

		FOR OHF USE					

LL1

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.

I. IDPH Facility ID Number: 0020404

Facility Name: WILLIAM L DAWSON NURSING HOME

Address: 3500 S GILES CHICAGO 60653
 Number City Zip Code

County: COOK

Telephone Number: (312) 326-2000 Fax # (312) 326-5270

IDPA ID Number: 36-2477301

Date of Initial License for Current Owners: 1975

Type of Ownership:

<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 _____	

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>PAMELA ORR</u>	
	(Title) <u>ADMINISTRATOR</u>	
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____
	(Print Name and Title) <u>BOB KAGDA</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>	

MAIL TO: OFFICE OF HEALTH FINANCE
 ILLINOIS DEPARTMENT OF PUBLIC AID
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404 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	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	334		2,173	2,507	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	62,337	3,527	136	66,000	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,671	3,527	2,309	68,507	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.61%

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

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

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

NONE

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

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

YES NO

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

YES NO

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

Date started / / 1975

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

YES Date NO

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

YES NO If YES, enter number of beds certified 31 and days of care provided 2,173

Medicare Intermediary MUTUAL OF OMAHA

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 WILLIAM L DAWSON NURSING HOME # 0020404 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	387,004	70,674	27,302	484,980		484,980		484,980		1
2	Food Purchase		488,308		488,308	(84,972)	403,336	(4,589)	398,747		2
3	Housekeeping	115,275	60,986		176,261		176,261		176,261		3
4	Laundry	143,541	49,351	12,575	205,467		205,467		205,467		4
5	Heat and Other Utilities			176,204	176,204		176,204		176,204		5
6	Maintenance	216,202	30,239	133,828	380,269		380,269		380,269		6
7	Other (specify):*			51,276	51,276		51,276		51,276		7
8	TOTAL General Services	862,022	699,558	401,185	1,962,765	(84,972)	1,877,793	(4,589)	1,873,204		8
	B. Health Care and Programs										
9	Medical Director			4,400	4,400		4,400		4,400		9
10	Nursing and Medical Records	2,772,626	200,484	16,375	2,989,485		2,989,485		2,989,485		10
10a	Therapy	99,941	2,423	7,005	109,369		109,369		109,369		10a
11	Activities	183,004	19,448		202,452		202,452		202,452		11
12	Social Services	108,386		630	109,016		109,016		109,016		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,163,957	222,355	28,410	3,414,722		3,414,722		3,414,722		16
	C. General Administration										
17	Administrative	346,798			346,798		346,798	(49,247)	297,551		17
18	Directors Fees										18
19	Professional Services			110,519	110,519		110,519	(17,448)	93,071		19
20	Dues, Fees, Subscriptions & Promotions			50,809	50,809		50,809	(29,783)	21,026		20
21	Clerical & General Office Expenses	266,004	48,345	71,910	386,259		386,259	(8,988)	377,271		21
22	Employee Benefits & Payroll Taxes			922,906	922,906	84,972	1,007,878	(2,640)	1,005,238		22
23	Inservice Training & Education			5,115	5,115		5,115		5,115		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,366	1,366		1,366		1,366		25
26	Insurance-Prop.Liab.Malpractice			210,855	210,855		210,855		210,855		26
27	Other (specify):*			120,000	120,000		120,000	(120,000)			27
28	TOTAL General Administration	612,802	48,345	1,493,480	2,154,627	84,972	2,239,599	(228,106)	2,011,493		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,638,781	970,258	1,923,075	7,532,114		7,532,114	(232,695)	7,299,419		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			153,232	153,232		153,232	52,225	205,457			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			146,698	146,698		146,698	(153)	146,545			32
33	Real Estate Taxes			307,774	307,774		307,774		307,774			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			37,246	37,246		37,246		37,246			35
36	Other (specify):* MIP INSURANCE			9,151	9,151		9,151		9,151			36
37	TOTAL Ownership			654,101	654,101		654,101	52,072	706,173			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,141	160,376	241,517		241,517		241,517			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,137	134,137		134,137		134,137			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		81,141	294,513	375,654		375,654		375,654			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,638,781	1,051,399	2,871,689	8,561,869		8,561,869	(180,623)	8,381,246			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 WILLIAM L DAWSON NURSING HOME

0020404

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	52,225	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,589)	2		13
14	Non-Care Related Interest	(153)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(400)	20		17
18	Fines and Penalties	(8,988)	21		18
19	Entertainment				19
20	Contributions	(11,063)	20		20
21	Owner or Key-Man Insurance	(2,640)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,000)	27		24
25	Fund Raising, Advertising and Promotional	(10,470)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,850)	20		28
29	Other-Attach Schedule <u>SEE PG 5A</u>	(66,695)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (180,623)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (180,623)		37

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

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

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

STATE OF ILLINOIS
 WILLIAM L DAWSON NURSING HOME

ID# 0020404
 Report Period Beginning: 01/01/2002
 Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	MARKETING SALARIES	\$ (49,247)	17	1
2	MARKETING CONSULTANT-REMPSON	(11,656)	19	2
3	MARKETING CONSULTANT-JASCULCA	(5,792)	19	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	(66,695)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404

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	(4,589)	0	0	0	0	0	0	0	0	0	0	(4,589)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,589)	0	0	0	0	0	0	0	0	0	0	(4,589)	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	(49,247)	0	0	0	0	0	0	0	0	0	0	(49,247)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,448)	0	0	0	0	0	0	0	0	0	0	(17,448)	19
20	Fees, Subscriptions & Promotions	(29,783)	0	0	0	0	0	0	0	0	0	0	(29,783)	20
21	Clerical & General Office Expenses	(8,988)	0	0	0	0	0	0	0	0	0	0	(8,988)	21
22	Employee Benefits & Payroll Taxes	(2,640)	0	0	0	0	0	0	0	0	0	0	(2,640)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(120,000)	0	0	0	0	0	0	0	0	0	0	(120,000)	27
28	TOTAL General Administration	(228,106)	0	0	0	0	0	0	0	0	0	0	(228,106)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(232,695)	0	0	0	0	0	0	0	0	0	0	(232,695)	29

STATE OF ILLINOIS

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

Report Period Beginning:

01/01/2002 Ending:

Summary B

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	52,225	0	0	0	0	0	0	0	0	0	0	52,225 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(153)	0	0	0	0	0	0	0	0	0	0	(153) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	52,072	0	0	0	0	0	0	0	0	0	0	52,072 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)	(180,623)	0	0	0	0	0	0	0	0	0	0	(180,623) 45

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404

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

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

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

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

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2002 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	PAMELA ORR	ADMINISTRATOR	ADMIN	100%	NONE	40	100.00	SALARY	\$ 148,018	17-1	1
2	MARJORIE MARTIN	ASST ADMIN	ADMIN	BY	" "	40	100.00	" "	51,947	17-1	2
3	CHERYL MARTIN	CONTROLLER	ACCOUNTING	ATTRIBU-	" "	40	100.00	" "	128,258	21-1	3
4	ROBYN MARTIN	ASST ADMIN	ADM/EMPL REL	TION	" "	20	50.00	" "	49,247	17-1	4
5	" "	ASST ADMIN	MARKETING**	" "	" "	20	50.00	" "	49,247	17-1	5
6	SHERRIE MARTIN	MED RECORDS	MED RECORDS	" "	" "	40	100.00	" "	11,801	10-1	6
7											7
8											8
9			** DISALLOWED ON PAGE 5A LINE 1								9
10											10
11											11
12											12
13								TOTAL	\$ 438,518		13

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

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404

Report Period Beginning: 01/01/2002

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	U.S.G.I. INC/REILLY MTGE		X	MORTGAGE	\$17,746.00	10/31/75	\$ 2,622,700	\$ 1,797,837	10/31/16	7.7500	\$ 142,332	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	INSURANCE FINANCING		X	INSURANCE FINANCING							4,213	6						
7												7						
8												8						
9	TOTAL Facility Related				\$17,746.00		\$ 2,622,700	\$ 1,797,837			\$ 146,545	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES							153	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 153	14						
15	TOTALS (line 9+line14)						\$ 2,622,700	\$ 1,797,837			\$ 146,698	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 9,151 Line # 36

* 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 WILLIAM L DAWSON NURSING HOME# 0020404 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.	\$	295,410	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.)			\$	300,094	2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,684	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	303,090	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.			\$	307,774	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	310,347	8	
		1998	315,857	9	
		1999	314,872	10	
		2000	292,487	11	
		2001	300,094	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% 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 WILLIAM L DAWSON NURSING HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0020404

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax 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>17-34-310-002-0000</u>	<u>NURSING HOME</u>	\$ <u>3,347.10</u>	\$ <u>3,347.10</u>
2. <u>17-34-310-003-0000</u>	<u>NURSING HOME</u>	\$ <u>1,637.55</u>	\$ <u>1,637.55</u>
3. <u>17-34-310-004-0000</u>	<u>NURSING HOME</u>	\$ <u>1,579.17</u>	\$ <u>1,579.17</u>
4. <u>17-34-310-055-0000</u>	<u>NURSING HOME</u>	\$ <u>292,489.61</u>	\$ <u>292,489.61</u>
5. <u>17-34-310-056-0000</u>	<u>NURSING HOME</u>	\$ <u>260.14</u>	\$ <u>260.14</u>
6. <u>17-34-310-057-0000</u>	<u>NURSING HOME</u>	\$ <u>520.21</u>	\$ <u>520.21</u>
7. <u>17-34-310-058-0000</u>	<u>NURSING HOME</u>	\$ <u>260.14</u>	\$ <u>260.14</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>300,093.92</u>	\$ <u>300,093.92</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.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404 Report Period Beginning:

01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>39,156</u>	<u>1974</u>	<u>\$ 149,500</u>	1
2	<u>PARKING LOT</u>			<u>11,683</u>	2
3	TOTALS	<u>39,156</u>		<u>\$ 161,183</u>	3

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404

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	245		1975	1974	\$ 955,670	\$ 19,113	30	\$ 31,856	\$ 12,743	\$ 876,039	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	COMPONENTS		1975		1,228,016		30	40,934	40,934	1,119,019	9
10	ELEVATOR		1975		97,338		20			97,338	10
11	SPRINKLER		1977		9,699		20			9,699	11
12	FREEZER REPAIRS *		1984		33,981		20	1,589	1,589	31,591	12
13	LINEN CHUTES		1985		1,925		15			1,925	13
14	ROOF REPAIRS		1985		32,489	977	20	1,624	647	28,420	14
15	AIR LOUVERS		1986		2,156	114	20	108	(6)	1,782	15
16	BRaille PLATES		1986		2,150	113	15		(113)	2,150	16
17	REG. VALVE		1987		2,760	88	20	138	50	2,082	17
18	BUILDING IMPROVEMENTS		1988		2,257	118	20	113	(5)	1,641	18
19	BUILDING IMPROVEMENTS		1990		5,052	160	20	253	93	3,071	19
20	BUILDING IMPROVEMENTS		1990		2,416	77	15	161	84	1,986	20
21	BUILDING IMPROVEMENTS		1991		12,963		15	864	864	9,586	21
22	BUILDING IMPROVEMENTS		1992		24,808	788	20	1,240	452	12,591	22
23	BUILDING IMPROVEMENTS		1993		13,446	345	30	448	103	4,256	23
24	BUILDING IMPROVEMENTS		1994		6,469	165	39	166	1	1,452	24
25	PARKING LOT REPAIRS		1994		15,295	1,020	15	1,020		8,669	25
26	WALK-IN FREEZER REPAIRS		1995		2,510	64	39	64		600	26
27	PLUMBING REPAIRS		1995		21,850	560	39	560		4,130	27
28	DOORS/FASCIA		1995		3,872	99	39	99		731	28
29	CEILING TILE		1995		90,187	2,312	39	2,312		16,365	29
30	CONCRETE REPAIRS		1995		4,309	287	15	287		2,152	30
31	DRYWALL/COUNTER TOPS/CABINETS/TILE		1996		2,251	58	39	58		394	31
32	ELEVATOR REPAIR		1996		6,833	175	39	175		1,160	32
33	ELEVATOR DOOR REPAIRS		1998		4,517	116	39	116		565	33
34	FIRE SYSTEM UPGRADE		1998		3,193	82	39	82		345	34
35	CONCRETE REPAIRS		1998		19,117	490	39	490		2,062	35
36	ROOF REPAIRS		1998		21,150	542	39	542		2,191	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404

Report Period Beginning:

01/01/2002 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LAUNDRY ROOM/DAMPERS/PATIO REMODELLING	1999	\$ 30,264	\$ 776	39	\$ 776	\$	\$ 3,042	37
38	DOORS/LOCKS/ELEVATOR REPAIRS	1999	14,549	373	39	373		1,334	38
39	LAUNDRY RM/HEAT-COOL/CABINETS/LOCKS/AWNING	1999	26,503	680	39	680		2,329	39
40	PLUMBING REPAIRS/FIRE SAFETY UPGRADE/LOCKS	1999	56,650	1,453	39	1,453		4,716	40
41	EMERGENCY ELECTRICAL OUTLETS/FIRE DAMPERS	1999	51,364	1,317	39	1,317		4,107	41
42	ALARM SYSTEM UPGRADE	2000	130,975	3,358	39	3,358		7,721	42
43	PARKING LOT RAMP / STONE WALL	2000	24,335	624	39	624		1,652	43
44	DISINFECTION SYSTEM / BOILERS / ELECTRICAL	2000	47,713	1,223	39	1,223		2,675	44
45	ALARM SYSTEM UPGRADE	2001	57,107	1,464	39	1,464		2,733	45
46	PARKING LOT PAVING	2001	25,000	1,668	15	1,668		2,501	46
47	CARPET TILE INSTALLATION	2002	3,429	70	39	70		70	47
48	DOORS/DOOR REFINISHING	2002	149,707	2,253	39	2,253		2,253	48
49	SINK PARTS/FAUCETS	2002	8,482	27	39	27		27	49
50	ROOF REPLACEMENT	2002	38,000	122	39	122		122	50
51									51
52									52
53									53
54									54
55									55
56	*LINE 12 - ITEM FROM 1984 TOTTALLING \$33,981 RESULTS FROM A PRIOR AUDIT AND IS NOT REFLECTED ON THE BALANCE SHEET.								
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,292,757	\$ 43,271		\$ 100,707	\$ 57,436	\$ 2,279,274	70

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

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 Report Period Beginning: 01/01/2002 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	\$ 915,236	\$ 84,928	\$ 74,522	\$ (10,406)	3-20 YRS	\$ 473,012	71
72	Current Year Purchases	100,339	16,583	5,742	(10,841)	3-15 YRS	5,742	72
73	Fully Depreciated Assets	41,589					41,589	73
74								74
75	TOTALS	\$ 1,057,164	\$ 101,511	\$ 80,264	\$ (21,247)		\$ 520,343	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY VAN	SPORTVAN '86	1985	\$	\$	\$	\$	4 YRS	\$ 19,262	76
77	ADMIN/ETC	JAGUAR '99	1998		1,775	7,869	6,094	4 YRS	62,966	77
78	" "	MERCEDES '99	1998		1,775	6,650	4,875	4 YRS	53,210	78
79	" "	SAAB '01	2001		4,900	9,967	5,067	4 YRS	14,951	79
80	TOTALS			\$	\$ 8,450	\$ 24,486	\$ 16,036		\$ 150,389	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,511,104	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 153,232	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 205,457	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 52,225	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,950,006	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

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: \$ 30,303 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

* 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.

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMIN,ETC	MERCEDES	\$ 864.13	\$ 10,370	17
18					18
19			LESS REIMBURSED:	(3,427)	19
20					20
21	TOTAL		\$ 864.13	\$ 6,943	21

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME # 0020404 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 81,880	\$		\$ 81,880	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			41,720			41,720	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			36,776			36,776	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				76,220		76,220	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 / RADIOLOGY	39-2					4,921		4,921	13
14	TOTAL			\$		\$ 160,376	\$ 81,141		\$ 241,517	14

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

Facility Name & ID Number **WILLIAM L DAWSON NURSING HOME**# **0020404**Report Period Beginning: **01/01/2002**

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	\$ 279,505	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 685,000)	1,689,197		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	772,000		5
6	Prepaid Insurance	156,400		6
7	Other Prepaid Expenses	87,137		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>INSUR/R.E. TAX ESCROW</u>	142,384		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,126,623	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	161,183		13
14	Buildings, at Historical Cost	2,290,723		14
15	Leasehold Improvements, at Historical Cost	968,055		15
16	Equipment, at Historical Cost	1,233,886		16
17	Accumulated Depreciation (book methods)	(2,903,549)		17
18	Deferred Charges	21,183		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	476,627		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,248,108	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,374,731	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 367,018	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	165,747		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,875		30
31	Accrued Taxes Payable (excluding real estate taxes)	54,558		31
32	Accrued Real Estate Taxes(Sch.IX-B)	303,090		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,000		35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,141,288	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,797,837		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)	\$ 1,797,837	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,939,125	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,435,606	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,374,731	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,502,301	1
2	Restatements (describe):		2
3			3
4	ROUNDING	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,502,300	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(428,504)	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	(39,710)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) CAPITAL STOCK	100,000	15
16	Other (describe) RETAINED EARNINGS	301,520	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (66,694)	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)	\$ 2,435,606	24 *

* This must agree with page 17, line 47.

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

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,940,410	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,940,410	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	147,510	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 147,510	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***	49,870	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49,870	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	GAIN ON SALE OF CD'S	4,647	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,647	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,142,437	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,962,765	31
32	Health Care	3,414,722	32
33	General Administration	2,154,627	33
B. Capital Expense			
34	Ownership	654,101	34
C. Ancillary Expense			
35	Special Cost Centers	241,517	35
36	Provider Participation Fee	134,137	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	9,072	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,570,941	40
41	Income before Income Taxes (line 30 minus line 40)**	(428,504)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (428,504)	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 PREPARED ON CASH BASIS

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

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

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

0020404

Report Period Beginning:

01/01/2002

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	1,960	2,040	\$ 58,156	\$ 28.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,351	26,945	624,256	23.17	3
4	Licensed Practical Nurses	35,832	39,221	833,773	21.26	4
5	Nurse Aides & Orderlies	133,722	146,563	1,244,640	8.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,429	6,123	99,941	16.32	8
9	Activity Director					9
10	Activity Assistants	16,374	18,189	183,004	10.06	10
11	Social Service Workers	6,604	7,427	108,386	14.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,626	43,707	387,004	8.85	15
16	Dishwashers					16
17	Maintenance Workers	21,629	24,006	216,202	9.01	17
18	Housekeepers	13,425	15,032	115,275	7.67	18
19	Laundry	16,575	18,266	143,541	7.86	19
20	Administrator	1,973	2,073	148,018	71.40	20
21	Assistant Administrator	3,776	4,097	146,833	35.84	21
22	Other Administrative	2,061	2,085	51,947	24.91	22
23	Office Manager	1,921	1,981	128,258	64.74	23
24	Clerical	8,189	8,753	137,746	15.74	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	962	1,043	11,801	11.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	335,409	367,551	\$ 4,638,781 *	\$ 12.62	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	\$ 18,740	1-3	35
36	Medical Director	O	4,400	9-3	36
37	Medical Records Consultant	N	3,920	10-3	37
38	Nurse Consultant	T	12,313	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		7,005	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	630	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 47,008		49

C. CONTRACT NURSES

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

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

0020404

Report Period Beginning: **01/01/2002**

Ending: **12/31/2002**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
PAMELA ORR	ADMINISTRATOR	**	\$ 148,018	Workers' Compensation Insurance	\$ 87,615	IDPH License Fee	\$ 200	
MARJORIE MARTIN	ADMINISTRATIVE	**	51,947	Unemployment Compensation Insurance	44,593	Advertising: Employee Recruitment	4,323	
ALLEN SPIEF	ASST ADMIN	0.00%	48,339	FICA Taxes	346,262	Health Care Worker Background Check	884	
ROBYN MARTIN	ASST ADMIN	**	98,494	Employee Health Insurance	397,855	(Indicate # of checks performed <u>74</u>)		
				Employee Meals	84,972	MARKETING/ADV/PROMO	18,320	
	** BY ATTRIBUTION 100%			Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	11,463	
				EMPLOYEE BENEFITS - OTHER	13,505	LICENSES & PERMITS	2,161	
TOTAL (agree to Schedule V, line 17, col. 1)				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	13,458	
(List each licensed administrator separately.)			\$ 346,798	PENSION/PROFIT SHARING PLANS	19,732			
				CHICAGO HEAD TAX	10,704	TRUST/FRANCHISE/CONTRIB/ETC	(11,463)	
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE	2,640	Less: Public Relations Expense	(9,039)	
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21	(2,640)	Non-allowable advertising	(1,431)	
			\$ 0			Yellow page advertising	(7,850)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,005,238	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,026	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
			\$				In-State Travel	
SEE SCHEDULE ATTACHED			110,519				Seminar Expense	
							Entertainment Expense	()
				TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$
TOTAL (agree to Schedule V, line 19, column 3)			\$ 110,519					
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WILLIAM L DAWSON NURSING HOME

0020404

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. IL COUNCIL LONG TERM CARE \$10,212
- (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. \$ 5,210 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 134,137
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 84,972 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KRUPNICK BOKOR KAGDA & BROOKS The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. NOT YET COMPLETED
- (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	18,740
	REPAIRS & MAINTENANCE	8,562
		0
		27,302
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	12,575
		0
		12,575
5	HEAT & OTHER UTILITIES	
	GAS HEAT	77,269
	ELECTRICITY	73,463
	WATER	23,909
	CABLE TV - LOBBY	1,563
		0
		176,204
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	850
	BUILDING REPAIRS	9,555
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	60,341
	ELEVATOR MAINTENANCE & REPAIR	10,197
	OUTSIDE LABOR	9,675
	EXTERMINATING SERVICE	10,714
	FIRE SERVICE	10,744
	AMORT - DEFERRED DECORATING	21,752
		0
		0
		133,828
7	OTHER	
	SCAVENGER	14,861
	SECURITY SERVICE	36,415
		51,276
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,400
		4,400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	142
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	3,920
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	12,313
		0
		0
		16,375
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	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	7,005
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		7,005
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	630
		0
		630
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	7,968
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	102,551
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	110,519
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,431
	EMPLOYEE WANT ADS XIX F	4,323
	CONTRIBUTIONS VI 20 XIX F	3,825
	DUES & SUBSCRIPTIONS XIX F	13,458
	LICENSES & PERMITS XIX F	2,361
	PUBLIC RELATIONS-PATIENT RELATED XIX F	9,039
	ADVERTISING-YELLOW PAGES VI 28 XIX F	7,850
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	400
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	7,238
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	884
21	CLERICAL & GENERAL OFFICE EXPENSES	50,809
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	989
	EQUIPMENT REPAIR & MAINTENANCE	21,018
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	8,988
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	110
	TELEPHONE	39,664
	MESSENGER SERVICE	1,141
		0
		71,910

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	346,262
	UNEMPLOYMENT COMPENSATION XIX D	44,593
	WORKERS COMPENSATION INSURANC XIX D	87,615
	HOSPITALIZATION INSURANCE XIX D	397,855
	EMPLOYEE BENEFITS - OTHER XIX D	13,505
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	2,640
	PENSION/PROFIT SHARING PLANS XIX D	19,732
	CHICAGO HEAD TAX XIX D	10,704
		922,906
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	5,115
		5,115
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,366
		1,366
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	210,855
		210,855
27	OTHER	
	BAD DEBTS VI 24	120,000
		0
		120,000

GRAND TOTAL COLUMN 3 OTHER

1,923,075

WILLIAM L DAWSON NURSING HOME
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2002

TOTAL FOOD PURCHASE	488,308	PATIENT MEALS	205521
LESS SALES TAX	(4,589)	ADD EMPLOYEE MEALS	43800
	-----		-----
NET FOOD	483,719	TOTAL MEALS/YEAR	249321
TOTAL PATIENT CENSUS	68,507	NET FOOD	483719
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	249321

TOTAL PATIENT MEALS	205521	COST PER MEAL	1.94
		TIME EMPLOYEE MEALS	43800
ADD # EMPLOYEE MEALS/DAY	120		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	84972
	-----		=====
TOTAL EMPLOYEE MEALS	43800		

WILLIAM L DAWSON NURSING HOME
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S									7,827,084	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	3,414,722	922,906	784,010	205,467	973,288	1,231,721	134,137	654,101		4,638,781
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	13,045		3,910			11,919		(28,874)		
CABLE TV			(1,563)			1,563				
CONTRACT NURSING										
INTEREST INCOME							(49,870)			
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		(2,640)				2,640				
MANAGEMENT FEES						0		0		
O2 INCOME										
BAD DEBTS						(120,000)	120,000			
DISCOUNTS LOST							0			
ANCILLARIES								0		
SETTLEMENT INTEREST										
RECLASSIFIED SALARIES	(98,435)	0	0	0	0	98,435	0	0		
PROFIT SHARING	0	(19,732)	0	0	0	0	19,732	0		
PRIOR EXPENSES	0	0	0	0	0	0	(10,247)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
GAIN ON SALE OF CD'S	0	0	0	0	0	0	(4,647)	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	3,329,332	900,534	786,357	205,467	973,288	1,226,278	209,105	625,227	8,255,588	4,638,781
PER FINANCIAL STATEMENTS	3,328,344	900,534	786,357	205,467	973,288	1,227,266	209,105	625,227	(428,504)	4,638,781
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									(428,504)	

WILLIAM L DAWSON NURSING HOME - COMPARISONS - 12/31/2002

ref.	12/31/2002			12/31/2001			DIFF	12/31/2000			
CAPACITY DAYS	89,425			89425			0	89670			
CENSUS DAYS	68,507			72879			(4,372)	72965			
OCCUPANCY %	76.61%			81.50%				81.37%			
SALARIES											
TOTAL General Services	8-1	862,022	10.29%	12.58	840873	10.28%	11.54	21,149	805411	10.68%	11.04
Social Services	12-1	108,386	1.29%	1.58	92408	1.13%	1.27	15,978	111955	1.48%	1.53
TOTAL Health Care and Programs	16-1	3,163,957	37.75%	46.18	3136317	38.34%	43.03	27,640	3169808	42.02%	43.44
Clerical & General Office Expenses	21-1	266,004	3.17%	3.88	259955	3.18%	3.57	6,049	190006	2.52%	2.60
TOTAL General Administration	28-1	612,802	7.31%	8.95	650832	7.96%	8.93	(38,030)	452296	6.00%	6.20
TOTAL Operation Expense	29-1	4,638,781	55.35%	67.71	4628022	56.57%	63.50	10,759	4427515	58.69%	60.68
ADJUSTED TOTALS											
Food	2-8	398,747	4.76%	5.82	394098	4.82%	5.41	4,649	353196	4.68%	4.84
Heat and Other Utilities	5-8	176,204	2.10%	2.57	284062	3.47%	3.90	(107,858)	189923	2.52%	2.60
Maintenance	6-8	380,269	4.54%	5.55	359419	4.39%	4.93	20,850	334429	4.43%	4.58
TOTAL General Services	8-8	1,873,204	22.35%	27.34	1962976	23.99%	26.93	(89,772)	1722007	22.83%	23.60
Administrative	17-8	297,551	3.55%	4.34	337278	4.12%	4.63	(39,727)	231426	3.07%	3.17
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	93,071	1.11%	1.36	79382	0.97%	1.09	13,689	79309	1.05%	1.09
Fees, Subscriptions, Promotions	20-8	21,026	0.25%	0.31	25007	0.31%	0.34	(3,981)	21999	0.29%	0.30
License Fee-IDPA	Pg21	200	0.00%	0.00	0	0.00%	0.00	200	0	0.00%	0.00
License Fee-Other	Pg21	2,161	0.03%	0.03	6719	0.08%	0.09	(4,558)	4564	0.06%	0.06
Clerical & General Office Expenses	21-8	377,271	4.50%	5.51	371723	4.54%	5.10	5,548	281950	3.74%	3.86
Employee Benefits & Payroll Taxes	22-8	1,005,238	11.99%	14.67	886107	10.83%	12.16	119,131	895311	11.87%	12.27
Payroll Taxes	Pg21	390,855	4.66%	5.71	399213	4.88%	5.48	(8,358)	416488	5.52%	5.71
W/C Insurance	Pg21	87,615	1.05%	1.28	60372	0.74%	0.83	27,243	65616	0.87%	0.90
Health Insurance	Pg21	397,855	4.75%	5.81	264757	3.24%	3.63	133,098	257915	3.42%	3.53
Inservice Training & Education	23-8	5,115	0.06%	0.07	1557	0.02%	0.02	3,558	4629	0.06%	0.06
Travel and Seminar	24-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Other Admin. Staff Transportation	25-8	1,366	0.02%	0.02	1086	0.01%	0.01	280	1667	0.02%	0.02
Insurance-Prop.Liab.Malpractice	26-8	210,855	2.52%	3.08	136167	1.66%	1.87	74,688	50654	0.67%	0.69
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
TOTAL General Administration	28-8	2,011,493	24.00%	29.36	1838307	22.47%	25.22	173,186	1566945	20.77%	21.48
TOTAL Operation Expense	29-8	7,299,419	87.09%	106.55	7265467	88.81%	99.69	33,952	6736736	89.30%	92.33
Real Estate Taxes	33-3	307,774	3.67%	4.49	268717	3.28%	3.69	39,057	315032	4.18%	4.32
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	8,381,246	100.00%	122.34	8180834	100.00%	112.25	200,412	7543901	100.00%	103.39
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		3199057.9	38.17%	46.70	3200786.2	39.13%	43.92	(1,728)	2647968.5	35.10%	36.29

WILLIAM L DAWSON NURSING HOME - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

#VALUE!

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest expense on Page 4 Line 32-4 = Page 9 Line 15-10.

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.

Depreciation expense on Page 4 line 30-4 = Page 13 Line 82-2.

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 = Page 14 Line 7-4.

Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 DOES NOT EQUAL Page 21-B.

Professional fees on Page 3 Line 19-3 = Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 DO NOT EQUAL Page 21-G.

NO DEFERRED MAINT

NO MGMT FEES

NO TRAVEL EXP