

		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>0028787</u></p> <p>Facility Name: <u>Taylorville Care Center</u></p> <p>Address: <u>600 South Houston</u> <u>Taylorville</u> <u>62568</u> Number City Zip Code</p> <p>County: <u>Christian</u></p> <p>Telephone Number: <u>(217) 824-9636</u> Fax # <u>(217) 824-2472</u></p> <p>IDPA ID Number: <u>37-11060662</u></p> <p>Date of Initial License for Current Owners: <u>08/01/1984</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 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 checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefeller</u> Telephone Number: <u>(618) 465-7717</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"> <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 747"></td> <td data-bbox="1281 722 1921 747">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1144 747 1281 771"></td> <td data-bbox="1281 747 1921 771">(Title) _____</td> </tr> <tr> <td data-bbox="1144 828 1281 885"></td> <td data-bbox="1281 828 1921 885">(Signed) <u>Compilation Report Attached</u> (Date)</td> </tr> <tr> <td data-bbox="1144 885 1281 909">Paid Preparer</td> <td data-bbox="1281 885 1921 909">(Print Name and Title) <u>Cindy A. Tefeller, Partner</u></td> </tr> <tr> <td data-bbox="1144 909 1281 933"></td> <td data-bbox="1281 909 1921 933"></td> </tr> <tr> <td data-bbox="1144 933 1281 958"></td> <td data-bbox="1281 933 1921 958">(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u></td> </tr> <tr> <td data-bbox="1144 958 1281 982"></td> <td data-bbox="1281 958 1921 982"><u>233 East Center Drive, Alton, IL 62002</u></td> </tr> <tr> <td data-bbox="1144 982 1281 1006"></td> <td data-bbox="1281 982 1921 1006">(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> <tr> <td colspan="2" data-bbox="1144 1006 1921 1130"> <p align="center">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> </td></tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Date)		(Type or Print Name) _____		(Title) _____		(Signed) <u>Compilation Report Attached</u> (Date)	Paid Preparer	(Print Name and Title) <u>Cindy A. Tefeller, Partner</u>				(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u>		<u>233 East Center Drive, Alton, IL 62002</u>		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	<p align="center">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>	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787 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>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</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>98</u>	TOTALS	<u>98</u>	<u>35,770</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>1,716</u>	<u>684</u>	<u>2,824</u>	<u>5,224</u>	8
9	SNF/PED					9
10	ICF	<u>16,420</u>	<u>10,157</u>		<u>26,577</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,136</u>	<u>10,841</u>	<u>2,824</u>	<u>31,801</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.90%

D. How many bed-hold days during this year were paid by Public Aid? 52 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/01/1984

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/01/1984 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 16 and days of care provided 2,824

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Taylorville Care Center

0028787

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	116,462	11,460	6,944	134,866		134,866		134,866		1
2	Food Purchase		134,231		134,231		134,231	(13,036)	121,195		2
3	Housekeeping	55,680	13,776		69,456		69,456	1,527	70,983		3
4	Laundry	49,817	20,173		69,990		69,990		69,990		4
5	Heat and Other Utilities			64,764	64,764		64,764	676	65,440		5
6	Maintenance	57,153	38,466	1,098	96,717	1,255	97,972	16,833	114,805		6
7	Other (specify):* Sanitation			4,428	4,428		4,428		4,428		7
8	TOTAL General Services	279,112	218,106	77,234	574,452	1,255	575,707	6,000	581,707		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,158,344	55,862	77,671	1,291,877		1,291,877	(4,762)	1,287,115		10
10a	Therapy		815	195,300	196,115		196,115		196,115		10a
11	Activities	21,483	3,994	4,576	30,053		30,053		30,053		11
12	Social Services	28,004			28,004		28,004		28,004		12
13	Nurse Aide Training			599	599		599		599		13
14	Program Transportation		1,426		1,426		1,426		1,426		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,207,831	62,097	287,746	1,557,674		1,557,674	(4,762)	1,552,912		16
	C. General Administration										
17	Administrative	75,957	11,606	195,000	282,563	(2,884)	279,679	(101,593)	178,086		17
18	Directors Fees										18
19	Professional Services			61,650	61,650		61,650	5,078	66,728		19
20	Dues, Fees, Subscriptions & Promotions			15,092	15,092	1,286	16,378	(5,051)	11,327		20
21	Clerical & General Office Expenses	30,131	15,930	9,127	55,188	50	55,238	38,544	93,782		21
22	Employee Benefits & Payroll Taxes			198,151	198,151	(1,255)	196,896	13,490	210,386		22
23	Inservice Training & Education					1,000	1,000		1,000		23
24	Travel and Seminar			3,172	3,172	548	3,720	190	3,910		24
25	Other Admin. Staff Transportation							1,595	1,595		25
26	Insurance-Prop.Liab.Malpractice			70,837	70,837		70,837	6,410	77,247		26
27	Other (specify):*										27
28	TOTAL General Administration	106,088	27,536	553,029	686,653	(1,255)	685,398	(41,337)	644,061		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,593,031	307,739	918,009	2,818,779		2,818,779	(40,099)	2,778,680		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Taylorville Care Center

#0028787

Report Period Beginning:

01/01/2001

Ending:

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			27,727	27,727		27,727	69,300	97,027			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							36,738	36,738			33
34	Rent-Facility & Grounds			277,800	277,800		277,800	(277,800)				34
35	Rent-Equipment & Vehicles			753	753		753		753			35
36	Other (specify):*											36
37	TOTAL Ownership			306,280	306,280		306,280	(171,762)	134,518			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		61,138	1,656	62,794		62,794		62,794			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		61,138	55,311	116,449		116,449		116,449			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,593,031	368,877	1,279,600	3,241,508		3,241,508	(211,861)	3,029,647			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

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	(1,831)	2		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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(2,539)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,365)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,590)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(478)	21		28
29	Other-Attach Schedule	(18,162)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (26,065)		\$	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)	(185,796)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (185,796)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (211,861)		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		X		45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Taylorville Care Center

ID# 0028787

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Machine Costs	\$ (9,840)	2	1
2	2002 IHCA Dues	(4,995)	20	2
3	2001 IHCA Dues	2,964	20	3
4	Depr on Items Req'd to be Capitalized			4
5	for Cost Reporting Purposes	3,288	30	5
6	PAC Dues & Other Non-allowable Dues	(838)	20	6
7	Donations	(780)	20	7
8	Offset SUTA Tax Refund	(59)	22	8
9	Civic Dues	(359)	17	9
10	Promotional Advertising	(163)	17	10
11	Insurance Reimbursement	(2,206)	6	11
12	Maintenance Refunds	(395)	6	12
13	Eliminate Non-Allowable Salaries	(2,223)	10	13
14	Eliminate Non-Care Related Costs	(2,556)	17	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	(18,162)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center

0028787 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	(13,036)	0	0	0	0	0	0	0	0	0	0	(13,036)	2
3	Housekeeping	0	1,527	0	0	0	0	0	0	0	0	0	1,527	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	676	0	0	0	0	0	0	0	0	0	676	5
6	Maintenance	(2,601)	19,434	0	0	0	0	0	0	0	0	0	16,833	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(15,637)	21,637	0	0	0	0	0	0	0	0	0	6,000	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	(4,762)	0	0	0	0	0	0	0	0	0	0	(4,762)	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	(4,762)	0	0	0	0	0	0	0	0	0	0	(4,762)	16
	C. General Administration													
17	Administrative	(3,178)	(98,415)	0	0	0	0	0	0	0	0	0	(101,593)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,078	0	0	0	0	0	0	0	0	0	5,078	19
20	Fees, Subscriptions & Promotions	(5,239)	188	0	0	0	0	0	0	0	0	0	(5,051)	20
21	Clerical & General Office Expenses	(478)	39,022	0	0	0	0	0	0	0	0	0	38,544	21
22	Employee Benefits & Payroll Taxes	(59)	13,549	0	0	0	0	0	0	0	0	0	13,490	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	190	0	0	0	0	0	0	0	0	0	190	24
25	Other Admin. Staff Transportation	0	1,595	0	0	0	0	0	0	0	0	0	1,595	25
26	Insurance-Prop.Liab.Malpractice	0	2,033	4,377	0	0	0	0	0	0	0	0	6,410	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(8,954)	(36,760)	4,377	0	(41,337)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,353)	(15,123)	4,377	0	(40,099)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Taylorville Care Center

0028787

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

	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	3,288	3,612	62,400	0	0	0	0	0	0	0	0	69,300 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	656	36,082	0	0	0	0	0	0	0	0	36,738 33
34	Rent-Facility & Grounds	0	0	(277,800)	0	0	0	0	0	0	0	0	(277,800) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	3,288	4,268	(179,318)	0	(171,762) 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
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(26,065)	(10,855)	(174,941)	0	(211,861) 45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerry & Marilyn King	100.00%	K & G Inc., d/b/a Mt. Vernon Countryside Manor	Mt. Vernon	King Management	Nashville	Home Office
Jerry & Marilyn King	100.00%	Aviston Nursing Center, Inc. d/b/a Countryside Manor	Aviston			
Jerry & Marilyn King	100.00%	King Management, Inc., d/b/a Nokomis Golden Manor	Nokomis			

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	3 See Schedule VIII	\$	King Management Co.	100.00%	\$ 1,527	\$ 1,527 1
2	V	5 See Schedule VIII		King Management Co.	100.00%	676	676 2
3	V	6 See Schedule VIII		King Management Co.	100.00%	19,434	19,434 3
4	V	17 See Schedule VIII	195,000	King Management Co.	100.00%	96,585	(98,415) 4
5	V	19 See Schedule VIII		King Management Co.	100.00%	5,078	5,078 5
6	V	20 See Schedule VIII		King Management Co.	100.00%	188	188 6
7	V	21 See Schedule VIII		King Management Co.	100.00%	39,022	39,022 7
8	V	22 See Schedule VIII		King Management Co.	100.00%	13,549	13,549 8
9	V	24 See Schedule VIII		King Management Co.	100.00%	190	190 9
10	V	25 See Schedule VIII		King Management Co.	100.00%	1,595	1,595 10
11	V	26 See Schedule VIII		King Management Co.	100.00%	2,033	2,033 11
12	V	30 See Schedule VIII		King Management Co.	100.00%	3,612	3,612 12
13	V	33 See Schedule VIII		King Management Co.	100.00%	656	656 13
14	Total		\$ 195,000			\$ 184,145	\$ * (10,855) 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

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

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	34 Rent - Facility & Grounds	\$ 277,800	Jerry & Marilyn King	100.00%	\$	\$ (277,800)	15
16	V	26 Insurance		Jerry & Marilyn King	100.00%	4,377	4,377	16
17	V	30 Depreciation		Jerry & Marilyn King	100.00%	62,400	62,400	17
18	V	33 Real Estate Taxes		Jerry & Marilyn King	100.00%	36,082	36,082	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		\$ 277,800			\$ 102,859	\$ * (174,941)	39

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

Facility Name & ID Number Taylorville Care Center # 0028787 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	Jerry King	Owner	Mgmt/Consultant	100.00%	170,052	15	25.51%	Salary	\$ 58,244	17,8	1
2	Denise King	Regional Director	Administrative	0.00%	102,615	13	25.51%	Salary	35,146	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00%	55,334	13	25.51%	Salary	18,952	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00%	97,630	0	0.00%	Salary	0	N/A	4
5	Elizabeth King	Dietary	Dietary	0.00%	2,400	0	0.00%	Salary	0	N/A	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00%	2,235	2	25.51%	Salary	765	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 113,107		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 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 King Management Company
 Street Address 935 South Mill Street
 City / State / Zip Code Nashville, IL 62263
 Phone Number (618) 327-3064
 Fax Number (618) 327-3083

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	3	Housekeeping	Patient Days	124,610	4	\$ 5,984	\$ 31,791	\$ 1,527	1
2	5	Utilities	Patient Days	124,610	4	2,650	31,791	676	2
3	6	Maintenance	Patient Days	124,610	4	76,174	31,791	19,434	3
4	17	Administrative	Patient Days	124,610	4	378,582	31,791	96,585	4
5	19	Professional Fees	Patient Days	124,610	4	19,903	31,791	5,078	5
6	20	Fees, Subs & Promotions	Patient Days	124,610	4	735	31,791	188	6
7	21	Clerical and Gen. Office Expense	Patient Days	124,610	4	152,952	31,791	39,022	7
8	22	Employee Benefits	Patient Days	124,610	4	53,108	31,791	13,549	8
9	24	Travel & Seminar	Patient Days	124,610	4	745	31,791	190	9
10	25	Other Admin. Staff Transport.	Patient Days	124,610	4	6,252	31,791	1,595	10
11	26	Insurance	Patient Days	124,610	4	7,969	31,791	2,033	11
12	30	Depreciation-Vehicles	Patient Days	124,610	4	5,518	31,791	1,408	12
13	30	Depreciation-Vehicles	Direct Cost	N/A	1	969	N/A		13
14	30	Depreciation-Other	Patient Days	124,610	4	8,640	31,791	2,204	14
15	30	Depreciation-Copier	Direct Cost	N/A	1	1,038	N/A		15
16	33	Property Taxes	Patient Days	124,610	4	2,571	31,791	656	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 723,790	\$ 568,048	\$ 184,145	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Schedule Not Applicable						\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	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 **Taylorville Care Center**# **0028787** Report Period Beginning: **01/01/2001** Ending: **12/31/2001****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 2000 report.			\$	34,600	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.)			\$	34,482	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(118)	3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	36,200	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.			\$	36,082	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1996	32,736	8		
		1997	33,305	9		
		1998	33,080	10		
		1999	33,015	11		
		2000	34,482	12		
Line 2: Real Estate Taxes paid are for the 2000 tax year		Line 7: \$36,082 Real Estate Tax				
Line 4: Accrual is based on 2000 taxes paid		656 Home Office Allocation		13	FROM R. E. TAX STATEMENT FOR 2000	13
		336,738 Total Real Estate Tax		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.

SEE ACCOUNTANTS' COMPILATION REPORT

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, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Taylorville Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0028787

CONTACT PERSON REGARDING THIS REPORT Linda Peppenhorst

TELEPHONE (618) 327-3064 FAX #: (618) 327-3083

A. Summary of Real Estate Tax Cost

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>17-13-28-401-005</u>	<u>Cheneys Add Lts 1 thru 6 Blk 3</u>	\$ <u>33,985.36</u>	\$ <u>33,985.36</u>
2. _____	<u>& Lts 1 thru 6 Blk 4 & OL 1 &</u>	\$ _____	\$ _____
3. _____	<u>Vac Austin St & Alley</u>	\$ _____	\$ _____
4. <u>17-13-23-319-013</u>	<u>Wilkinson's Third Add Lot 8 Blk 4</u>	\$ <u>321.86</u>	\$ <u>321.86</u>
5. <u>17-13-28-401-006</u>	<u>N 1/2 S 1/2 NW SE EX E440</u>	\$ <u>174.94</u>	\$ <u>174.94</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>34,482.16</u>	\$ <u>34,482.16</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 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 Taylorville Care Center# 0028787 Report Period Beginning:01/01/2001 Ending:12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,610 B. General Construction Type: Exterior Brick Frame Non-Comb. Sprinkle Number of Stories OneC. 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).

Taylorville Estates is a 39 unit (27,945 square foot) retirement center which is located on the property adjacent to Taylorville Care CenterF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>98 Bed Nursing Home</u>	<u>186,200</u>	<u>1984</u>	<u>\$ 40,000</u>	<u>1</u>
2	<u>Home Office Land</u>		<u>1989</u>	<u>1,605</u>	<u>2</u>
3	TOTALS	<u>186,200</u>		<u>\$ 41,605</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

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	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	98	1984	1974	\$ 1,560,000	\$	25	\$ 62,400	\$ 62,400	\$ 1,092,217	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	80 Gallon Water Fixture		1985	1,581		10			1,581	9
10	Improvement to Building		1985	12,510	500	25	500		8,007	10
11	Improvement to Parking Lot		1986	1,184		10			1,184	11
12	New Light Fixtures		1987	997		10			997	12
13	Tile Floor		1987	5,941	141	10		(141)	5,941	13
14	Roof		1988	55,100		10			55,100	14
15	Addition to Alarm System		1988	5,610		10			5,610	15
16	Concrete Driveway		1989	2,729	182	15	182		2,304	16
17	Nurses Station		1991	4,809		15	321	321	3,420	17
18	Water Heater		1993	3,750	250	15	250		2,208	18
19	Air Conditioner		1993	2,800	280	10	280		2,356	19
20	New Office		1993	1,500	38	40	38		300	20
21	4" Backflow Preventer		1994	3,966	159	25	159		1,269	21
22	Carpeting		1994	2,471	247	10	247		1,812	22
23	Circulating Pump on Water Heater		1994	2,450	175	14	175		1,269	23
24	Fence		1995	3,590	239	15	239		1,575	24
25	Water Heater		1995	1,602	107	15	107		739	25
26	Sprinkler Heads		1995	1,600	107	15	107		650	26
27	New Roof		1996	25,000	2,500	10	2,500		13,542	27
28	Water Softener		1996	5,908	492	12	492		2,626	28
29	Ceramic Tile		1997	5,167	517	10	517		2,541	29
30	Garage		1997	7,841	784	10	784		3,528	30
31	Rooftop A/C, Ducts & Gas Lines		1997	10,940	1,094	10	1,094		4,923	31
32	Beauty Shop Addition		1997	6,823	455	15	455		1,820	32
33	Carpet		1998	4,154	415	10	415		1,522	33
34	Windows		1998	5,681	568	10	568		1,988	34
35										35
36										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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Heating & A/C Units	1998	\$ 4,128	\$ 826	5	\$ 826	\$	\$ 2,684		37
38 Air Conditioner Units	1999	25,051	2,505	10	2,505		6,472		38
39 Rear Parking Lot/Driveway	1999	2,995	299	10	299		674		39
40 Air Conditioner Units	2000	4,834	483	10	483		644		40
41 Landscaping	2001	2,300	77	10	77		77		41
42 Electrical	2001	6,725	561	10	561		561		42
43 Cabinets	2001	27,445	1,029	20	1,029		1,029		43
44 Water Heater	2001	5,800	193	15	193		193		44
45									45
46									46
47									47
48									48
49									49
50 Home Office Parking Lot	1989	504		10			504		50
51 Home Office Building	1995	25,010		25	1,000	1,000	6,169		51
52 Home Office Interior Finishes Lower Level	1996	1,551		15	103	103	569		52
53 Home Office Carpet	1996	542		5	54	54	542		53
54 Home Office Cabinets	1996	858		20	43	43	236		54
55 Home Office Electrical	1996	297		15	20	20	109		55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70 TOTAL (lines 4 thru 69)		\$ 1,853,744	\$ 15,223		\$ 79,023	\$ 63,800	\$ 1,241,492		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 108,271	\$ 10,195	\$ 13,983	\$ 3,788	5-10	\$ 70,126	71
72	Current Year Purchases	28,831	2,309	2,613	304	5-10	2,613	72
73	Fully Depreciated Assets	236,086					236,086	73
74								74
75	TOTALS	\$ 373,188	\$ 12,504	\$ 16,596	\$ 4,092		\$ 308,825	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	Home Office Vehicle	1998 Ford F150 Truck	1997	\$ 6,757	\$	\$ 1,408	\$ 1,408	4	\$ 6,757	76
77	Facility Business	1994 Chevy Van	1995	13,590				4	13,590	77
78										78
79										79
80	TOTALS			\$ 20,347	\$	\$ 1,408	\$ 1,408		\$ 20,347	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,288,884	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 27,727	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,027	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 69,300	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,570,664	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	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	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: Section Not Applicable
 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? N/A YES N/A NO
 16. Rental Amount for movable equipment: \$ 753 Description: Dishwasher

(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>Section Not Applicable</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	390	\$	\$ 390
2	Books and Supplies		209		209
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	\$	599	\$	\$ 599
10	SUM OF line 9, col. 1 and 2 (e)	\$	599		

- (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.

C. CONTRACTUAL INCOME

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

\$ None

D. NUMBER OF AIDES TRAINED

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

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	4,446	\$ 92,015	\$	4,446	\$ 92,015	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		710	17,470		710	17,470	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		4,133	85,816	815	4,133	86,631	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				61,138		61,138	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Ambulance, Lab & X-Ray	39,3					1,656		1,656	13
14	TOTAL			\$	9,289	\$ 195,301	\$ 63,609	9,289	\$ 258,910	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report 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	\$ 337,526	\$	1
2 Cash-Patient Deposits	2,709		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 5,630)	554,611		3
4 Supply Inventory (priced at cost)	4,733		4
5 Short-Term Investments	217,912		5
6 Prepaid Insurance			6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): <u>Related Party Note Rec.</u>	65,000		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,182,491	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost	192,446		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	363,263		16
17 Accumulated Depreciation (book methods)	(376,622)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	12,165		19
20 Accumulated Amortization - Organization & Pre-Operating Costs	(12,165)		20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): <u>Construction in Progress</u>	8,280		23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 187,367	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,369,858	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 110,670	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	2,709		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	127,383		30
31 Accrued Taxes Payable (excluding real estate taxes)	15,429		31
32 Accrued Real Estate Taxes(Sch.IX-B)			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)	\$ 256,191	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 256,191	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 1,113,667	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,369,858	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 970,968	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 970,968	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	433,099	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	(290,400)	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)	\$ 142,699	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,113,667	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

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	\$ 3,053,753	1
2	Discounts and Allowances for all Levels	220,045	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,273,798	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	272,664	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 272,664	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	91,541	19
20	Radiology and X-Ray	2,148	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 93,689	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,276	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,276	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	22,172	28
28a	<u>Diaper Charges</u>	3,008	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,180	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,674,607	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	574,452	31
32	Health Care	1,557,674	32
33	General Administration	686,653	33
B. Capital Expense			
34	Ownership	306,280	34
C. Ancillary Expense			
35	Special Cost Centers	62,794	35
36	Provider Participation Fee	53,655	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,241,508	40
41	Income before Income Taxes (line 30 minus line 40)**	433,099	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 433,099	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Taylorville Care Center

0028787

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	1,960	1,937	\$ 40,579	\$ 20.95	1
2	Assistant Director of Nursing	1,903	2,034	37,013	18.20	2
3	Registered Nurses	6,032	6,607	110,496	16.72	3
4	Licensed Practical Nurses	24,066	25,521	336,123	13.17	4
5	Nurse Aides & Orderlies	63,606	65,960	634,133	9.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,020	3,148	21,483	6.82	10
11	Social Service Workers	3,497	3,681	28,004	7.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,944	17,170	116,462	6.78	15
16	Dishwashers					16
17	Maintenance Workers	3,952	4,286	57,153	13.33	17
18	Housekeepers	7,776	8,512	55,680	6.54	18
19	Laundry	7,718	8,030	49,817	6.20	19
20	Administrator	2,008	2,195	58,277	26.55	20
21	Assistant Administrator	1,685	2,004	17,680	8.82	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,194	2,168	30,131	13.90	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(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,361	153,253	\$ 1,593,031 *	\$ 10.39	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	176	\$ 6,944	1,3	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	15	1,041	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	900	10,3	39
40	Physical Therapy Consultant	Contract	2,337	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	88	4,576	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	279	\$ 25,398		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	4,432	73,394	10,3	52
53	TOTAL (lines 50 - 52)	4,432	\$ 73,394		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5	6	7	8	9	10	11	12	13
1	Section Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assoc. - \$3674
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,160 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 53,655
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,831
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 47%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

TAYLORVILLE CARE CENTER
RECLASSIFICATIONS
12/31/01

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	1,286
CLERICAL & GENERAL OFFICE EXPENSES	21	50
SEMINARS & TRAVEL	24	1,548
ADMINISTRATIVE	17	(2,884)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
BACKGROUND CHECKS	\$674	
SUBSCRIPTIONS	136	
MISC DUES & LICENSES	276	
IDPH LICENSE	200	
TAXES	50	
SEMINARS	<u>1,548</u>	
TOTAL	2884	
MAINTENANCE	6	1,255
EMPLOYEE BENEFITS	22	(1,255)
TO RECLASS EMPLOYEE UNIFORMS		
INSERVICE TRAINING & EDUCATION	23	1,000
TRAVEL & SEMINAR	24	(1,000)
TO RECLASS TRAINING		

KING-TAYLORVILLE D/B/A TAYLORVILLE CARE CENTER
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII, LINE 27
12/31/01

OTHER REVENUE:

SODA INCOME	\$12,494
SUTA TAX REFUND	59
VENDING INCOME	396
MISCELLANEOUS	694
RESIDENT A/R ENTRIES	604
MEDICARE COST REPORT SETTLEMENT	834
FLU SHOTS	120
MAINTENANCE REFUNDS	395
MEDICAL SUPPLIES REFUNDS	2,539
INSURANCE REIMBURSEMENT	2,206
MEALS	1,831
	<u>22,172</u>

TAYLORVILLE CARE CENTER
ATTACHMENT TO SCHEDULE XIX, SECTION G
12/31/2001

NAME OF PERSONS ATTENDING	JOB TITLE	DATE	LOCATION	SEMINAR TITLE	SEMINAR SPONSOR	SEMINAR COST
Tami Burnett	DON	1/30/2001	Springfield	Restorative Nursing	The Institute	135
Sandra Payne	Medicare Coord.	1/30/2001	Springfield	Restorative Nursing	The Institute	135
Marge Oblinger	Administrator	3/28/2002	Springfield	INHAA Annual Convention and Trade Show	INHAA	85
Sandra Payne	Medicare Coord	3/23/2001	Springfield	Burn Care	Regional Burn Center	75
Donna Compton	R.N.	3/23/2001	Springfield	Burn Care	Regional Burn Center	75
Tami Burnett	DON	3/23/2001	Springfield	Burn Care	Regional Burn Center	75
Violet Dickson	Social Services	3/7 & 3/8	Springfield	SSPI 6th Annual Convention: Our Care is Timeless	SSPI	148
Wendy Bradley	Social Services	3/7 & 3/8	Springfield	SSPI 6th Annual Convention: Our Care is Timeless	SSPI	148
Kelly Conrath	Activities	4/4/2001	Springfield	The Art of Low Functioning Activity Residents	IHCA	85
Marge Oblinger	Administrator	5/9/2001	Springfield	Achieving Survey Success in Dietary and Nutritional Services	IHCA	85
Vickie Barker	Dietary	5/9/2001	Springfield	Achieving Survey Success in Dietary and Nutritional Services	IHCA	65
Sandra Payne	Medicare Coord.	5/23/2001	Springfield	Pain Management in the New Millennium: Fact and Fiction	IHCA	85
Sandra Payne	Administrator	8/1/2001	Springfield	Changing Traditions in Long-Term Care	IHCA	85
Sharon Manning	Activities	9/26-9/27	Breese	36 Hour Activity Director's Education Course	OSI	315
		10/10-10/11				
Tami Burnett	Medicare Coord.	10/25/2001	Springfield	The MDS & Care Plans	Medical Educational Services	79
Denise Kindred	ADON	10/25/2001	Springfield	The MDS & Care Plans	Medical Educational Services	79
Pam Katcher	Care Plan Coord.	10/25/2001	Springfield	The MDS & Care Plans	Medical Educational Services	79
Sandra Payne	Administrator	10/25/2001	Springfield	The MDS & Care Plans	Medical Educational Services	79
Violet Dickson	Social Services	10/11/2001	Springfield	MDS...by the Book	IHCA	85
				IHCA Convention	IHCA	646
				Miscellaneous Travel/Lodging - IHCA Convention		724
				Miscellaneous Travel/Lodging - Activities Convention		177
				Miscellaneous Seminar Travel Expenses		175
						3,720