

		FOR OHF USE					

LL1

**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>0020404</u></p> <p>Facility Name: <u>WILLIAM L DAWSON NURSING HOME</u></p> <p>Address: <u>3500 S GILES</u> <u>CHICAGO</u> <u>60653</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(312) 326-2000</u> Fax # <u>(312) 326-5270</u></p> <p>IDPA ID Number: <u>36-2477301</u></p> <p>Date of Initial License for Current Owners: <u>1975</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>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"> <tr> <td data-bbox="1464 738 1645 933">Officer or Administrator of Provider</td> <td data-bbox="1645 738 2491 933">(Signed) _____ (Date) _____ (Type or Print Name) <u>PAMELA ORR</u> (Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td data-bbox="1464 933 1645 1218">Paid Preparer</td> <td data-bbox="1645 933 2491 1218">(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></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>PAMELA ORR</u> (Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<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 _____																												
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>PAMELA ORR</u> (Title) <u>ADMINISTRATOR</u>																												
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																												

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404 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	245	Skilled (SNF)	245	89,425	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	245	TOTALS	245	89,425	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	144		3,220	3,364	8
9	SNF/PED					9
10	ICF	66,791	2,533	191	69,515	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,935	2,533	3,411	72,879	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.50%

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)

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 1975

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 31 and days of care provided 3,220

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAU 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

WILLIAM L DAWSON NURSING HOME

0020404

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	365,359	73,466	33,932	472,757		472,757	0	472,757		1
2	Food Purchase		476,835		476,835	(78,840)	397,995	(3,897)	394,098		2
3	Housekeeping	122,232	77,577	0	199,809		199,809	0	199,809		3
4	Laundry	139,093	54,220	10,838	204,151		204,151	0	204,151		4
5	Heat and Other Utilities			284,062	284,062		284,062	0	284,062		5
6	Maintenance	214,189	28,824	116,406	359,419		359,419	0	359,419		6
7	Other (specify):*			48,680	48,680		48,680	0	48,680		7
8	TOTAL General Services	840,873	710,922	493,918	2,045,713	(78,840)	1,966,873	(3,897)	1,962,976		8
	B. Health Care and Programs										
9	Medical Director	0		4,800	4,800		4,800	0	4,800		9
10	Nursing and Medical Records	2,847,113	260,228	23,650	3,130,991		3,130,991	0	3,130,991		10
10a	Therapy	63,764	676	8,838	73,278		73,278	0	73,278		10a
11	Activities	133,032	18,989	0	152,021		152,021	0	152,021		11
12	Social Services	92,408		10,686	103,094		103,094	0	103,094		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	3,136,317	279,893	47,974	3,464,184	0	3,464,184	0	3,464,184		16
	C. General Administration										
17	Administrative	390,877		0	390,877		390,877	(53,599)	337,278		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			96,431	96,431		96,431	(17,049)	79,382		19
20	Dues, Fees, Subscriptions & Promotions			61,952	61,952		61,952	(36,945)	25,007		20
21	Clerical & General Office Expenses	259,955	40,561	76,852	377,368		377,368	(5,645)	371,723		21
22	Employee Benefits & Payroll Taxes			809,907	809,907	78,840	888,747	(2,640)	886,107		22
23	Inservice Training & Education			1,557	1,557		1,557	0	1,557		23
24	Travel and Seminar			0	0		0	0	0		24
25	Other Admin. Staff Transportation			1,086	1,086		1,086	0	1,086		25
26	Insurance-Prop.Liab.Malpractice			136,167	136,167		136,167	0	136,167		26
27	Other (specify):*			120,000	120,000		120,000	(120,000)	0		27
28	TOTAL General Administration	650,832	40,561	1,303,952	1,995,345	78,840	2,074,185	(235,878)	1,838,307		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,628,022	1,031,376	1,845,844	7,505,242	0	7,505,242	(239,775)	7,265,467		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

WILLIAM L DAWSON NURSING HOME

#0020404

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			157,018	157,018		157,018	50,903	207,921			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			149,620	149,620		149,620	0	149,620			32
33	Real Estate Taxes			268,717	268,717		268,717	0	268,717			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			40,180	40,180		40,180	0	40,180			35
36	Other (specify):* MIP INSURANCE			9,490	9,490		9,490	0	9,490			36
37	TOTAL Ownership			625,025	625,025	0	625,025	50,903	675,928			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		103,852	1,450	105,302		105,302	0	105,302			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			134,137	134,137		134,137	0	134,137			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	103,852	135,587	239,439	0	239,439	0	239,439			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,628,022	1,135,228	2,606,456	8,369,706	0	8,369,706	(188,872)	8,180,834			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	50,903	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,897)	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	(400)	20		17
18	Fines and Penalties	(5,645)	21		18
19	Entertainment				19
20	Contributions	(16,898)	20		20
21	Owner or Key-Man Insurance	(2,640)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,000)	27		24
25	Fund Raising, Advertising and Promotional	(19,647)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(70,648)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (188,872)		\$ 0	30

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 0		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (188,872)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY						
48		49		50		51
						52

ID# 0020404

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (53,599)	17	1
2	MARKETING CONSULTANT	(17,049)	19	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(70,648)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME# 0020404

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	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,897)	0	0	0	0	0	0	0	0	0	0	(3,897)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,897)	0	(3,897)	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	(53,599)	0	0	0	0	0	0	0	0	0	0	(53,599)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,049)	0	0	0	0	0	0	0	0	0	0	(17,049)	19
20	Fees, Subscriptions & Promotions	(36,945)	0	0	0	0	0	0	0	0	0	0	(36,945)	20
21	Clerical & General Office Expenses	(5,645)	0	0	0	0	0	0	0	0	0	0	(5,645)	21
22	Employee Benefits & Payroll Taxes	(2,640)	0	0	0	0	0	0	0	0	0	0	(2,640)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	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):*	(120,000)	0	0	0	0	0	0	0	0	0	0	(120,000)	27
28	TOTAL General Administration	(235,878)	0	(235,878)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(239,775)	0	(239,775)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME# 0020404

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	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	50,903	0	0	0	0	0	0	0	0	0	0	50,903	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	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	50,903	0	50,903	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(188,872)	0	(188,872)	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

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 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	PAMELA ORR	ADMINISTRATOR	ADMIN	100%	NONE	40	100.00	SALARY	\$ 166,201	17-1	1
2	MARJORIE MARTIN	ASST ADMIN	ADMIN	BY	" "	40	100.00	" "	64,375	17-1	2
3	CHERYL MARTIN	CONTROLLER	ACCOUNTING	ATTRIBU-	" "	60	75.00	" "	141,387	21-1	3
4	ROBYN MARTIN	ASST ADMIN	ADM/EMPL REL	TION	" "	20	50.00	" "	53,600	17-1	4
5	" "	ASST ADMIN	MARKETING**	" "	" "	20	50.00	" "	53,599	17-1	5
6	SHERRIE MARTIN	MED RECORDS	MED RECORDS	" "	" "	40	100.00	" "	17,916	10-1	6
7											7
8											8
9			** DISALLOWED ON PAGE 5A LINE 1								9
10											10
11											11
12											12
13								TOTAL	\$ 497,078		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 WILLIAM L DAWSON NURSING HOME

0020404 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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	U.S.G.I. INC/REILLY MTGE		X	MORTGAGE	\$17,746.00	10/31/75	\$ 2,622,700	\$ 1,868,454	10/31/16	7.75	\$ 147,582	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	INSURANCE FINANCING		X	INSURANCE FINANCING							2,019	6								
7												7								
8												8								
9	TOTAL Facility Related				\$17,746.00		\$ 2,622,700	\$ 1,868,454			\$ 149,601	9								
B. Non-Facility Related*																				
10	IRS LATE FEES		X								19	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 19	14								
15	TOTALS (line 9+line14)						\$ 2,622,700	\$ 1,868,454			\$ 149,620	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.)

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 WILLIAM L DAWSON NURSING HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0020404

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>17-34-310-002-0000</u>	<u>NURSING HOME</u>	\$ <u>3,262.32</u>	\$ <u>3,262.32</u>
2. <u>17-34-310-003-0000</u>	<u>NURSING HOME</u>	\$ <u>1,596.07</u>	\$ <u>1,596.07</u>
3. <u>17-34-310-004-0000</u>	<u>NURSING HOME</u>	\$ <u>1,539.06</u>	\$ <u>1,539.06</u>
4. <u>17-34-310-055-0000</u>	<u>NURSING HOME</u>	\$ <u>285,075.53</u>	\$ <u>285,075.53</u>
5. <u>17-34-310-056-0000</u>	<u>NURSING HOME</u>	\$ <u>253.50</u>	\$ <u>253.50</u>
6. <u>17-34-310-057-0000</u>	<u>NURSING HOME</u>	\$ <u>507.00</u>	\$ <u>507.00</u>
7. <u>17-34-310-058-0000</u>	<u>NURSING HOME</u>	\$ <u>253.50</u>	\$ <u>253.50</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>292,486.98</u>	\$ <u>292,486.98</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 WILLIAM L DAWSON NURSING HOME

0020404 Report Period Beginning:

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 4 + BASEMENT

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: _____ 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>39,156</u>	<u>1974</u>	<u>\$ 149,500</u>	1
2					2
3	TOTALS	39,156		\$ 149,500	3

Facility Name & ID Number **WILLIAM L DAWSON NURSING HOME**# **0020404**

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	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	245	1975	1974	\$ 955,670	\$ 19,113	30	\$ 31,856	\$ 12,743	\$ 844,183	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	COMPONENTS		1975	1,228,016	0	30	40,934	40,934	1,078,085	9
10	ELEVATOR		1975	97,338	0	20	0		97,338	10
11	SPRINKLER		1977	9,699	0	20	0		9,699	11
12	FREEZER REPAIRS *		1984	33,981	0	20	1,589	1,589	30,002	12
13	LINEN CHUTES		1985	1,925	93	15	0	(93)	1,925	13
14	ROOF REPAIRS		1985	32,489	1,949	20	1,624	(325)	26,796	14
15	AIR LOUVERS		1986	2,156	114	20	108	(6)	1,674	15
16	BRaille PLATES		1986	2,150	113	15	76	(37)	2,150	16
17	REG. VALVE		1987	2,760	88	20	138	50	1,944	17
18	BUILDING IMPROVEMENTS		1988	2,257	118	20	113	(5)	1,528	18
19	BUILDING IMPROVEMENTS		1990	5,052	160	20	253	93	2,818	19
20	BUILDING IMPROVEMENTS		1990	2,416	77	15	161	84	1,825	20
21	BUILDING IMPROVEMENTS		1991	12,963	1,084	15	864	(220)	8,722	21
22	BUILDING IMPROVEMENTS		1992	24,808	788	20	1,240	452	11,351	22
23	BUILDING IMPROVEMENTS		1993	13,446	345	30	448	103	3,808	23
24	BUILDING IMPROVEMENTS		1994	6,469	165	39	166	1	1,286	24
25	PARKING LOT REPAIRS		1994	15,295	1,020	15	1,020		7,649	25
26	WALK-IN FREEZER REPAIRS		1995	2,510	64	39	64		536	26
27	PLUMBING REPAIRS		1995	21,850	560	39	560		3,570	27
28	DOORS/FASCIA		1995	3,872	99	39	99		632	28
29	CEILING TILE		1995	90,187	2,312	39	2,312		14,053	29
30	CONCRETE REPAIRS		1995	4,309	287	15	287		1,865	30
31	DRYWALL/COUNTER TOPS/CABINETS/TILE		1996	2,251	58	39	58		336	31
32	ELEVATOR REPAIR		1996	6,833	175	39	175		985	32
33	ELEVATOR DOOR REPAIRS		1998	4,517	116	39	116		449	33
34	FIRE SYSTEM UPGRADE		1998	3,193	82	39	82		263	34
35	CONCRETE REPAIRS		1998	19,117	490	39	490		1,572	35
36	ROOF REPAIRS		1998	21,150	542	39	542		1,649	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number **WILLIAM L DAWSON NURSING HOME**

0020404

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LAUNDRY ROOM/DAMPERS/PATIO REMODELLING	1999	\$ 30,264	\$ 776	39	\$ 776	\$	\$ 2,266	37
38	DOORS/LOCKS/ELEVATOR REPAIRS	1999	14,549	373	39	373		961	38
39	LAUNDRY RM/HEAT-COOL/CABINETS/LOCKS/AWNING	1999	26,503	680	39	680		1,649	39
40	PLUMBING REPAIRS/FIRE SAFETY UPGRADE/LOCKS	1999	56,650	1,453	39	1,453		3,263	40
41	EMERGENCY ELECTRICAL OUTLETS/FIRE DAMPERS	1999	51,364	1,317	39	1,317		2,790	41
42	ALARM SYSTEM UPGRADE	2000	130,975	3,358	39	3,358		4,363	42
43	PARKING LOT RAMP / STONE WALL	2000	24,335	624	39	624		1,028	43
44	DISINFECTION SYSTEM / BOILERS / ELECTRICAL	2000	47,713	1,223	39	1,223		1,452	44
45	ALARM SYSTEM UPGRADE	2001	57,107	1,269	39	1,269			45
46	PARKING LOT PAVING	2001	25,000	833	15	833			46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56	*LINE 12 - ITEM FROM 1984 TOTTALLING \$33,981 RESULTS FROM A PRIOR AUDIT AND IS NOT REFLECTED ON THE BALANCE SHEET.								
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)		\$ 3,093,139	\$ 41,918		\$ 97,281	\$ 55,363	\$ 2,176,465	70

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 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	\$ 942,178	\$ 106,081	\$ 75,938	\$ (30,143)	3-20 YRS	\$ 439,406	71
72	Current Year Purchases	14,647	1,701	673	(1,028)	3-15 YRS	673	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 956,825	\$ 107,782	\$ 76,611	\$ (31,171)		\$ 440,079	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	FACILITY VAN	SPORTVAN '86	1985	\$ 19,262	\$ 0	\$ 0	\$ 0	4 YRS	\$ 19,262	76
77	ADMIN/ETC	JAGUAR '99	1995	62,966	1,775	15,742	13,967	4 YRS	55,097	77
78	" "	MERCEDES '99	1998	53,210	1,775	13,303	11,528	4 YRS	46,560	78
79	" "	SAAB '01	2001	39,868	3,768	4,984	1,216	4 YRS	4,984	79
80	TOTALS			\$ 175,306	\$ 7,318	\$ 34,029	\$ 26,711		\$ 125,903	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)	\$ 4,374,770	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 157,018	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 207,921	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 50,903	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,742,447	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

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?

16. Rental Amount for movable equipment: \$ 30,994 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>ADMIN,ETC</u>	<u>MERCEDES</u>	\$ <u>864.13</u>	\$ <u>10,506</u>	17
18					18
19			<u>LESS REIMBURSED:</u>	<u>(1,320)</u>	19
20					20
21	TOTAL		\$ <u>864.13</u>	\$ <u>9,186</u>	21

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

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

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

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

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2001 Ending: 12/31/2001
XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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							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					101,128		101,128	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									12	
13	INHALATION / RADIOLOGY Other (specify): LAB / SUPPLIES	39-3 39-2				1,450		2,724		1,450 2,724	13
14	TOTAL			\$		\$ 1,450		\$ 103,852		\$ 105,302	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 **WILLIAM L DAWSON NURSING HOME**# **0020404**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	\$ 316,106	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>565,000</u>)	2,228,042		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	650,000		5
6	Prepaid Insurance	172,415		6
7	Other Prepaid Expenses	47,174		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>INSUR/R.E.TAX ESCROW</u>	228,643		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,642,380	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	149,500		13
14	Buildings, at Historical Cost	2,290,723		14
15	Leasehold Improvements, at Historical Cost	768,436		15
16	Equipment, at Historical Cost	1,132,130		16
17	Accumulated Depreciation (book methods)	(2,750,316)		17
18	Deferred Charges	35,025		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	449,733		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>DEPOSITS</u>	1,368		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,076,599	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,718,979	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 403,431	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	217,202		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	302,641		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,677		31
32	Accrued Real Estate Taxes(Sch.IX-B)	295,410		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,000		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,247,361	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,868,454		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>DUE TO ROBT MARTIN CONSTR.</u>	100,863		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,969,317	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,216,678	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,502,301	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,718,979	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,389,415	1
2	Restatements (describe):		2
3	PREPAID MAINTENANCE AGREEMENT	(1,500)	3
4	ROUNDING	4	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,387,919	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	169,846	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	(55,464)	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)	\$ 114,382	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)	\$ 2,502,301	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	\$ 8,459,874	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,459,874	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	26,198	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 26,198	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	500	24
25	Interest and Other Investment Income***	65,104	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 65,604	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,551,676	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	2,045,713	31
32	Health Care	3,464,184	32
33	General Administration	1,995,345	33
B. Capital Expense			
34	Ownership	625,025	34
C. Ancillary Expense			
35	Special Cost Centers	105,302	35
36	Provider Participation Fee	134,137	36
D. Other Expenses (specify):			
37	OUT OF PERIOD EXPENSES	12,124	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,381,830	40
41	Income before Income Taxes (line 30 minus line 40)**	169,846	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 169,846	43

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

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

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

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404

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	2,476	2,621	\$ 84,192	\$ 32.12	1
2	Assistant Director of Nursing	190	190	4,947	26.04	2
3	Registered Nurses	20,352	21,034	590,231	28.06	3
4	Licensed Practical Nurses	43,999	46,392	835,993	18.02	4
5	Nurse Aides & Orderlies	158,675	164,229	1,313,835	8.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,700	7,970	63,764	8.00	8
9	Activity Director					9
10	Activity Assistants	12,093	14,781	133,032	9.00	10
11	Social Service Workers	5,435	5,996	92,408	15.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,595	45,669	365,359	8.00	15
16	Dishwashers					16
17	Maintenance Workers	23,798	26,773	214,189	8.00	17
18	Housekeepers	8,148	8,781	122,232	13.92	18
19	Laundry	17,386	18,182	139,093	7.65	19
20	Administrator	1,955	2,101	166,201	79.11	20
21	Assistant Administrator	4,161	4,550	160,301	35.23	21
22	Other Administrative	2,926	3,065	64,375	21.00	22
23	Office Manager	1,812	1,963	141,387	72.03	23
24	Clerical	7,761	8,877	118,568	13.36	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	1,628	1,699	17,915	10.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	361,090	384,873	\$ 4,628,022 *	\$ 12.02	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	\$ 30,258	1-3	35
36	Medical Director	O	4,800	9-3	36
37	Medical Records Consultant	N	800	10-3	37
38	Nurse Consultant	T	21,393	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	2,550	10a-3	41
42	Respiratory Therapy Consultant		3,675	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	10,686	12-3	45
46	Other(specify)	S			46
47	AUDIOLOGIST		240	10-3	47
48	PSYCHIATRIC		400	10-3	48
49	TOTAL (lines 35 - 48)		\$ 74,802		49

C. CONTRACT NURSES

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$7,657
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,316 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 134,137
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 78,840 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KRUPNICK BOKOR KAGDA & BROOKS The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	30,258
	REPAIRS & MAINTENANCE	3,674
		0
		33,932
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	8,418
	CONTRACTED LAUNDRY SERVICES	2,420
		10,838
5	HEAT & OTHER UTILITIES	
	GAS HEAT	106,837
	ELECTRICITY	150,375
	WATER	25,338
	CABLE TV - LOBBY	1,512
		0
		284,062
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	0
	BUILDING REPAIRS	110
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	50,681
	ELEVATOR MAINTENANCE & REPAIR	9,662
	OUTSIDE LABOR	10,911
	EXTERMINATING SERVICE	8,352
	FIRE SERVICE	3,732
	AMORT - DEFERRED DECORATING	32,958
		0
		0
		116,406
7	OTHER	
	SCAVENGER	14,346
	SECURITY SERVICE	34,334
		48,680
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,800
		4,800

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	817
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	800
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B 48-2	400
	RN CONSULTANT XVIII B 38-2	21,393
	AUDIOLOGIST XVIII B 47-2	240
		0
		23,650
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	2,613
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	THERAPY CONTRACT SERVICES	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	2,550
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	3,675
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		8,838
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	10,686
		0
		10,686
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	9,456
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	86,975
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	96,431
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	4,907
	EMPLOYEE WANT ADS XIX F	5,646
	CONTRIBUTIONS VI 20 XIX F	10,585
	DUES & SUBSCRIPTIONS XIX F	11,454
	LICENSES & PERMITS XIX F	6,719
	PUBLIC RELATIONS-PATIENT RELATED XIX F	14,740
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	400
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	6,313
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,188
21	CLERICAL & GENERAL OFFICE EXPENSES	61,952
	BANK CHARGES	385
	EQUIPMENT REPAIR & MAINTENANCE	17,746
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	5,645
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	807
	TELEPHONE	50,894
	MESSENGER SERVICE	1,375
		0
		76,852

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	342,701
	UNEMPLOYMENT COMPENSATION XIX D	56,512
	WORKERS COMPENSATION INSURANC XIX D	60,372
	HOSPITALIZATION INSURANCE XIX D	264,757
	EMPLOYEE BENEFITS - OTHER XIX D	17,441
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	2,640
	PENSION/PROFIT SHARING PLANS XIX D	54,780
	CHICAGO HEAD TAX XIX D	10,704
		809,907
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,557
		1,557
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,086
		1,086
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	136,167
		136,167
27	OTHER	
	BAD DEBTS VI 24	120,000
		0
		120,000

GRAND TOTAL COLUMN 3 OTHER

1,845,844

WILLIAM L DAWSON NURSING HOME
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2001

TOTAL FOOD PURCHASE	476,835	PATIENT MEALS	218637
LESS SALES TAX	(3,897)	ADD EMPLOYEE MEALS	43800
	-----		-----
NET FOOD	472,938	TOTAL MEALS/YEAR	262437
TOTAL PATIENT CENSUS	72,879	NET FOOD	472938
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	262437

TOTAL PATIENT MEALS	218637	COST PER MEAL	1.8
		TIME EMPLOYEE MEALS	43800
ADD # EMPLOYEE MEALS/DAY	120		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	78840
	-----		=====
TOTAL EMPLOYEE MEALS	43800		