

		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>0035659</u></p> <p>Facility Name: <u>TAMERLANE HEALTH CARE CENTRE</u></p> <p>Address: <u>3601 16 AVENUE</u> <u>STERLING</u> <u>61081</u> Number City Zip Code</p> <p>County: <u>WHITESIDE</u></p> <p>Telephone Number: <u>(815) 626-0233</u> Fax # <u>(815) 626-6740</u></p> <p>IDPA ID Number: <u>36-3651798</u></p> <p>Date of Initial License for Current Owners: <u>07/01/89</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>01/01/2002</u> to <u>12/31/2002</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>BOB HEDGES</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>BOB HEDGES</u>			(Title) <u>PRESIDENT</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>		(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE# 0035659 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	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					8
9	SNF/PED					9
10	ICF	24,501	243		24,744	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,501	243		24,744	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.85%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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

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

YES NO

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

YES NO

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

Date started 07/01/89

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

YES Date 07/01/89 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

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

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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	99,915	7,882	4,458	112,255		112,255		112,255		1
2	Food Purchase		87,397		87,397	(5,968)	81,429	(232)	81,197		2
3	Housekeeping	54,097	4,562		58,659		58,659		58,659		3
4	Laundry	22,979	4,886	1,104	28,969		28,969		28,969		4
5	Heat and Other Utilities			32,710	32,710		32,710	1,073	33,783		5
6	Maintenance	21,262	2,249	18,363	41,874		41,874	11,078	52,952		6
7	Other (specify):*			2,895	2,895		2,895		2,895		7
8	TOTAL General Services	198,253	106,976	59,530	364,759	(5,968)	358,791	11,919	370,710		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	373,287	14,836	52,186	440,309		440,309	1,679	441,988		10
10a	Therapy			3,338	3,338		3,338		3,338		10a
11	Activities	33,332	1,166		34,498		34,498		34,498		11
12	Social Services	131,219		3,003	134,222		134,222		134,222		12
13	Nurse Aide Training										13
14	Program Transportation			1,439	1,439		1,439		1,439		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	537,838	16,002	68,966	622,806		622,806	1,679	624,485		16
	C. General Administration										
17	Administrative	77,084		360,000	437,084		437,084	(291,843)	145,241		17
18	Directors Fees										18
19	Professional Services			31,997	31,997		31,997	2,528	34,525		19
20	Dues, Fees, Subscriptions & Promotions			11,318	11,318		11,318	(2,638)	8,680		20
21	Clerical & General Office Expenses	23,309	9,345	12,644	45,298		45,298	36,992	82,290		21
22	Employee Benefits & Payroll Taxes			142,365	142,365	5,968	148,333		148,333		22
23	Inservice Training & Education			1,010	1,010		1,010		1,010		23
24	Travel and Seminar							6,594	6,594		24
25	Other Admin. Staff Transportation			5,357	5,357		5,357		5,357		25
26	Insurance-Prop.Liab.Malpractice			50,656	50,656		50,656		50,656		26
27	Other (specify):*			1,873	1,873		1,873	19,117	20,990		27
28	TOTAL General Administration	100,393	9,345	617,220	726,958	5,968	732,926	(229,250)	503,676		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	836,484	132,323	745,716	1,714,523		1,714,523	(215,652)	1,498,871		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 TAMERLANE HEALTH CARE CENTRE

#0035659

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

12/31/2002

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			13,301	13,301		13,301	34,203	47,504			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,672	10,672		10,672	94,946	105,618			32
33	Real Estate Taxes			14,719	14,719		14,719		14,719			33
34	Rent-Facility & Grounds			116,583	116,583		116,583	(116,583)				34
35	Rent-Equipment & Vehicles			14,374	14,374		14,374		14,374			35
36	Other (specify):*							4,132	4,132			36
37	TOTAL Ownership			169,649	169,649		169,649	16,698	186,347			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			38,808	38,808		38,808		38,808			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,808	38,808		38,808		38,808			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	836,484	132,323	954,173	1,922,980		1,922,980	(198,954)	1,724,026			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 TAMERLANE HEALTH CARE CENTRE

0035659

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

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	1,561	30		9
10	Interest and Other Investment Income	(157)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(232)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(2,895)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,873)	27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	49			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,547)		\$	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)	(195,407)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (195,407)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (198,954)		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
TAMERLANE HEALTH CARE CENTRE

Page 5A

ID# 0035659

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 777	6	1
2	BANK CHARGES	(728)	21	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	49		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE

0035659

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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	(232)	0	0	0	0	0	0	0	0	0	0	(232)	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	1,073	0	0	0	0	0	0	0	0	0	1,073	5
6	Maintenance	777	10,301	0	0	0	0	0	0	0	0	0	11,078	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	545	11,374	0	11,919	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	1,679	0	0	0	0	0	0	0	0	0	1,679	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	1,679	0	1,679	16								
	C. General Administration													
17	Administrative	0	(291,843)	0	0	0	0	0	0	0	0	0	(291,843)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,528	0	0	0	0	0	0	0	0	0	2,528	19
20	Fees, Subscriptions & Promotions	(2,895)	257	0	0	0	0	0	0	0	0	0	(2,638)	20
21	Clerical & General Office Expenses	(728)	37,720	0	0	0	0	0	0	0	0	0	36,992	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	6,594	0	0	0	0	0	0	0	0	0	6,594	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):*	(1,873)	20,990	0	0	0	0	0	0	0	0	0	19,117	27
28	TOTAL General Administration	(5,496)	(223,754)	0	(229,250)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,951)	(210,701)	0	(215,652)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE

0035659

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,561	0	32,642	0	0	0	0	0	0	0	0	34,203	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(157)	0	95,103	0	0	0	0	0	0	0	0	94,946	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(116,583)	0	0	0	0	0	0	0	0	(116,583)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	1,008	3,124	0	0	0	0	0	0	0	0	4,132	36
37	TOTAL Ownership	1,404	1,008	14,286	0	16,698	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)	(3,547)	(209,693)	14,286	0	(198,954)	45							

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE

0035659

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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
<u>WILLIAM IRVINE</u>	<u>50</u>	<u>COLONIAL ACRES</u>	<u>ROCK FALL</u>	<u>HI CARE MGMT</u>	<u>SPRINGFEILD</u>	<u>MANAGEMENT</u>
<u>ROBERT HEDGES</u>	<u>50</u>	<u>CARBONDALE NURSING & REHAB</u>	<u>CARBONDALE</u>	<u>H & I PROPERTIES</u>	<u>SPRINGFEILD</u>	<u>LANDLORD</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
<u>1</u>	<u>V</u>	<u>17</u>	<u>MANAGEMENT FEES</u>	<u>\$ 360,000</u>	<u>HI CARE MANAGEMENT</u>		<u>\$ (360,000)</u>
<u>2</u>	<u>V</u>	<u>5</u>	<u>UTILITIES</u>			<u>1,073</u>	<u>1,073</u>
<u>3</u>	<u>V</u>	<u>6</u>	<u>MAINTENANCE</u>			<u>10,301</u>	<u>10,301</u>
<u>4</u>	<u>V</u>	<u>10</u>	<u>NURSING CONSULTANT</u>			<u>1,679</u>	<u>1,679</u>
<u>5</u>	<u>V</u>	<u>17</u>	<u>OFFICER SALARIES</u>			<u>68,157</u>	<u>68,157</u>
<u>6</u>	<u>V</u>	<u>20</u>	<u>DUES & SUBSRIPTIONS</u>			<u>257</u>	<u>257</u>
<u>7</u>	<u>V</u>	<u>21</u>	<u>CLERICAL</u>			<u>37,720</u>	<u>37,720</u>
<u>8</u>	<u>V</u>	<u>27</u>	<u>PAYROLL TAXES/GRP INSUR</u>			<u>20,990</u>	<u>20,990</u>
<u>9</u>	<u>V</u>	<u>24</u>	<u>TRAVEL & EDUCATION</u>			<u>6,594</u>	<u>6,594</u>
<u>10</u>	<u>V</u>	<u>19</u>	<u>PROFESSIONAL FEES</u>			<u>2,528</u>	<u>2,528</u>
<u>11</u>	<u>V</u>	<u>36</u>	<u>AMORT.COMP SOFT/DEPREC</u>			<u>1,008</u>	<u>1,008</u>
<u>12</u>	<u>V</u>						
<u>13</u>	<u>V</u>						
<u>14</u>	Total		\$ 360,000			\$ 150,307	\$ * (209,693)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2		3	4	5	6	7	8	
Schedule V		Line		Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item				Name of Related Organization				
15	V	34	RENT		\$ 116,583			\$	(116,583)	15
16	V	30	DEPRECIATION			H & I PROPERTIES		32,642	32,642	16
17	V	32	INTEREST			H & I PROPERTIES		95,103	95,103	17
18	V	36	AMORT.-DEFERRED MORT. COSTS			H & I PROPERTIES		3,124	3,124	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				\$ 116,583			\$ 130,869	\$ * 14,286	39

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

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT	50.00	COLONIAL			SALARY	\$ 34,078	17-8	1
2					18,831						2
3					CARBONDALE						3
4					37,090						4
5											5
6	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT	50.00	COLONIAL			SALARY	34,078	17-8	6
7					18,831						7
8					CARBONDALE						8
9					37,090						9
10											10
11	MARTHA IRVINE	BOOKKEEPING			COLONIAL \$1396			SALARY	2,526	21-8	11
12					TAMMER. \$2526						12
13								TOTAL	\$ 70,682		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 TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization HI CARE MANAGEMENT
 Street Address 827 S. FIFTH STREET
 City / State / Zip Code SPRINGFIELD, IL 62703
 Phone Number (217) 528-0044
 Fax Number (217) 528-3412

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	65,348	3	\$ 2,834	\$ 24,744	\$ 1,073	1
2	6	MAINTENANCE	PER RESIDENT DAY	65,348	3	27,205	20,067	24,744	10,301
3	10	NURSING CONSULTANT	PER RESIDENT DAY	65,348	3	4,435	24,744	1,679	3
4	17	OFFICER SALARIES	PER RESIDENT DAY	65,348	3	180,000	180,000	24,744	68,157
5	20	DUES & SUBSRIPTIONS	PER RESIDENT DAY	65,348	3	679	24,744	257	5
6	21	CLERICAL	PER RESIDENT DAY	65,348	3	99,617	77,389	24,744	37,720
7	27	PAYROLL TAXES/GRP INSUR	PER RESIDENT DAY	65,348	3	55,433	24,744	20,990	7
8	24	TRAVEL & EDUCATION	PER RESIDENT DAY	65,348	3	17,414	24,744	6,594	8
9	19	PROFESSIONAL FEES	PER RESIDENT DAY	65,348	3	6,677	24,744	2,528	9
10	36	AMORT.COMP SOFT/DEPREC	PER RESIDENT DAY	65,348	3	2,662	24,744	1,008	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					\$ 396,956	\$ 277,456	\$ 150,307	25

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

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 H&I PROPERTIES, L.L.C.
 Street Address 827 S. FIFTH STREET
 City / State / Zip Code SPRINGFIELD, IL 62703
 Phone Number (217) 528-0044
 Fax Number (217) 528-3412

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	\$ 32,642	\$ 1	\$ 32,642	1
2	32	INTEREST	DIRECT	1	1	95,103	1	95,103	2
3	36	AMORT.-DEF. MORT. COST	DIRECT	1	1	3,124	1	3,124	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					\$ 130,869	\$	\$ 130,869	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	GMAC		X	AUTO LOAN	\$699.00	11/18/02	\$ 28,556	\$ 28,556	12/03/03	0.0799	\$ 245	1								
2	ILLINI BANK		X	PARKING LOT	\$302.00	07/18/01	9,500	5,339	07/18/04	0.0938	651	2								
3												3								
4												4								
5	ILLINI BANK		X	MORTGAGE	\$11,067.00	6/11/02	1,389,870	1,374,729	5/30/05	7.2500	95,103	5								
Working Capital																				
6	ILLINI BANK		X	WORKING CAPITAL	INTREREST	REVOLV	10,000	195,724	08/06/03	PRIME +	9,776	6								
7												7								
8												8								
9	TOTAL Facility Related				\$12,068.00		\$ 1,437,926	\$ 1,604,348			\$ 105,775	9								
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES								10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,437,926	\$ 1,604,348			\$ 105,775	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 TAMERLANE HEALTH CARE CENTRE# 0035659 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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.	\$	14,355	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	14,537	2
3. Under or (over) accrual (line 2 minus line 1).			\$	182	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	14,537	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.			\$	14,719	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	14,734	8	
		1998	14,389	9	
		1999	14,106	10	
		2000	14,355	11	
		2001	14,537	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL.					
THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.					
		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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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 TAMERLANE HEALTH CARE CENTRE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0035659

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 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 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>11-10-329-006</u>	<u>NURSING HOME</u>	\$ <u>14,536.72</u>	\$ <u>14,536.72</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>14,536.72</u>	\$ <u>14,536.72</u>

B. Real Estate Tax Cost Allocation:

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

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

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,130 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSINGHOME</u>	<u>217,800</u>	<u>1998</u>	<u>\$ 111,500</u>	1
2					2
3	TOTALS	217,800		\$ 111,500	3

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE

0035659

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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	70		1998	1958	\$ 887,968	\$ 22,769	39	\$ 22,769	\$	\$ 99,614	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		IMPROVEMENTS		1992	14,227	452	31.5	452		4,636	9
10		IMPROVEMENTS		1993	3,670	94	39	94		866	10
11		IMPROVEMENTS		1994	7,850	201	39	201		1,630	11
12		PLUMBING WORK		1995	3,302	85	39	85		648	12
13		INSTALLED BOILER TANK		1995	600	15	39	15		115	13
14		INSTALLED 2 PUMPS		1995	2,289	59	39	59		445	14
15		PLUMBING WORK		1995	10,752	276	39	276		2,059	15
16		DOORS		1995	2,094	54	39	54		389	16
17		TWO DOORS		1995	1,055	27	39	27		192	17
18		INSTALLED ATTIC FAN & DUCT		1995	2,412	62	39	62		437	18
19		PARKING LOT		1995	32,070	2,138	39	2,138		15,590	19
20		WALL PROTECTOR		1997	3,328	85	39	85		493	20
21		SEPTIC FIELD-PLUMBING WORK		1998	25,965	666	39	666		2,747	21
22		2 NEW WATER HEATERS		1999	12,083	310	39	310		1,097	22
23		CIRCUIT BREAKER PANELS		1999	2,230	57	39	57		202	23
24		ELECTRICAL WORK		1999	2,374	61	39	61		216	24
25		BREAKER PANELS		2001	2,542	92	27.5	92		142	25
26		BLACKTOP		2001	11,161	744	15	744		1,147	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			1,027,972	28,247	28,247		132,665	

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

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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	\$ 60,978	\$ 4,497	\$ 6,098	\$ 1,601	10YRS	\$ 41,374	71
72	Current Year Purchases	1,063	266	53	(213)	10 YRS	53	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	102,500	9,873	10,250	377	10 YRS	46,125	74
75	TOTALS	\$ 164,541	\$ 14,636	\$ 16,401	\$ 1,765		\$ 87,552	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	HSKG,NSG,ACT	1994 FORD VAN	1995	\$ 26,501	\$	\$	\$	5	\$ 26,501	76
77	HSKG,NSG,ACT	2000CHEVY TRUCK	2002	28,556	3,060	2,856	(204)	5	2,856	77
78										78
79										79
80	TOTALS			\$ 55,057	\$ 3,060	\$ 2,856	\$ (204)		\$ 29,357	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)	\$ 1,359,070	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,943	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,504	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,561	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 249,574	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: _____

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? YES NO

16. Rental Amount for movable equipment: \$ 7,227 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	Chevy Suburban 2000	\$ 715.00	\$ 7,147	17
18					18
19					19
20					20
21	TOTAL		\$ 715.00	\$ 7,147	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.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	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 prescripts							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.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE

0035659

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 (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	\$ 29,188	\$	1
2	Cash-Patient Deposits	274,260		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,776		6
7	Other Prepaid Expenses	985		7
8	Accounts Receivable (owners or related parties)	123,129		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 471,338	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	140,004		15
16	Equipment, at Historical Cost	117,098		16
17	Accumulated Depreciation (book methods)	(124,709)		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): COMP. SOFTWARE	7,448		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 139,841	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 611,179	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 144,354	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	229,619		29
30	Accrued Salaries Payable	32,971		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,616		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,537		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 435,097	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 435,097	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 176,082	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 611,179	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 165,495	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 165,496	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	10,586	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,586	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)	\$ 176,082	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,933,409	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,933,409	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***	157	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 157	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)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,933,566	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	364,759	31
32	Health Care	622,806	32
33	General Administration	726,958	33
B. Capital Expense			
34	Ownership	169,649	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	38,808	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,922,980	40
41	Income before Income Taxes (line 30 minus line 40)**	10,586	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 10,586	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 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 TAMERLANE HEALTH CARE CENTRE

0035659

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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	1,896	2,127	\$ 38,783	\$ 18.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,871	2,070	40,581	19.60	3
4	Licensed Practical Nurses	7,811	8,336	140,941	16.91	4
5	Nurse Aides & Orderlies	18,109	19,375	152,982	7.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,708	1,927	16,554	8.59	9
10	Activity Assistants	2,656	2,833	16,778	5.92	10
11	Social Service Workers	14,171	15,395	131,219	8.52	11
12	Dietician					12
13	Food Service Supervisor	1,876	2,088	20,902	10.01	13
14	Head Cook	5,598	6,108	38,226	6.26	14
15	Cook Helpers/Assistants	6,257	6,632	40,787	6.15	15
16	Dishwashers					16
17	Maintenance Workers	1,961	2,256	21,262	9.42	17
18	Housekeepers	7,481	8,204	54,097	6.59	18
19	Laundry	3,750	3,932	22,979	5.84	19
20	Administrator	1,900	2,080	77,084	37.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,941	2,132	23,309	10.93	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	78,986	85,495	\$ 836,484 *	\$ 9.78	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 4,458	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	3,338	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	1,940	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,336		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	280	\$ 13,323	10-3	50
51	Licensed Practical Nurses	895	34,876	10-3	51
52	Nurse Aides	176	3,387	10-3	52
53	TOTAL (lines 50 - 52)	1,351	\$ 51,586		53

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5	6	7	8	9	10	11	12	13
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	06/00	\$ 1,588	3YRS	\$	\$ 265	\$ 529	\$ 529	\$ 265	\$	\$	\$	\$
2	PAINT/DECORATING	06/02	1,485	3 YRS				248	495	495	247		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,073		\$	\$ 265	\$ 529	\$ 777	\$ 760	\$ 495	\$ 247	\$	\$

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE

0035659

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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. ICLTC -\$2830, ILHEALTH CARE-\$2509
- (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. \$ _____ 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. \$ 38,808
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. \$ 5,968 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? 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? 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	4,458
	REPAIRS & MAINTENANCE	0
		0
		4,458
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,104
		0
		1,104
5	HEAT & OTHER UTILITIES	
	GAS HEAT	10,217
	ELECTRICITY	17,387
	WATER	4,700
	CABLE TV - LOBBY	406
		0
		32,710
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,137
	PAINTING & DECORATING	275
	BUILDING REPAIRS	1,465
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	5,060
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	844
	FIRE SERVICE	9,582
		0
		0
		0
		18,363
7	OTHER	
	SCAVENGER	2,895
	SECURITY SERVICE	0
		2,895
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	51,586
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	600
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		52,186
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	3,338
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,338
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	1,063
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	1,940
	SOCIAL WORKER XVIII B 45-2	0
		0
		3,003
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	1,439
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	360,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,544
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	19,453
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	31,997
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	1,704
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,543
	LICENSES & PERMITS XIX F	744
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,895
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	432
21	CLERICAL & GENERAL OFFICE EXPENSES	11,318
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	728
	EQUIPMENT REPAIR & MAINTENANCE	912
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	11,004
	MESSENGER SERVICE	0
		0
		12,644

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	64,078
	UNEMPLOYMENT COMPENSATION XIX D	7,152
	WORKERS COMPENSATION INSURANC XIX D	21,699
	HOSPITALIZATION INSURANCE XIX D	44,800
	EMPLOYEE BENEFITS - OTHER XIX D	4,636
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		142,365
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,010
		1,010
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	5,357
		5,357
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	50,656
		50,656
27	OTHER	
	BAD DEBTS VI 24	1,873
		0
		1,873

GRAND TOTAL COLUMN 3 OTHER

745,716

TAMERLANE HEALTH CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2002

TOTAL FOOD PURCHASE	87,397	PATIENT MEALS	74232
LESS SALES TAX	(232)	ADD EMPLOYEE MEALS	5475
	-----		-----
NET FOOD	87,165	TOTAL MEALS/YEAR	79707
TOTAL PATIENT CENSUS	24,744	NET FOOD	87165
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	79707

TOTAL PATIENT MEALS	74232	COST PER MEAL	1.09
		TIME EMPLOYEE MEALS	5475
ADD # EMPLOYEE MEALS/DAY	15		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	5968
	-----		=====
TOTAL EMPLOYEE MEALS	5475		