

Facility Name & ID Number Taylorville Care Center# 0028787 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	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>1,286</u>	<u>182</u>	<u>2,871</u>	<u>4,339</u>	8
9	SNF/PED					9
10	ICF	<u>18,484</u>	<u>9,440</u>		<u>27,924</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,770</u>	<u>9,622</u>	<u>2,871</u>	<u>32,263</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.20%

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

32 (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 08/01/1984

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

YES Date 08/01/1984 NO

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

YES NO If YES, enter number of beds certified 16 and days of care provided 2,871Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center # 0028787 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				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	121,390	13,992	7,925	143,307		143,307		143,307		1
2	Food Purchase		131,832		131,832		131,832	(9,646)	122,186		2
3	Housekeeping	67,759	14,593		82,352		82,352	182	82,534		3
4	Laundry	45,777	12,747		58,524		58,524		58,524		4
5	Heat and Other Utilities			73,120	73,120		73,120	751	73,871		5
6	Maintenance	59,040	36,637		95,677		95,677	12,911	108,588		6
7	Other (specify):* Sanitation			7,808	7,808		7,808		7,808		7
8	TOTAL General Services	293,966	209,801	88,853	592,620		592,620	4,198	596,818		8
B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,184,513	60,032	41,222	1,285,767	17,911	1,303,678		1,303,678		10
10a	Therapy			350,590	350,590		350,590		350,590		10a
11	Activities	23,363	3,641	11,209	38,213		38,213		38,213		11
12	Social Services	33,228			33,228		33,228		33,228		12
13	Nurse Aide Training										13
14	Program Transportation		1,135		1,135		1,135		1,135		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,241,104	64,808	412,621	1,718,533	17,911	1,736,444		1,736,444		16
C. General Administration											
17	Administrative	63,153	10,979	135,000	209,132	(1,811)	207,321	95,699	303,020		17
18	Directors Fees										18
19	Professional Services			38,266	38,266		38,266	4,117	42,383		19
20	Dues, Fees, Subscriptions & Promotions			5,332	5,332	1,061	6,393	45	6,438		20
21	Clerical & General Office Expenses	53,034	22,990	8,646	84,670	50	84,720	37,800	122,520		21
22	Employee Benefits & Payroll Taxes			247,449	247,449	700	248,149	13,452	261,601		22
23	Inservice Training & Education			18,592	18,592	(17,911)	681		681		23
24	Travel and Seminar			1,705	1,705		1,705	77	1,782		24
25	Other Admin. Staff Transportation							1,197	1,197		25
26	Insurance-Prop.Liab.Malpractice			71,897	71,897		71,897	5,043	76,940		26
27	Other (specify):*										27
28	TOTAL General Administration	116,187	33,969	526,887	677,043	(17,911)	659,132	157,430	816,562		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,651,257	308,578	1,028,361	2,988,196		2,988,196	161,628	3,149,824		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Taylorville Care Center

#0028787

Report Period Beginning:

01/01/2002

Ending:

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			30,632	30,632		30,632	65,778	96,410			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							36,126	36,126			33
34	Rent-Facility & Grounds			277,800	277,800		277,800	(277,800)				34
35	Rent-Equipment & Vehicles			539	539		539		539			35
36	Other (specify):*											36
37	TOTAL Ownership			308,971	308,971		308,971	(175,896)	133,075			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,286	1,367	72,653		72,653		72,653			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		71,286	55,022	126,308		126,308		126,308			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,651,257	379,864	1,392,354	3,423,475		3,423,475	(14,268)	3,409,207			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/2002

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	(434)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(48)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,167)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,233)	17		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,917)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(273)	21		28
29	Other-Attach Schedule	(616)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (16,688)		\$	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)	2,420	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,420		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (14,268)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Taylorville Care Center

ID# 0028787
 Report Period Beginning: 01/01/2002
 Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IDPH License 2003	\$ (200)	17	1
2	Chamber of Commerce Dues	(404)	17	2
3	Vending Machine Cost	(997)	2	3
4	Record Deferred Maintenance Costs	522	6	4
5	Eliminate Deferred Maintenance in Expense	(1,878)	6	5
6	Record 2002 IHCA Dues paid and eliminated in 2001	2,394	20	6
7	Depr. On items required to be capitalized for cost rpt	497	30	7
8	Donations	(550)	20	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	(616)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center

0028787

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	(9,646)	0	0	0	0	0	0	0	0	0	0	(9,646)	2
3	Housekeeping	0	182	0	0	0	0	0	0	0	0	0	182	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	751	0	0	0	0	0	0	0	0	0	751	5
6	Maintenance	(1,356)	14,267	0	0	0	0	0	0	0	0	0	12,911	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(11,002)	15,200	0	0	0	0	0	0	0	0	0	4,198	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(5,837)	101,536	0	0	0	0	0	0	0	0	0	95,699	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,117	0	0	0	0	0	0	0	0	0	4,117	19
20	Fees, Subscriptions & Promotions	(73)	118	0	0	0	0	0	0	0	0	0	45	20
21	Clerical & General Office Expenses	(273)	38,073	0	0	0	0	0	0	0	0	0	37,800	21
22	Employee Benefits & Payroll Taxes	0	13,452	0	0	0	0	0	0	0	0	0	13,452	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	77	0	0	0	0	0	0	0	0	0	77	24
25	Other Admin. Staff Transportation	0	1,197	0	0	0	0	0	0	0	0	0	1,197	25
26	Insurance-Prop.Liab.Malpractice	0	1,843	3,200	0	0	0	0	0	0	0	0	5,043	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(6,183)	160,413	3,200	0	157,430	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,185)	175,613	3,200	0	161,628	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Taylorville Care Center

0028787

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 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	497	2,881	62,400	0	0	0	0	0	0	0	0	65,778 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	685	35,441	0	0	0	0	0	0	0	0	36,126 33
34	Rent-Facility & Grounds	0	0	(277,800)	0	0	0	0	0	0	0	0	(277,800) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	497	3,566	(179,959)	0	(175,896) 37							
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(16,688)	179,179	(176,759)	0	(14,268) 45							

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	3 See Schedule VIII	\$	King Management Co.	100.00%	182	182
2	V	5 See Schedule VIII		King Management Co.	100.00%	751	751
3	V	6 See Schedule VIII		King Management Co.	100.00%	14,267	14,267
4	V	17 See Schedule VIII		King Management Co.	100.00%	101,536	101,536
5	V	19 See Schedule VIII		King Management Co.	100.00%	4,117	4,117
6	V	20 See Schedule VIII		King Management Co.	100.00%	118	118
7	V	21 See Schedule VIII		King Management Co.	100.00%	38,073	38,073
8	V	22 See Schedule VIII		King Management Co.	100.00%	13,452	13,452
9	V	24 See Schedule VIII		King Management Co.	100.00%	77	77
10	V	25 See Schedule VIII		King Management Co.	100.00%	1,197	1,197
11	V	26 See Schedule VIII		King Management Co.	100.00%	1,843	1,843
12	V	30 See Schedule VIII		King Management Co.	100.00%	2,881	2,881
13	V	33 See Schedule VIII		King Management Co.	100.00%	685	685
14	Total		\$			\$ 179,179	\$ * 179,179

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
15	V	34 Rent - Facility & Grounds	\$ 277,800	Jerry & Marilyn King	100.00%	\$	\$ (277,800)
16	V	26 Insurance		Jerry & Marilyn King	100.00%	3,200	3,200
17	V	30 Depreciation		Jerry & Marilyn King	100.00%	62,400	62,400
18	V	33 Real Estate Taxes		Jerry & Marilyn King	100.00%	35,441	35,441
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 277,800			\$ 101,041	\$ * (176,759)

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2002 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	Jerry King	Owner	Mgmt/Consultant	100.00	175,979	15	25.52%	Salary	\$ 60,311	17,8	1
2	Denise King	Regional Director	Administrative	0.00	113,090	15	25.52%	Salary	38,758	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	36,873	10	25.52%	Salary	12,637	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00	98,380	0	0.00		0	N/A	4
5	Elizabeth King	Dietary	Dietary	0.00	2,496	0	0.00		0	N/A	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00	2,234	2	25.52%	Salary	766	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 112,472		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2002 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 King Management Company
 Street Address 935 South Mill Street
 City / State / Zip Code Nashville, IL 62263
 Phone Number (618) 327-3064
 Fax Number (618) 327-3083

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)		
1	3	Housekeeping	Patient Days	126,359	4	\$ 715	\$ 715	32,252	\$ 182	1
2	5	Utilities	Patient Days	126,359	4	2,941	32,252	32,252	751	2
3	6	Maintenance	Patient Days	126,359	4	55,895	49,510	32,252	14,267	3
4	17	Administrative	Patient Days	126,359	4	397,804	391,138	32,252	101,536	4
5	19	Professional Fees	Patient Days	126,359	4	16,131	32,252	32,252	4,117	5
6	20	Fees, Subs & Promotions	Patient Days	126,359	4	464	32,252	32,252	118	6
7	21	Clerical and Gen. Office Expense	Patient Days	126,359	4	149,166	121,226	32,252	38,073	7
8	22	Employee Benefits	Patient Days	126,359	4	52,703	32,252	32,252	13,452	8
9	24	Travel & Seminar	Patient Days	126,359	4	300	32,252	32,252	77	9
10	25	Other Admin. Staff Transport	Patient Days	126,359	4	4,688	32,252	32,252	1,197	10
11	26	Insurance	Patient Days	126,359	4	7,220	32,252	32,252	1,843	11
12	30	Depreciation-Vehicles	Patient Days	126,359	4	2,365	32,252	32,252	604	12
13										13
14	30	Depreciation-Other	Patient Days	126,359	4	8,922	32,252	32,252	2,277	14
15	30	Depreciation-Copier	Direct Cost	126,359	4	948	0	0	0	15
16	33	Property Taxes	Patient Days	126,359	4	2,685	32,252	32,252	685	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 702,947	\$ 562,589		\$ 179,179	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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	Schedule Not Applicable						\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$	\$			\$	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$	\$			\$	15								

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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Taylorville Care Center**# **0028787** Report Period Beginning: **01/01/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$	36,200		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.)		\$	35,441		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(759)		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	36,200		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ 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.		\$	35,441		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1997	33,305	8		
	1998	33,080	9		
	1999	33,015	10		
	2000	34,482	11		
	2001	35,441	12		
				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
Line 2: Real Estate Taxes paid are for the 2001 tax year.	Line 7: \$35,441 Real Estate Tax				
Line 4: Accrual is based on the 2001 taxes paid.	685 Home office allocation				
	\$36,126 Total Real Estate Tax Schedule V, Line 33				

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Taylorville Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0028787

CONTACT PERSON REGARDING THIS REPORT Linda Peppenhorst

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>17-13-28-401-005</u>	<u>Cheneys Add Lts 1 thru 6 Blk 3 &</u>	\$ <u>35,284.76</u>	\$ <u>35,284.76</u>
2. _____	<u>Lts 1 thru 6 Blk 4 & OL 1 & Vac</u>	\$ _____	\$ _____
3. _____	<u>Austin St & Alley</u>	\$ _____	\$ _____
4. <u>17-13-28-401-006</u>	<u>N 1/2 S 1/2 NW SE EX E440</u>	\$ <u>156.34</u>	\$ <u>156.34</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>35,441.10</u>	\$ <u>35,441.10</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 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.

Facility Name & ID Number Taylorville Care Center# 0028787 Report Period Beginning:01/01/2002 Ending:12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,610 B. General Construction Type: Exterior Brick Frame Non-Comb. Sprinkle Number of Stories OneC. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

Taylorville Estates is a 39 unit (27,945 square foot) retirement center which is located on the property adjacent to Taylorville Care CenterF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2002 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	98	1984	1974	\$ 1,560,000	\$	25	\$ 62,400	\$ 62,400	\$ 1,154,617	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	80 Gallon Water Fixture		1985	1,581		10			1,581	9
10	Improvement to Building		1985	12,510	500	25	500		8,509	10
11	Improvement to Parking Lot		1986	1,184		10			1,184	11
12	New Light Fixtures		1987	997		10			997	12
13	Tile Floor		1987	5,941	142	10		(142)	5,941	13
14	Roof		1988	55,100		10			55,100	14
15	Addition to Alarm System		1988	5,610		10			5,610	15
16	Concrete Driveway		1989	2,729	182	15	182		2,486	16
17	Nurses Station		1991	4,809		15	321	321	3,740	17
18	Water Heater		1993	3,750	250	15	250		2,458	18
19	Air Conditioner		1993	2,800	280	10	280		2,636	19
20	New Office		1993	1,500	38	40	38		338	20
21	4" Backflow Preventer		1994	3,966	159	25	159		1,428	21
22	Carpeting		1994	2,471	247	10	247		2,059	22
23	Circulating Pump on Water Heater		1994	2,450	175	14	175		1,444	23
24	Fence		1995	3,590	239	15	239		1,815	24
25	Water Heater		1995	1,602	107	15	107		846	25
26	Sprinkler Heads		1995	1,600	107	15	107		756	26
27	New Roof		1996	25,000	2,500	10	2,500		16,042	27
28	Water Softener		1996	5,908	492	12	492		3,118	28
29	Ceramic Tile		1997	5,167	517	10	517		3,057	29
30	Garage		1997	7,841	784	10	784		4,313	30
31	Rooftop A/C, Ducts & Gas Lines		1997	10,940	1,094	10	1,094		6,017	31
32	Beauty Shop Addition		1997	6,823	455	15	455		2,274	32
33	Carpet		1998	4,154	415	10	415		1,938	33
34	Windows		1998	5,681	568	10	568		2,556	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37 Heating & A/C Units	1998	\$ 4,128	\$ 826	5	\$ 826	\$	\$ 3,509	37	
38 Air Conditioner Units	1999	25,051	2,505	10	2,505		8,977	38	
39 Rear Parking Lot/Driveway	1999	2,995	300	10	300		973	39	
40 Air Conditioner Units	2000	4,834	483	10	483		1,128	40	
41 Landscaping	2001	2,300	230	10	230		307	41	
42 Electrical	2001	6,725	672	10	672		1,233	42	
43 Cabinets	2001	27,445	1,372	20	1,372		2,401	43	
44 Water Heater	2001	5,800	387	15	387		580	44	
45 Wallpaper & Installation	2002	9,016	1,202	5	1,202		1,202	45	
46 Wallguards	2002	5,729	286	15	286		286	46	
47 Water Heater	2002	6,759	113	15	113		113	47	
48 Carpet/Baseboard Remodel	2002	16,561	1,242	10	1,242		1,242	48	
49								49	
50 Home Office Parking Lot	1989	504		10			504	50	
51 Home Office Building	1995	25,021		25	1,001	1,001	7,173	51	
52 Home Office Interior Finishes Lower Level	1996	1,552		15	103	103	673	52	
53 Home Office Carpet	1996	543		5			543	53	
54 Home Office Cabinets	1996	859		20	43	43	279	54	
55 Home Office Electrical	1996	297		15	20	20	129	55	
56 Home Office Front Door	2002	408		10	10	10	10	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)		\$ 1,892,231	\$ 18,869		\$ 82,625	\$ 63,756	\$ 1,324,122	70	

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 95,573	\$ 11,509	\$ 12,842	\$ 1,333	5 to 10	\$ 66,758	71
72	Current Year Purchases	4,694	254	339	85	5 to 10	339	72
73	Fully Depreciated Assets	252,621					252,621	73
74								74
75	TOTALS	\$ 352,888	\$ 11,763	\$ 13,181	\$ 1,418		\$ 319,718	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Home Office Vehicle	2002 Ford F150 P/U	2002	\$ 3,621	\$	\$ 604	\$ 604	4	\$ 604	76
77	Facility Business	1994 Chevy Van	1995	13,590				4	13,590	77
78										78
79										79
80	TOTALS			\$ 17,211	\$	\$ 604	\$ 604		\$ 14,194	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,303,935	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 30,632	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,410	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 65,778	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,658,034	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /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: \$ 539 Description: Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section Not Applicable</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	7,312	\$ 144,047	\$	7,312	\$ 144,047	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,456	41,145		1,456	41,145	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		8,380	165,398		8,380	165,398	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts				71,286		71,286	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab & X-Ray	39,3					1,367		1,367	13
14	TOTAL			\$	17,148	\$ 350,590	\$ 72,653	17,148	\$ 423,243	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center # 0028787 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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 113,484	\$	1
2	Cash-Patient Deposits	5,088		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,083)	661,183		3
4	Supply Inventory (priced at cost)	4,742		4
5	Short-Term Investments	221,287		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Related Party - Note Rec.</u>	41,306		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,047,090	\$	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	230,512		15
16	Equipment, at Historical Cost	341,925		16
17	Accumulated Depreciation (book methods)	(404,963)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,165		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(12,165)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 167,474	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,214,564	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 177,165	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,088		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,983		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,292		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Related Parties</u>	7,281		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 314,809	\$	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)	\$ 314,809	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 899,755	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,214,564	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,113,667	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,113,667	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	421,738	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	(630,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>Prior Year Book Depreciation Adj.</u>	2,292	15
16	Other (describe) <u>Prior Year IL Replacement Tax Adj.</u>	(7,942)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (213,912)	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)	\$ 899,755	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/2002

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	\$ 3,140,636	1
2	Discounts and Allowances for all Levels	187,851	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,328,487	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	501,695	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 501,695	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	2,465	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,465	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,575	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,575	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	4,239	28
28a	<u>Diaper Charges</u>	1,752	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,991	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,845,213	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	592,620	31
32	Health Care	1,718,533	32
33	General Administration	677,043	33
B. Capital Expense			
34	Ownership	308,971	34
C. Ancillary Expense			
35	Special Cost Centers	72,653	35
36	Provider Participation Fee	53,655	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,423,475	40
41	Income before Income Taxes (line 30 minus line 40)**	421,738	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 421,738	43

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

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

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

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

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/2002

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	1,975	2,182	\$ 46,925	\$ 21.51	1
2	Assistant Director of Nursing	1,272	1,294	26,876	20.77	2
3	Registered Nurses	7,509	7,783	125,235	16.09	3
4	Licensed Practical Nurses	21,181	22,286	296,190	13.29	4
5	Nurse Aides & Orderlies	69,774	71,531	689,287	9.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,866	3,210	23,363	7.28	10
11	Social Service Workers	3,555	3,758	33,228	8.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,392	17,239	121,390	7.04	15
16	Dishwashers					16
17	Maintenance Workers	3,907	4,273	59,040	13.82	17
18	Housekeepers	8,932	9,427	67,759	7.19	18
19	Laundry	7,033	7,297	45,777	6.27	19
20	Administrator	2,141	2,121	63,153	29.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,313	4,773	53,034	11.11	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)	150,850	157,174	\$ 1,651,257 *	\$ 10.51	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	185	\$ 7,925	1,3	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	16	933	10,3	37
38	Nurse Consultant	Contract	17,911	10,5	38
39	Pharmacist Consultant	Contract	1,190	10,3	39
40	Physical Therapy Consultant	101	5,030	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	190	11,209	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	492	\$ 53,798		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 320	10,3	50
51	Licensed Practical Nurses	1,052	31,855	10,3	51
52	Nurse Aides	105	1,894	10,3	52
53	TOTAL (lines 50 - 52)	1,165	\$ 34,069		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Wallpapering	2/2002	\$ 1,878	3 YRS	\$	\$	\$	\$ 522	\$ 626	\$ 626	\$ 104	\$
2												
3												
4												
5												
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16												
17												
18												
19												
20	TOTALS		\$ 1,878		\$	\$	\$	\$ 522	\$ 626	\$ 626	\$ 104	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assoc. \$2,394
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,258 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 53,655
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 434
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 49%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

TAYLORVILLE CARE CENTER
RECLASSIFICATIONS
12/31/02

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	1,061
CLERICAL & GENERAL OFFICE EXPENSES	21	50
EMPLOYEE BENEFITS & PAYROLL TAXES	22	700
ADMINISTRATIVE	17	(1,811)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
BACKGROUND CHECKS	\$516	
SUBSCRIPTIONS	345	
IDPH LICENSE	200	
TAXES	50	
EMPLOYEE CHRISTMAS	<u>700</u>	
TOTAL	1811	
NURSING AND MEDICAL RECORDS	10	17,911
INSERVICE TRAINING AND EDUCATION TO RECLASS NURSE IOC CONSULTING	23	(17,911)

KING-TAYLORVILLE D/B/A TAYLORVILLE CARE CENTER
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII, LINE 27
12/31/02

OTHER REVENUE:

SODA INCOME	\$2,479
FOOD REFUND	48
VENDING INCOME	1,504
MISCELLANEOUS	102
RESIDENT A/R ENTRIES	(353)
MEDICARE INTEREST	25
MEALS	434
	<hr/>
	<u>4,239</u>