

		FOR OHF USE				

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

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>0036301</u></p> <p>Facility Name: <u>MODERN CARE CONVALESCENT & N H</u></p> <p>Address: <u>1500 WEST WALNUT</u> <u>JACKSONVILLE</u> <u>62650</u> Number City Zip Code</p> <p>County: <u>MORGAN</u></p> <p>Telephone Number: <u>217-245-4183</u> Fax # <u>217-243-2915</u></p> <p>IDPA ID Number: <u>37-1265180</u></p> <p>Date of Initial License for Current Owners: <u>07/01/90</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</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>MORTON DOPPELT, PRESIDENT</u> Telephone Number: <u>217-245-4183</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<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>1/1/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MICHAEL SCHNEIDER</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> <td></td> </tr> <tr> <td rowspan="5" style="width: 15%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>CYNTHIA S. FOOTE</u> <u>PARTNER</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>ZUMBAHLEN, EYTH, SURRETT & FOOTE, LTD.</u> <u>1395 LINCOLN AVENUE, JACKSONVILLE, IL 62650</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>217-245-5121</u> Fax # <u>217-243-3356</u></td> <td></td> </tr> <tr> <td colspan="2">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>MICHAEL SCHNEIDER</u>			(Title) <u>ADMINISTRATOR</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>CYNTHIA S. FOOTE</u> <u>PARTNER</u>		(Firm Name & Address) <u>ZUMBAHLEN, EYTH, SURRETT & FOOTE, LTD.</u> <u>1395 LINCOLN AVENUE, JACKSONVILLE, IL 62650</u>		(Telephone) <u>217-245-5121</u> Fax # <u>217-243-3356</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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Facility Name & ID Number MODERN CARE CONVALESCENT & N H

0036-301 Report Period Beginning: 1/1/02 Ending: 12/31/02

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	68	Skilled (SNF)	68	24,820	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	68	TOTALS	68	24,820	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	2,129	3,988	0	6,117	8
9	SNF/PED					9
10	ICF	7,330	9,782	584	17,696	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,459	13,770	584	23,813	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.94%

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

70 (Do not include bed-hold days in Section B.)

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

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

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

YES NO

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

YES NO

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

Date started 7/1/90

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

YES Date 7/1/90 NO

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

YES NO If YES, enter number of beds certified 68 and days of care provided 2,155

Medicare Intermediary ADMINISTAR FEDERAL-KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/02 Fiscal Year: _____

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

STATE OF ILLINOIS

Facility Name & ID Number **MODERN CARE CONVALESCENT & N H** # **0036-301** Report Period Beginning: **1/1/02** Ending: **12/31/02** Page 3

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 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	174,811	18,339	4,809	197,959	489	198,448		198,448		1
2	Food Purchase		150,592		150,592		150,592	(425)	150,167		2
3	Housekeeping	101,044	5,416	3,577	110,037	653	110,690		110,690		3
4	Laundry	22,488	7,775		30,263		30,263		30,263		4
5	Heat and Other Utilities			56,344	56,344	(6,428)	49,916	(2,653)	47,263		5
6	Maintenance	44,487	41,707		86,194		86,194		86,194		6
7	Other (specify):*										7
8	TOTAL General Services	342,830	223,829	64,730	631,389	(5,286)	626,103	(3,078)	623,025		8
	B. Health Care and Programs										
9	Medical Director					2,475	2,475		2,475		9
10	Nursing and Medical Records	833,556	97,840	577	931,973	174	932,147	(40,837)	891,310		10
10a	Therapy			194,930	194,930		194,930		194,930		10a
11	Activities	66,472	6,667		73,139		73,139		73,139		11
12	Social Services	43,661		3,917	47,578		47,578		47,578		12
13	Nurse Aide Training										13
14	Program Transportation			2,617	2,617	(161)	2,456	(713)	1,743		14
15	Other (specify):*					100	100		100		15
16	TOTAL Health Care and Programs	943,689	104,507	202,041	1,250,237	2,588	1,252,825	(41,550)	1,211,275		16
	C. General Administration										
17	Administrative	68,298			68,298		68,298		68,298		17
18	Directors Fees			61,600	61,600		61,600		61,600		18
19	Professional Services			26,000	26,000	(3,775)	22,225	(1,028)	21,197		19
20	Dues, Fees, Subscriptions & Promotions			30,341	30,341	(5,216)	25,125	(10,245)	14,880		20
21	Clerical & General Office Expenses	87,483	13,109		100,592	6,428	107,020		107,020		21
22	Employee Benefits & Payroll Taxes			319,900	319,900	3,285	323,185		323,185		22
23	Inservice Training & Education										23
24	Travel and Seminar					4,417	4,417		4,417		24
25	Other Admin. Staff Transportation					844	844		844		25
26	Insurance-Prop.Liab.Malpractice			38,136	38,136		38,136		38,136		26
27	Other (specify):*			23,966	23,966	(3,285)	20,681	(20,038)	643		27
28	TOTAL General Administration	155,781	13,109	499,943	668,833	2,698	671,531	(31,311)	640,220		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,442,300	341,445	766,714	2,550,459		2,550,459	(75,939)	2,474,520		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.

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			58,307	58,307		58,307	(7,546)	50,761			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,218	27,218		27,218	(5,879)	21,339			32
33	Real Estate Taxes			16,696	16,696		16,696	(4,320)	12,376			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			7,997	7,997		7,997	(7,997)				36
37	TOTAL Ownership			110,218	110,218		110,218	(25,742)	84,476			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,230	37,230		37,230		37,230			42
43	Other (specify):* Replacement Taxes			783	783		783	(783)				43
44	TOTAL Special Cost Centers			38,013	38,013		38,013	(783)	37,230			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,442,300	341,445	914,945	2,698,690		2,698,690	(102,464)	2,596,226			45

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

Facility Name & ID Number MODERN CARE CONVALESCENT & N H

0036301

Report Period Beginning: 1/1/02

Ending: 12/31/02

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	(2,653)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,546)	30		9
10	Interest and Other Investment Income	(5,879)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(425)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(7,997)	36		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(600)	20		17
18	Fines and Penalties				18
19	Entertainment	(1,436)	20		19
20	Contributions	(315)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,028)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,237)	27		24
25	Fund Raising, Advertising and Promotional	(7,975)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(783)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(234)	20		28
29	Other-Attach Schedule	(62,643)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (101,751)		\$	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)	(713)	14	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (713)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (102,464)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
 MODERN CARE CONVALESCENT & N H

ID# 0036301

Report Period Beginning: 1/1/02

Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MEDICARE DRUGS	\$ (40,837)	10	1
2	APARTMENT EXPENSES	(17,486)	27	2
3	APARTMENT REAL ESTATE TAXES	(4,320)	33	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	(62,643)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MODERN CARE CONVALESCENT & N H

0036301

Report Period Beginning:

1/1/02

Ending:

12/31/02

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	(425)	0	0	0	0	0	0	0	0	0	0	(425)	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	(2,653)	0	0	0	0	0	0	0	0	0	0	(2,653)	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	(3,078)	0	0	0	0	0	0	0	0	0	0	(3,078)	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	(40,837)	0	0	0	0	0	0	0	0	0	0	(40,837)	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	(713)	0	0	0	0	0	0	0	0	0	0	(713)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(41,550)	0	0	0	0	0	0	0	0	0	0	(41,550)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,028)	0	0	0	0	0	0	0	0	0	0	(1,028)	19
20	Fees, Subscriptions & Promotions	(10,245)	0	0	0	0	0	0	0	0	0	0	(10,245)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	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):*	(20,038)	0	0	0	0	0	0	0	0	0	0	(20,038)	27
28	TOTAL General Administration	(31,311)	0	0	0	0	0	0	0	0	0	0	(31,311)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(75,939)	0	0	0	0	0	0	0	0	0	0	(75,939)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/02 Ending: 12/31/02

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	(7,546)	0	0	0	0	0	0	0	0	0	0	(7,546) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(5,879)	0	0	0	0	0	0	0	0	0	0	(5,879) 32
33	Real Estate Taxes	(4,320)	0	0	0	0	0	0	0	0	0	0	(4,320) 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):*	(7,997)	0	0	0	0	0	0	0	0	0	0	(7,997) 36
37	TOTAL Ownership	(25,742)	0	0	0	0	0	0	0	0	0	0	(25,742) 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):*	(783)	0	0	0	0	0	0	0	0	0	0	(783) 43
44	TOTAL Special Cost Centers	(783)	0	0	0	0	0	0	0	0	0	0	(783) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(102,464)	0	0	0	0	0	0	0	0	0	0	(102,464) 45

Facility Name & ID Number MODERN CARE CONVALESCENT & N H

0036301

Report Period Beginning:

1/1/02

Ending:

12/31/02

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
MORTON DOPPELT	21.43			M.H. DOPPELT INC	JACKSONVILLE	CONSULTING
MARSHA DOPPELT	21.42					
STUART GREEN	28.57					
LOIS VANBEBBER	14.29					
PAULINE PROKOP	14.29					
SEE SUPPLEMENTAL SCHEDULE				R&D PHARMACY	JACKSONVILLE	RETAIL
				R&D PHARMACY	JACKSONVILLE	RETAIL

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		
1	V	VAN RENTAL	\$ 1,485	R&D PHARMACY	100.00%	\$ 772	\$	(713)
2	V							
3	V							
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 1,485			\$ 772	\$ *	(713)

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

Facility Name & ID Number MODERN CARE CONVALESCENT & N F # 0036301 Report Period Beginning: 1/1/02 Ending: 12/31/02

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	MORTON DOPPELT	PRESIDENT	DIRECTOR	21.43		5	12.00		\$		1
2	M.H. DOPPELT INC.		DIRECTOR					DIRECTOR FEE	30,800	18-3	2
3											3
4	STUART GREEN	TREASURER	DIRECTOR	28.57		24	60.00	DIRECTOR FEE	15,400	18-3	4
5	PAULINE PROKOP	V PRESIDENT	DIRECTOR	14.29		1	2.00	DIRECTOR FEE	12,600	18-3	5
6	LOIS VAN BEBBER	DIRECTOR	DIRECTOR	14.29		1	2.00	DIRECTOR FEE	2,800	18-3	6
7	MARSHA DOPPELT	OFFICE CLERK	DIRECTOR	21.42		40	100.00	SALARY	24,604	21-1	7
8	MARSHA DOPPELT							RETIREMENT	607	22-3	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 86,811		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 MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/02 Ending: 12/31/02

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

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	U. S. Bank		x	Mortgage	\$10,000.00	6/2/1999	\$ 765,931	\$ 740,251	2/5/2004	6.8500	\$ 18,256	1						
2												2						
3	Firststar Bank		x	Mortgage	\$10,000.00	6/2/1999	400,000		5/20/2003	7.7500	7,002	3						
4												4						
5												5						
Working Capital																		
6	Jacksonville Savings Bank		x	Cash Flow-Line of Credit		3/31/2002	50,035	50,035	3/1/03	5.7500	1,402	6						
7	U. S. Bank		x	Cash Flow-Line of Credit		3/4/2002	150,000	50,000	3/4/03	5.7500	558	7						
8												8						
9	TOTAL Facility Related				\$20,000.00		\$ 1,365,966	\$ 840,286			\$ 27,218	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,365,966	\$ 840,286			\$ 27,218	15						

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

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

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

Facility Name & ID Number **MODERN CARE CONVALESCENT & N H**# **0036301**

Report Period Beginning:

1/1/02

Ending:

12/31/02**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	12,182	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.)			\$	12,523	2
3. Under or (over) accrual (line 2 minus line 1).			\$	341	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	12,035	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 _____ 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.			\$	12,376	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	12,568	8	
		1998	12,331	9	
		1999	12,084	10	
		2000	12,182	11	
		2001	12,523	12	
REAL ESTATE TAX ACCRUAL BASED ON PRIOR YEARS REAL ESTATE TAXES PAID					
				FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 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 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 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 2002 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,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Modern Care, Inc. COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0036-301

CONTACT PERSON REGARDING THIS REPORT Mike Schneider

TELEPHONE 217-245-4183 FAX #: 217-243-2915

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of t cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

(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>09-18-402-001</u>	<u>PASSAVANT PARK REAR</u>	\$ <u>3,730.00</u>	\$ _____
2. <u>09-18-200-002</u>	<u>LANDS PT W 1/2 NE SEC 18</u>	\$ <u>12,523.00</u>	\$ <u>12,523.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>16,253.00</u>	\$ <u>12,523.00</u>

B. Real Estate Tax Cost Allocation:

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number MODERN CARE CONVALESCENT & N H# 0036301 Report Period Beginning:1/1/02

Ending:

12/31/02**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 20,069 B. General Construction Type: Exterior BRICK Frame _____ 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).

PARC BROOKE APARTMENTS, RESIDENTIAL RENTAL; SQUARE FOOTAGE 6,552 SQ. FEET.F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>20,069</u>	<u>1990</u>	<u>\$ 75,000</u>	1
2					2
3	TOTALS	<u>20,069</u>		<u>\$ 75,000</u>	3

Facility Name & ID Number MODERN CARE CONVALESCENT & N H

0036301

Report Period Beginning:

1/1/02

Ending:

12/31/02

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	68		1990	1961	\$ 850,000	\$ 26,984	31.5	\$ 26,984	\$	\$ 337,300	4
5				1990	4,963	158	31.5	158		1,954	5
6			1990	1968	35,000	1,111	31.5	1,111		13,761	6
7											7
8											8
	Improvement Type**										
9	ADDITION OF 764 SQ. FEET TO EXISTING										
10	DINING ROOM/DAY ROOM										
11				1997	106,549	2,732	39	2,732		15,368	10
12	SCREENED 26 X 26 FOOT GAZEBO FOR										
13	RESIDENTS OUTSIDE ENJOYMENT										
14				1997	25,000	1,250	20	1,250		6,823	13
15	WINDOW COVERINGS										
16				1998	7,484		7	1,069	1,069	4,280	15
17	LAND IMPROVEMENT-LANDSCAPING										
18				1990	40,000		10			40,000	17
19	WATER HEATERS										
20				1999	7,461	621	7	1,066	445	3,682	19
21	CARRIER CHILLER										
22				1999	12,250	551	39	314	(237)	1,047	21
23	KITCHEN REMODELING										
24				2000	4,428	114	39	111	(3)	314	23
25	PARKING LOT										
26				2000	33,415	3,797	15	2,228	(1,569)	4,827	25
27	NEW SIDING										
28				2001	14,724	378	39	378		724	27
29	NORTH WALL										
30				2001	13,701	351	39	351		410	29
31	WINDOWS										
32				2001	9,576	246	39	246		266	31
33	SHOWER FLOOR AND WALLS										
34				2002	4,823	62	39	62		62	33
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number MODERN CARE CONVALESCENT & N H

0036301

Report Period Beginning:

1/1/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,169,374	\$ 38,355		\$ 38,060	\$ (295)	\$ 430,818	70

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

Facility Name & ID Number MODERN CARE CONVALESCENT & NH # 0036301 Report Period Beginning: 1/1/02 Ending: 12/31/02

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	\$ 97,987	\$ 4,201	\$ 11,315	\$ 7,114	5-7 YEARS	\$ 49,000	71
72	Current Year Purchases	15,751	15,751	1,386	(14,365)	5-7 YEARS	1,386	72
73	Fully Depreciated Assets	554,046					554,046	73
74								74
75	TOTALS	\$ 667,784	\$ 19,952	\$ 12,701	\$ (7,251)		\$ 604,432	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	TRANSPORT RESIDENTS	FORD ECONOLINE 1996	1996	\$ 37,000	\$	\$	\$	5	\$ 37,000	76
77										77
78										78
79										79
80	TOTALS			\$ 37,000	\$	\$	\$		\$ 37,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,949,158	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,307	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,761	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,546)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,072,250	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	LAND-APARTMENTS	\$ 55,000	\$	\$	86
87	APARTMENT BUILDING	186,500	6,782	26,845	87
88	REMODELING-APARTMENTS	5,593	203	668	88
89	EQUIPMENT-APARTMENTS	6,137	1,012	3,656	89
90					90
91	TOTALS	\$ 253,230	\$ 7,997	\$ 31,169	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: _____

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.	_____ /2003	\$ _____
13.	_____ /2004	\$ _____
14.	_____ /2005	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(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			\$	\$	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 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	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		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		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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.

STATE OF ILLINOIS

Facility Name & ID Number MODERN CARE CONVALESCENT & N H # 0036301 Report Period Beginning: 1/1/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 68,296	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	303,100		3
4	Supply Inventory (priced at cost)	13,275		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,239		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>DUE FROM EMPLOYEES</u>	5,766		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 402,676	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	99,659		12
13	Land	130,000		13
14	Buildings, at Historical Cost	1,361,467		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	710,921		16
17	Accumulated Depreciation (book methods)	(1,158,444)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>GOODWILL</u>	100,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,243,603	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,646,279	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 76,608	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,035		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	1,856		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,035		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	783		35
Other Current Liabilities(specify):				
36	<u>SECURITY DEPOSITS</u>	1,400		36
37	<u>MORTGAGE PAYABLE</u>	70,820		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 263,537	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	669,431		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)	\$ 669,431	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 932,968	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 713,311	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,646,279	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,330,619	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,330,619	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	\$ 55,942	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	\$ (73,250)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PURCHASE OF STOCK	\$ (600,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (617,308)	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)	\$ 713,311	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	\$ 2,725,647	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,725,647	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,879	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,879	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	APARTMENT RENTAL INCOME	23,106	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,106	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,754,632	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	631,389	31
32	Health Care	1,250,225	32
33	General Administration	668,845	33
	B. Capital Expense		
34	Ownership	110,218	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	37,230	36
	D. Other Expenses (specify):		
37	REPLACEMENT TAXES	783	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,698,690	40
41	Income before Income Taxes (line 30 minus line 40)**	55,942	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 55,942	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.

*** 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 **MODERN CARE CONVALESCENT & N H**

0036301

Report Period Beginning:

1/1/02

Ending:

12/31/02

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	1,920	2,161	\$ 49,657	\$ 22.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,075	4,502	75,956	16.87	3
4	Licensed Practical Nurses	13,080	13,737	182,957	13.32	4
5	Nurse Aides & Orderlies	44,841	47,698	461,658	9.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,849	4,221	44,711	10.59	8
9	Activity Director	1,954	2,118	20,699	9.77	9
10	Activity Assistants	5,201	5,603	45,772	8.17	10
11	Social Service Workers	3,807	4,226	43,662	10.33	11
12	Dietician					12
13	Food Service Supervisor	1,880	2,264	30,598	13.52	13
14	Head Cook	2,022	2,151	18,274	8.50	14
15	Cook Helpers/Assistants	14,770	15,478	114,907	7.42	15
16	Dishwashers	1,663	1,708	11,032	6.46	16
17	Maintenance Workers	5,251	5,611	44,487	7.93	17
18	Housekeepers	12,761	13,518	101,044	7.47	18
19	Laundry	2,024	2,233	22,489	10.07	19
20	Administrator	1,944	2,313	68,298	29.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,040	2,337	41,893	17.93	23
24	Clerical	3,797	4,166	45,590	10.94	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	1,131	1,432	18,616	13.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,010	137,477	\$ 1,442,300 *	\$ 10.49	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	155	\$ 4,809	1-3	35
36	Medical Director	26	2,475	9-6	36
37	Medical Records Consultant	19	577	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,200	10-6	39
40	Physical Therapy Consultant	1,509	94,976	10a-3	40
41	Occupational Therapy Consultant	1,368	95,651	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	53	4,303	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	72	3,917	12-3	45
46	Other(specify)				46
47	DENTAL CONSULTANT	6	100	15-6	47
48					48
49	TOTAL (lines 35 - 48)	3,304	\$ 208,008		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 MODERN CARE CONVALESCENT & N H

0036301

Report Period Beginning: 1/1/02

Ending: 12/31/02

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. IL HEALTHCARE ASSOCIATION
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 7 YRS.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,666 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. _____
- (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. \$ 37,230
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. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
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? 40
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? 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Employee Benefits	3,285	
Other-General Administration		3,285
To reclassify employee physicals to employee benefits		
Dietary	116	
Dues, Fees, Subscriptions, Other		116
To reclassify dietary manager dues		
Dietary	373	
Housekeeping	653	
Nursing		1,026
To reclassify uniform costs		
Travel & Seminar	4,690	
Dues, Fees, Subscriptions, Promotions		4,690
To reclassify travel and seminar expense		
Other Administration Staff Transportation	272	
Dues & Subscription		272
To reclassify mileage to other administrative staff transportation		
Clerical & General	6,428	
Heat & Other Utilities		6,428
To reclassify telephone expense		
Medical Director	2,475	
Pharmacist Consultant-		
Nursing & Medical Records	1,200	
Dental Consultant-Other-Healthcare	100	
Professional Fees		3,775
To reclassify consultant services		
Program Transportation	138	
Dues, Fees, Subscriptions		138
To reclassify shuttle bus license		
Other Administration Staff Transportation	572	
Program Transportation		572
To reclassify van rental used 28% for administration travel		
Program Transportation	273	
Travel and Seminar		273
To reclassify travel for nursing and program employees		

Ownership from 1/1/02 to 8/31/02	Percentage
Morton Doppelt	15.00
Marsha Doppelt	15.00
Stuart Green	20.00
Lois Vanbebber	10.00
Pauline Prokop	10.00
Gerald Raymond	15.00
Sheryl Raymond	15.00

On August 31, 2002 the corporation purchased the shares of Gerald & Sheryl Raymond who were owners of R & D Pharmacy. Therefore, on September 1, 2002 the ownership percentages changed as reflected on page 6, VII A.

Page 19, Reconciliation of Book Income to Taxable Income

Income Per Books	\$ 55,943
Rounding	<u>(1)</u>
Taxable Income	<u>\$ 55,942</u>

Page 23, Line 19 Summary of Legal Services

Workmen's Compensation Issues	\$ 321
Employment	45
Unallowable Legal	<u>1,028</u>
Total	<u><u>\$ 1,394</u></u>

Page 3, Line 15

Dental Consultant	<u><u>\$ 100</u></u>
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Page 4, Line 36

Apartment Depreciation Expense	<u><u>\$ 7,997</u></u>
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Page 21, Part G. Out of State Travel

Mileage Paid To/From Out-Of-State Seminars:

11/4/2002 Food Show-Allen Food-Debbie Lowry-St. Louis, MO
248 Miles @.32/mile \$ 79.36

Mileage Paid To/From Seminars:

03/14/03 IHCA-Region 5 Meeting-Mike Schneider- Morris University Center-Edwardsville, IL 153 miles @ .32 mile	\$ 49.00
02/06/02 ICC/FR & R1, Deerfield, IL- Preparation for Mike Schneider/Elaine Seaborn- 528 miles @ .32 mile	168.96
04/23/02 Springfield Drive-In, Chamber of Commerce- Mike Schneider-Meet Staff Legislators 78 miles @ .32 mile	24.96
04/21/02 Plumbing Systems Maintenance-Ernie Wright 380 miles @ .32 mile	121.60
06/18/02 IHCA-Recent Labor Relations Development for LTC-Edwardsville, IL SUI-Mike Schneider 152 miles @ .32 mile	48.00
06/25/02 Balancing: Documentation Care Reimbursement- Crowne Plaza-Springfield, IL Mike Schneider-41 miles @ .32 mile	13.12
9/9-9/11/02 IHCA Ann. Convention-Mike Schneider- Springfield, IL-128 miles @ .32 mile	40.96
07/10/02 Fire Protection-Ernie Wright-Peoria, IL 165 miles @ .32 mile	<u>52.80</u>
Total	\$ <u>519.40</u>