34	Rent-Facility & Grounds			118,281	118,281		118,281	(118,281)	0			34
35	Rent-Equipment & Vehicles			13,974	13,974		13,974	0	13,974			35
36	Other (specify):*				0		0	1,416	1,416			36
37	TOTAL Ownership			186,027	186,027	0	186,027	(35,568)	150,459			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0	19,783	19,783	0	19,783			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			30,113	30,113		30,113	0	30,113			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	30,113	30,113	19,783	49,896	0	49,896			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	844,863	157,462	674,172	1,676,497	0	1,676,497	(2,056)	1,674,441			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 NEW BEGINNINGS CARE CENTRE

0035642

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,512)	30		9
10	Interest and Other Investment Income	(254)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(484)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(10,141)	21		18
19	Entertainment	0	20		19
20	Contributions	(147)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,597)	27		24
25	Fund Raising, Advertising and Promotional	(8,298)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	2,716			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,717)		\$ 0	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)	26,661		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 26,661		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,056)		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		17,115	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>Therapy</u>	x		2,668	10	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 19,783		47

STATE OF ILLINOIS
 NEW BEGINNINGS CARE CENTRE

ID# 0035642

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 2716	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48	Total	2,716		48
49				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(484)	0	0	0	0	0	0	0	0	0	0	(484)	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	420	0	0	0	0	0	0	0	0	0	420	5
6	Maintenance	2,716	4,118	0	0	0	0	0	0	0	0	0	6,834	6
7	Other (specify):*	0	20	0	0	0	0	0	0	0	0	0	20	7
8	TOTAL General Services	2,232	4,558	0	6,790	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	25,743	0	0	0	0	0	0	0	0	0	25,743	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	700	0	0	0	0	0	0	0	0	0	700	19
20	Fees, Subscriptions & Promotions	(8,445)	151	0	0	0	0	0	0	0	0	0	(8,294)	20
21	Clerical & General Office Expenses	(10,141)	16,666	0	0	0	0	0	0	0	0	0	6,525	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,046	0	0	0	0	0	0	0	0	0	1,046	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(6,597)	7,599	0	0	0	0	0	0	0	0	0	1,002	27
28	TOTAL General Administration	(25,183)	51,905	0	26,722	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,951)	56,463	0	33,512	29								

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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
WILLIAM IRVINE	50	TAMMERLANE HEALTHCARE CTR INC.	STERLING	HI CARE	SPRINGFEID	MANAGEMENT
		CARBONDALE NURSING & REHAB CTR	CARBONDALE	H&I PROPERTIES	SPRINGFEILD	REAL ESTATE
ROBERT HEDGES	50	SYCAMORE HEATHCARE LLC	QUINCY			

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	5	\$	HI CARE MANAGEMENT		\$ 420	\$ 420	1
2	V	6		HI CARE MANAGEMENT		4,118	4,118	2
3	V	7		HI CARE MANAGEMENT		20	20	3
4	V	17		HI CARE MANAGEMENT		25,743	25,743	4
5	V	20		HI CARE MANAGEMENT		151	151	5
6	V	21		HI CARE MANAGEMENT		16,666	16,666	6
7	V	27		HI CARE MANAGEMENT		7,599	7,599	7
8	V	24		HI CARE MANAGEMENT		1,046	1,046	8
9	V	19		HI CARE MANAGEMENT		700	700	9
10	V	36		HI CARE MANAGEMENT		427	427	10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 56,890	\$ * 56,890	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	34	RENT	\$ 118,281			\$	(118,281)	15
16	V	30	DEPRECIATION		H & I PROPERTIES		25,654	25,654	16
17	V	32	INTEREST		H & I PROPERTIES		61,409	61,409	17
18	V	36	AMORT.-DEFERRED MORT COSTS		H & I PROPERTIES		989	989	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 118,281			\$ 88,052	\$ * (30,229)	39

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

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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	ROBERT HEDGES	PRESIDENT	OFFICE MGMT	50.00				SALARY	\$	17-8	1
2											2
3	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT	50.00				SALARY		17-8	3
4											4
5	MARTHA IRVINE							SALARY		21-8	5
6	WILLIAM'S SPOUSE										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

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 H & I PROPERTIES,L.L.C.
 Street Address 827 S. FIFTH STREET
 City / State / Zip Code SPRINGFIELD, IL 62703
 Phone Number (217)528-0044
 Fax Number (217)5283412

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	113,069	4	\$ 3,308	\$ 14,368	\$ 420	1
2	6	MAINTENANCE	PER RESIDENT DAY	113,069	4	32,407	26,833	14,368	4,118
3	7	SCAVENGER	PER RESIDENT DAY	113,069	4	161	14,368	20	3
4	17	OFFICER SALARIES	PER RESIDENT DAY	113,069	4	202,582	202,582	14,368	25,743
5	20	DUES & SUBSRIPTIONS	PER RESIDENT DAY	113,069	4	1,192	14,368	151	5
6	21	CLERICAL	PER RESIDENT DAY	113,069	4	131,151	108,009	14,368	16,666
7	27	INSURANCE	PER RESIDENT DAY	113,069	4	59,800	14,368	7,599	7
8	24	TRAVEL & EDUCATION	PER RESIDENT DAY	113,069	4	8,232	14,368	1,046	8
9	19	PROFESSIONAL FEES	PER RESIDENT DAY	113,069	4	5,511	14,368	700	9
10	36	DEPREC./COMP. SOFTWARE	PER RESIDENT DAY	113,069	4	3,360	14,368	427	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					\$ 447,704	\$ 337,424	\$ 56,890	25

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

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 H & I PROPERTIES,L.L.C.
 Street Address 827 S. FIFTH STREET
 City / State / Zip Code SPRINGFIELD, IL 62703
 Phone Number (217)528-0044
 Fax Number (217)528-0044

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	30	DEPRECIATION	DIRECT	1	1	\$ 25,654	\$ 1	\$ 25,654	1
2	32	INTEREST	DIRECT	1	1	61,409	1	61,409	2
3	36	AMORT.-MORT. COSTS	DIRECT	1	1	989	1	989	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					\$ 88,052	\$	\$ 88,052	25

Facility Name & ID Number

NEW BEGINNINGS CARE CENTRE

0035642

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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	Reporting Period Interest Expense									
												Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
												YES	NO				Original	Balance		
A. Directly Facility Related																				
Long-Term																				
1	ILLINI BANK		X	ROOF	\$1,378.00	06/04/97	\$ 65,000	\$ 7,430	06/04/02	0.0975	\$ 1,544	1								
2	ILLINI BANK		X	AUTO LOAN	\$1,135.00	03/15/00	5,055	2,276	03/15/03	0.0900	289	2								
3	ILLINI BANK		X	WSAHER MICHINE	\$193.00	04/10/01	6,000	4,646	03/23/04	0.1008	392	3								
4												4								
5	UNITED COMMUNITY BANK		X	RELATED PARTY MORT.	\$9,857.00	08/07/98	1,031,250	897,104	08/07/03	0.0800	61,409	5								
Working Capital																				
6	ILLINI BANK		X	LINE OF CREDIT	INTEREST	REVOLV	26,000	198,800	REVOLV	PRIME+	6,991	6								
7	SHAREHOLDERS LOAN	X		WORKING CAPITAL		1/31/97	137,600	374,944			2,871	7								
8	H & I	X		WORKING CAPITAL	\$1,571.00	01/26/01	150,000	146,785	12/30/06	0.0950	12,494	8								
9	TOTAL Facility Related				\$14,134.00		\$ 1,420,905	\$ 1,631,985			\$ 85,990	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14								
15	TOTALS (line 9+line14)						\$ 1,420,905	\$ 1,631,985			\$ 85,990	15								

* 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 NEW BEGINNINGS CARE CENTRE

0035642 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2000 report.		\$ 13,347	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.)		\$ 14,206	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 859	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 14,207	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19____ 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.		\$ 15,066	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996	80,154	8
	1997	13,852	9
	1998	13,842	10
	1999	13,348	11
	2000	14,206	12
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL.			
THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.			
FOR OHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2000 \$	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: 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 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 2001 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,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NEW BEGINNINGS CARE CENTRE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0035642

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 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 2000

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-27-401-002</u>	<u>NURSING HOME</u>	\$ <u>14,206.58</u>	\$ <u>14,206.58</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>14,206.58</u>	\$ <u>14,206.58</u>

B. Real Estate Tax Cost Allocation:

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642 Report Period Beginning:

01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12780+- B. General Construction Type: Exterior MASONRY Frame _____ Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>67,000</u>	<u>1998</u>	<u>\$ 83,295</u>	1
2					2
3	TOTALS	67,000		\$ 83,295	3

Facility Name & ID Number **NEW BEGINNINGS CARE CENTRE**

0035642

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	55		1998		\$ 698,118	\$ 17,900	39	\$ 17,900	\$	\$ 60,432	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		PARKING LOT IMPROVEMENTS		1992	17,677	561	31.5	561		5,324	9
10		CURTAIN TRACKS		1993	5,650	179	31.5	179		1,604	10
11		REWIRING WORK		1996	6,043	155	39	155		872	11
12		ROOF		1997	66,564	1,707	39	1,707		7,326	12
13		OUTDOOR FLOOD LIGHTS		1997	2,856	73	39	73		295	13
14		HAND RAILS & WALL GUARDS		1999	2,524	65	39	65		165	14
15		STORAGE BARN		1999	2,100	54	39	54		137	15
16		BACKFLOW PREVENTER		2000	1,696	62	27.5	62		95	16
17		ROOF		2000	2,680	97	27.5	97		150	17
18		NEW WATER HEATER		2001	3,096	61	27.5	61		61	18
19		ALARM SYSTEM		2001	5,013	99	27.5	99		99	19
20		OVERBED LIGHT		2001	3,687	73	27.5	73		73	20
21		CARPET		2001	1,730	346	5	346		346	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

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

See Page 12A, Line 70 for total

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

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			819,434	21,432	21,432	0	76,979	

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

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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	\$ 33,148	\$ 5,670	\$ 3,315	\$ (2,355)	10	\$ 11,628	71
72	Current Year Purchases	14,723	2,945	736	(2,209)	10 YRS	736	72
73	Fully Depreciated Assets	21,095			0		21,095	73
74		77,542	7,754	7,754	0		27,139	74
75	TOTALS	\$ 146,508	\$ 16,369	\$ 11,805	\$ (4,564)		\$ 60,598	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		95 BUICK CENTURY	2000	\$ 6,181	\$ 1,978	\$ 1,030	\$ (948)	3	\$ 2,060	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 6,181	\$ 1,978	\$ 1,030	\$ (948)		\$ 2,060	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)	\$ 1,055,418	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,779	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,267	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,512)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 139,637	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?

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</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: \$ 3,623

Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>ADMINISTRATION</u>	<u>00 CADILAC DEVILLE</u>	\$ <u>863.00</u>	\$ <u>10,351</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 863.00	\$ 10,351	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?</p> <p><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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			2,668			2,668	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts			17,115			17,115	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 19,783	\$		\$ 19,783	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 NEW BEGINNINGS CARE CENTRE# 0035642Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (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	\$ 26,256	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	166,026		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,753		6
7	Other Prepaid Expenses	1,500		7
8	Accounts Receivable (owners or related parties)	48,844		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 272,379	\$ 0	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	119,586		15
16	Equipment, at Historical Cost	83,452		16
17	Accumulated Depreciation (book methods)	(72,762)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 130,276	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 402,655	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 275,630	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30		28
29	Short-Term Notes Payable	359,937		29
30	Accrued Salaries Payable	27,895		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,037		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,207		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 689,736	\$ 0	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	374,944		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 374,944	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,064,680	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (662,025)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 402,655	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (338,655)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (338,655)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(323,370)	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)	\$ (323,370)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (662,025)	24 *

* This must agree with page 17, line 47.

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

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,352,805	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,352,805	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(18)	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ (18)	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	254	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 254	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending commissions</u>	86	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 86	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,353,127	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	386,168	31
32	Health Care	762,803	32
33	General Administration	311,386	33
B. Capital Expense			
34	Ownership	186,027	34
C. Ancillary Expense			
35	Special Cost Centers	0	35
36	Provider Participation Fee	30,113	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,676,497	40
41	Income before Income Taxes (line 30 minus line 40)**	(323,370)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (323,370)	43

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

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

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

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

Facility Name & ID Number **NEW BEGINNINGS CARE CENTRE**

0035642

Report Period Beginning: **01/01/2001**

Ending:

12/31/2001

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	1,749	1,937	\$ 31,200	\$ 16.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,621	4,042	69,519	17.20	3
4	Licensed Practical Nurses	5,524	5,927	86,172	14.54	4
5	Nurse Aides & Orderlies	26,853	29,204	252,035	8.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,011	2,426	25,938	10.69	8
9	Activity Director	1,919	2,207	18,670	8.46	9
10	Activity Assistants	4,548	4,938	29,581	5.99	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,912	2,084	19,858	9.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,617	11,701	80,972	6.92	15
16	Dishwashers					16
17	Maintenance Workers	3,686	3,987	30,258	7.59	17
18	Housekeepers	8,836	10,104	69,412	6.87	18
19	Laundry	3,870	4,214	24,903	5.91	19
20	Administrator	2,018	2,363	48,481	20.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,906	2,639	22,463	8.51	23
24	Clerical	751	855	8,862	10.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Plan Supervisors	453	678	13,302	19.62	32
33	Other(specify) ADMISSIONS	1,318	1,466	13,237	9.03	33
34	TOTAL (lines 1 - 33)	81,592	90,772	\$ 844,863 *	\$ 9.31	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 4,374	1-3	35
36	Medical Director	O	4,100	9-3	36
37	Medical Records Consultant	Number	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	850	10-3	39
40	Physical Therapy Consultant	L	463	10a-3	40
41	Occupational Therapy Consultant	Y	1,825	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	1,850	12-3	45
46	Other(specify) LPN CONSULTANT	S	600	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,062		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	75	\$ 3,025		50
51	Licensed Practical Nurses	2,314	82,280		51
52	Nurse Aides	4,500	91,232		52
53	TOTAL (lines 50 - 52)	6,889	\$ 176,537		53

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY1998	6 FY1999	7 FY2000	8 FY2001	9 FY2002	10 FY2003	11 FY2004	12 FY2005	13 FY2006
1	PAINT/DECORATING	07/97	\$ 1,766	3 YRS	\$ 588	\$ 588	\$ 295	\$	\$	\$	\$	\$	\$
2	PAINT/DECORATING	07/99	4,771	3 YRS		795	1,590	1,590	796				
3	PAINT/DECORATING	07/00	3,379	3 YRS			563	1,126	1,126	564			
4											180		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 9,916		\$ 588	\$ 1,383	\$ 2,448	\$ 2,716	\$ 1,922	\$ 564	\$ 180	\$	\$

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	4,374
	REPAIRS & MAINTENANCE	0
		0
		4,374
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	263
		0
		263
5	HEAT & OTHER UTILITIES	
	GAS HEAT	5,275
	ELECTRICITY	18,601
	WATER	9,383
	CABLE TV - LOBBY	1,193
		0
		34,452
6	MAINTENANCE	
	GROUNDS MAINTENANCE	215
	PAINTING & DECORATING	1,080
	BUILDING REPAIRS	7,499
	MAINTENANCE TRAVEL	
	EQUIPMENT MAINTENANCE & REPAIR	5,211
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	743
	FIRE SERVICE	3,095
		0
		0
		0
		17,843
7	OTHER	
	SCAVENGER	2,083
	SECURITY SERVICE	0
		2,083
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,100
		4,100

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	176,537
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	6
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	850
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
	LPN CONSULTANT	600
		0
		177,993
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	835
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	713
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	463
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	1,825
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,836
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	174
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	1,850
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,024
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	11,461
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	21,120
		0
		32,581
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	8,298
	EMPLOYEE WANT ADS XIX F	5,273
	CONTRIBUTIONS VI 20 XIX F	147
	DUES & SUBSCRIPTIONS XIX F	377
	LICENSES & PERMITS XIX F	559
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	250
		14,904
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES	366
	EQUIPMENT REPAIR & MAINTENANCE	2,442
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	10,141
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	5,391
	MESSENGER SERVICE	0
		0
		18,340

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	64,632
	UNEMPLOYMENT COMPENSATION XIX D	8,186
	WORKERS COMPENSATION INSURANC XIX D	26,976
	HOSPITALIZATION INSURANCE XIX D	4,116
	EMPLOYEE BENEFITS - OTHER XIX D	5,785
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		109,695
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,242
		1,242
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,047
		1,047
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	26,658
		26,658
27	OTHER	
	BAD DEBTS VI 24	6,597
		0
		6,597

GRAND TOTAL COLUMN 3 OTHER

458,032

NEW BEGINNINGS CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2001

TOTAL FOOD PURCHASE	73,904	PATIENT MEALS	43104
LESS SALES TAX	(484)	ADD EMPLOYEE MEALS	1825
	-----		-----
NET FOOD	73,420	TOTAL MEALS/YEAR	44929
TOTAL PATIENT CENSUS	14,368	NET FOOD	73420
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	44929

TOTAL PATIENT MEALS	43104	COST PER MEAL	1.63
		TIME EMPLOYEE MEALS	1825
ADD # EMPLOYEE MEALS/DAY	5		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	2975
	-----		=====
TOTAL EMPLOYEE MEALS	1825		