

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	300	Skilled (SNF)	300	109,800	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	300	TOTALS	300	109,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF	45,598	4,986	7,958	58,542	8
9	SNF/PED					9
10	ICF	16,681	0	130	16,811	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,279	4,986	8,088	75,353	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.63%

D. How many bed-hold days during this year were paid by Public Aid? NONE (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 01/01/72

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 36 and days of care provided 7,320

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 01/01/00 Fiscal Year: 12/31/00

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	334,016	55,728		389,744	161	389,905		389,905		1
2	Food Purchase		570,368		570,368	(44,358)	526,010	(98,077)	427,933		2
3	Housekeeping	42,111	40,091	206,500	288,702	1,544	290,246	9,165	299,411		3
4	Laundry	86,048	38,301		124,349	128	124,477		124,477		4
5	Heat and Other Utilities			262,174	262,174		262,174		262,174		5
6	Maintenance	103,095		293,531	396,626	2,779	399,405	42,038	441,443		6
7	Other (specify):*										7
8	TOTAL General Services	565,270	704,488	762,205	2,031,963	(39,746)	1,992,217	(46,874)	1,945,343		8
	B. Health Care and Programs										
9	Medical Director			48,000	48,000		48,000		48,000		9
10	Nursing and Medical Records	1,988,836	329,607	7,432	2,325,875	5,062	2,330,937	(1,155)	2,329,782		10
10a	Therapy	86,286			86,286		86,286		86,286		10a
11	Activities	93,093	9,674	2,472	105,239		105,239		105,239		11
12	Social Services	33,139		824	33,963		33,963		33,963		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,201,354	339,281	58,728	2,599,363	5,062	2,604,425	(1,155)	2,603,270		16
	C. General Administration										
17	Administrative	97,911			97,911		97,911		97,911		17
18	Directors Fees										18
19	Professional Services			1,032,963	1,032,963		1,032,963	(961,584)	71,379		19
20	Dues, Fees, Subscriptions & Promotions			31,854	31,854	(2,678)	29,176	(16,646)	12,530		20
21	Clerical & General Office Expenses	640,784	32,930	51,528	725,242	59	725,301	122,586	847,887		21
22	Employee Benefits & Payroll Taxes			639,312	639,312	37,303	676,615	74,401	751,016		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,852	3,852		3,852	19,987	23,839		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			500	500		500	68,201	68,701		26
27	Other (specify):*			18,000	18,000		18,000	(18,000)			27
28	TOTAL General Administration	738,695	32,930	1,778,009	2,549,634	34,684	2,584,318	(711,055)	1,873,263		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,505,319	1,076,699	2,598,942	7,180,960		7,180,960	(759,084)	6,421,876		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	
30	D. Ownership											
	Depreciation			132,643	132,643		132,643	478,212	610,855			30
31	Amortization of Pre-Op. & Org.							10,022	10,022			31
32	Interest			121,923	121,923		121,923	996,190	1,118,113			32
33	Real Estate Taxes							396,896	396,896			33
34	Rent-Facility & Grounds			1,397,201	1,397,201		1,397,201	(1,397,201)				34
35	Rent-Equipment & Vehicles			12,041	12,041		12,041	27,201	39,242			35
36	Other (specify):* mortg. Insur.							58,631	58,631			36
37	TOTAL Ownership			1,663,808	1,663,808		1,663,808	569,951	2,233,759			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,758,055	858,465	2,369,358	4,985,878		4,985,878	(1,276,639)	3,709,239			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,700	164,700		164,700		164,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	1,758,055	858,465	2,534,058	5,150,578		5,150,578	(1,276,639)	3,873,939			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,263,374	1,935,164	6,796,808	13,995,346		13,995,346	(1,465,771)	12,529,575			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 ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning: 01/01/00

Ending: 12/31/00

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	87,491	30		9
10	Interest and Other Investment Income	(34)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(710)	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	(1,874)	32		18
19	Entertainment				19
20	Contributions	(3,650)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)	27		24
25	Fund Raising, Advertising and Promotional	(13,301)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(861)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 49,061		\$	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)	(565,593)	various	34
35	Other- Attach Schedule see pg 5a	(949,239)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,514,832)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,465,771)		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			X			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

STATE OF ILLINOIS
ALDEN LAKELAND REHAB & HCC

Page 5A

ID# 0017319

Report Period Beginning: 01/01/00

Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	back out non-cost: gl5026 hmo nurs supplies	(70,337)	39 1
2	back out non-cost: gl5080 hmo oxygen supplies	(63,430)	39 2
3	back out non-cost: gl5040 hmo therapy c/a	(695,315)	39 3
4	back out non-cost in 5212.3.&4(occ.ther part b)	(22,707)	39 4
5	back out hmo drug c/a(non-cost) gl 5046	(96,617)	39 5
6	record deferred maint. Exp. On '99 painting	4,206	6 6
7	back out deferred maint. Exp. On '00 painting	(7,132)	6 7
8	record deferred maint. Exp. On '00 painting	1,189	6 8
9	record deferred maint. Exp. On '98 painting	31,588	6 9
10	Uptown Chamber of Commerce(non-allow. Costs)	(600)	20 10
11	add back prior year exp aj in gl 5724 credit	411	20 11
12	add back prior year exp aj in gl 5721 ECIN credit	585	20 12
13	add back prior year exp aj in gl 5725(social work.)	750	24 13
14	deduct pac. fees in gl 5725	(606)	24 14
15	back out related party commun.relations salaries	(31,224)	21 15
16			16
17			17
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89			89
90	Total	(949,239)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319 Report Period Beginning:

01/01/00

Ending:

12/31/00

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)	
1	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(710)	0	0	(97,367)	0	0	0	0	0	0	0	(98,077)	2
3	Housekeeping	0	0	0	0	0	9,165	0	0	0	0	0	9,165	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	29,851	0	12,187	0	0	0	0	0	0	0	0	42,038	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	29,141	0	12,187	(97,367)	0	9,165	0	0	0	0	0	(46,874)	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	(1,155)	0	0	0	0	0	0	(1,155)	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	(1,155)	0	0	0	0	0	0	(1,155)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(961,599)	0	0	0	0	15	0	0	0	(961,584)	19
20	Fees, Subscriptions & Promotions	(17,416)	0	770	0	0	0	0	0	0	0	0	(16,646)	20
21	Clerical & General Office Expenses	(31,224)	14,077	51,503	66,192	22,038	0	0	0	0	0	0	122,586	21
22	Employee Benefits & Payroll Taxes	0	0	74,827	0	(426)	0	0	0	0	0	0	74,401	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	144	0	19,843	0	0	0	0	0	0	0	0	19,987	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	67,990	211	0	0	0	0	0	0	0	0	68,201	26
27	Other (specify):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	TOTAL General Administration	(66,496)	82,067	(814,445)	66,192	21,612	0	0	15	0	0	0	(711,055)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,355)	82,067	(802,258)	(31,175)	20,457	9,165	0	15	0	0	0	(759,084)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319

Report Period Beginning:

01/01/00 Ending:12/31/00

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)	
30	D. Ownership													
	Depreciation	87,491	375,406	15,315	0	0	0	0	0	0	0	0	478,212	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	10,022	0	0	0	0	10,022	31
32	Interest	(1,908)	974,556	6,955	0	0	0	16,587	0	0	0	0	996,190	32
33	Real Estate Taxes	0	388,295	8,601	0	0	0	0	0	0	0	0	396,896	33
34	Rent-Facility & Grounds	0	(1,397,201)	0	0	0	0	0	0	0	0	0	(1,397,201)	34
35	Rent-Equipment & Vehicles	0	0	27,201	0	0	0	0	0	0	0	0	27,201	35
36	Other (specify):*	0	58,631	0	0	0	0	0	0	0	0	0	58,631	36
37	TOTAL Ownership	85,583	399,687	58,072	0	0	0	26,609	0	0	0	0	569,951	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	(948,407)	0	0	(35,179)	(78,028)	0	(215,025)	0	0	0	0	(1,276,639)	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	(948,407)	0	0	(35,179)	(78,028)	0	(215,025)	0	0	0	0	(1,276,639)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(900,178)	481,754	(744,186)	(66,354)	(57,571)	9,165	(188,416)	15	0	0	0	(1,465,771)	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
SEE PAGE 6K...		SEE PAGE 6K...		SEE PAGE 6K...		

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	34 RENTAL INCOME	\$ 1,397,201	LAWRENCE AVE. BUILDING PARTNERSHIP	0.00%	\$	\$ (1,397,201)	1
2	V	32 INTEREST	7,556	LAWRENCE AVE. BUILDING PARTNERSHIP			(7,556)	2
3	V	21 G&A: ACCTG/BANK FEES		LAWRENCE AVE. BUILDING PARTNERSHIP		14,077	14,077	3
4	V	33 REAL ESTATE TAXES		LAWRENCE AVE. BUILDING PARTNERSHIP		388,295	388,295	4
5	V	30 DEPRECIATION		LAWRENCE AVE. BUILDING PARTNERSHIP		375,406	375,406	5
6	V	36 MORTG. INSUR.		LAWRENCE AVE. BUILDING PARTNERSHIP		58,631	58,631	6
7	V	26 GENERAL INSUR.		LAWRENCE AVE. BUILDING PARTNERSHIP		67,990	67,990	7
8	V	32 MORTGAGE INTEREST				982,112	982,112	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,404,757			\$ 1,886,511	\$ * 481,754	14

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item			Name of Related Organization							
15	V	6	<u>maintenance/utilities</u>	\$		<u>Alden Management Services, Inc.</u>	<u>100.00%</u>	\$	<u>12,187</u>	\$	<u>12,187</u>	15
16	V	19	<u>professional fees</u>		<u>978,300</u>	<u>Alden Management Services, Inc.</u>			<u>16,701</u>		<u>(961,599)</u>	16
17	V	20	<u>licenses/fees</u>			<u>Alden Management Services, Inc.</u>			<u>770</u>		<u>770</u>	17
18	V	21	<u>gen'l & admin</u>			<u>Alden Management Services, Inc.</u>			<u>51,503</u>		<u>51,503</u>	18
19	V	22	<u>employee costs</u>			<u>Alden Management Services, Inc.</u>			<u>74,827</u>		<u>74,827</u>	19
20	V	24	<u>auto/seminar</u>			<u>Alden Management Services, Inc.</u>			<u>19,843</u>		<u>19,843</u>	20
21	V	26	<u>insurance</u>			<u>Alden Management Services, Inc.</u>			<u>211</u>		<u>211</u>	21
22	V	30	<u>depreciation</u>			<u>Alden Management Services, Inc.</u>			<u>15,315</u>		<u>15,315</u>	22
23	V	32	<u>interest</u>			<u>Alden Management Services, Inc.</u>			<u>6,955</u>		<u>6,955</u>	23
24	V	33	<u>real estate tax</u>			<u>Alden Management Services, Inc.</u>			<u>8,601</u>		<u>8,601</u>	24
25	V	35	<u>auto lease</u>			<u>Alden Management Services, Inc.</u>			<u>27,201</u>		<u>27,201</u>	25
26	V											26
27	V											27
28	V											28
29	V											29
30	V											30
31	V											31
32	V											32
33	V											33
34	V											34
35	V											35
36	V											36
37	V											37
38	V											38
39	Total			\$	978,300			\$	234,114	\$ *	(744,186)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 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)		
15	V	2 tube feeding	\$ 173,486	Pyramid Healthcare Services, Inc.	0.00%	\$ 76,119	\$	(97,367)	15
16	V	39 nursing supplies	68,965	Pyramid Healthcare Services, Inc.		63,695		(5,270)	16
17	V	39 supplies/per diem fees/misc	83,080	Pyramid Healthcare Services, Inc.		53,171		(29,909)	17
18	V	21 gen'l & admin		Pyramid Healthcare Services, Inc.		66,192		66,192	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 325,531			\$ 259,177	\$ *	(66,354)	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V	39	drugs	\$ 218,916	Forum Extended Care II	0.00%	\$ 164,785	\$ (54,131)	15
16	V	10	house stock	4,672	Forum Extended Care II		3,517	(1,155)	16
17	V	39	iv	96,642	Forum Extended Care II		72,745	(23,897)	17
18	V	22	employee vaccinations	1,723	Forum Extended Care II		1,297	(426)	18
19	V	21	gen'l & admin.		Forum Extended Care II		22,038	22,038	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 321,953			\$ 264,382	\$ * (57,571)	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V	3	HOUSEKEEPING	\$ 206,763	TRIPOINT SERVICES	0.00%	\$ 215,928	\$ 9,165	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 206,763			\$ 215,928	\$ * 9,165	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 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)	
15	V	39 THERAPY	\$ 1,433,188	COMMUNITY PHYSICAL THERAPY	100.00%	\$ 1,218,163	\$ (215,025)	15
16	V	31 AMORTIZATION		COMMUNITY PHYSICAL THERAPY		10,022	10,022	16
17	V	32 INTEREST		COMMUNITY PHYSICAL THERAPY		16,587	16,587	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,433,188			\$ 1,244,772	\$ * (188,416)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 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)	
15	V	19 construction management fee	\$ 6,057	Alden Bennett Construction	0.00%	\$ 5,972	\$ (85)	15
16	V	19 designing/architect fee	2,864	Adlen Design Group		2,964	100	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 8,921			\$ 8,936	\$ *	15 39

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	Floyd Schlossberg	President-AMS	CEO	100.00	179,339	3.108	7.77	salary	\$ 15,106	21-1	1
2	Lauren Magnusson	Clinical Coordin.	nursing review	a.	68,703	3.108	7.77	salary	5,787	21-1	2
3	Terry Magnusson	Administrator/other	admin/mainten.	b.	71,237	3.108	7.77	salary	2,383	21-1	3
4	Audra Schlossberg-Elisco	Massage Therapist	massage therapy	c.	6,851	0	0.00	fee	0	10a-3	4
5											5
6											6
7											7
8											8
9											9
10	a. Lauren is the daughter of Floyd Schlossberg and worked as a clinical coordinator for Alden Management Services in 2000.										10
11	b. Terry is the son-in-law of Floyd Schlossberg.He was the administrator of Alden Valley Ridge for 7 months and in construction/misc. for 5 months in 2000.										11
12	c. Daughter of Floyd Schlossberg. Audra worked as a massage therapist for the year at various Alden facilities.										12
13								TOTAL	\$ 23,276		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 ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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	US DEPT OF HUD		X	MORTGAGE	VARIES	3/94	\$ 11,977,000	\$ 11,704,638	12/34	8.3800	\$ 982,112	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	CPT INTEREST	X		WORKING CAPITAL	NONE						16,587	6							
7	interest on lines of credit		x	operations	none						120,049	7							
8											6,955	8							
9	TOTAL Facility Related						\$ 11,977,000	\$ 11,704,638			\$ 1,125,703	9							
B. Non-Facility Related*																			
10	LAW.AVE INTEREST INCOM	X		income: offset income expense							(7,556)	10							
11	interest income-operations			gl 4301:offset interest exp							(34)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (7,590)	14							
15	TOTALS (line 9+line14)						\$ 11,977,000	\$ 11,704,638			\$ 1,118,113	15							

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

(See instructions.)

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

(See instructions.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories _____

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	300 BED FACILITY		1995	\$ 1,040,001	1
2					2
3	TOTALS			\$ 1,040,001	3

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/00

Ending:

12/31/00

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	300		1995	1978	\$ 8,882,363	\$ 221,780	40	\$ 222,059	\$ 279	\$ 1,449,639	4
5			1995		577		40	14	14	78	5
6			1995		245		40	6	6	33	6
7				1996	13,250	331	40	331		1,629	7
8											8
	Improvement Type**										
9		GENERAL REMODELING		1994	1,640,753	42,645	15	109,384	66,739	660,862	9
10		NEW AIR CONDITIONER		1994	185,718	4,827	15	12,381	7,554	68,759	10
11		OXYGEN AND SUCTION SYSTEM		1994	89,080	2,315	15	5,939	3,624	35,298	11
12		3RD FLOOR NURSES STATION		1994	14,234	370	15	949	579	5,364	12
13		REBUILD SHOWERS AND STALL		1994	47,131	1,225	15	3,142	1,917	18,020	13
14		PATIENT ROOM LIGHTING		1994	34,763	903	15	2,318	1,415	13,101	14
15		CARPETING		1994	20,688	537	10	1,379	842	11,790	15
16		NEW DOOR LOCK AND HARDWARE		1994	25,312	658	10	1,687	1,029	14,633	16
17		VARIOUS OTHER ITEMS		1994	85,896	2,234	10	5,726	3,492	32,360	17
18		DECORATING		1986	5,000		3			5,000	18
19		DOCORATING,PUMPS, ROOF REPAIR, COMPRESSOR REPAIR		1987	15,543		3-5			15,543	19
20		ELECTRICAL REPAIRS, CARPENTRY,PUMP REPAIR		1988	15,804		5			15,804	20
21		PUMP REPAIR		1989	2,510		5			2,510	21
22		REPAIR: PUMPS AND COMPRESSOR		1990	32,782	2,126	5-10	2,126		32,782	22
23		REPAIR: PUMPS, FANS, HEATER,ROOF		1991	16,753		5			16,753	23
24		REPAIR: BOILER,FANS, THERMOSTAT		1992	32,033	478	5-20	478		30,770	24
25		COLOR RENDERING,REPAIR: COOLING TOWER, ELECT TIMER,		1993	8,916	490	5-15	490		5,276	25
26		DRAPERIES AND CUBICLES; COMPRESSOR REPAIR		1994	45,438	1,541	5-20	1,541		36,120	26
27		REPAIR: ELEVATOR, LAUNDRY ROOM, PUMPS,A.C, INSULLATIO		1995	415,705	23,767	5-20	23,767		150,082	27
28		NEW ELECTRIC GENERATOR, NEW COOLING TOWER		1996	191,725	9,815	5-20	9,815		47,487	28
29		INSTALL NEW CIRCUITS		1997	2,176	435	5	435		1,705	29
30		CLEAN FAN COILS		1997	4,622	924	5	924		3,312	30
31		REPAIR LIGHTING CIRCUIT & BALLAST		1997	2,327	465	5	465		1,707	31
32		REBUILD COMPRESSOR		1997	4,268	854	5	854		2,988	32
33		REPAIR CALL LIGHTS		1997	2,350	470	5	470		1,567	33
34		ISTALL NEW SMOKE DETECTOR		1997	2,661	532	5	532		1,774	34
35		SPRAYED FIREPROOFING		1997	3,965	793	5	793		2,577	35
36		TOTAL (lines 4 thru 35)			\$ 11,844,588	\$ 320,516		\$ 408,007	\$ 87,491	\$ 2,685,322	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.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/00

Ending:

12/31/00

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Climate Service, Inc (replace fans)	1998		4,725	945	5	945		2,835	9
10		**Wigdahl(replaced outlets)	1998		2,300	230	10	230		671	10
11		Wigdahl(replaced outlets)	1998		334	33	10	33		97	11
12		Long Elevator(modify restrictors)	1998		2,200	110	20	110		312	12
13		Incorporation(kickplates & correr guards)	1998		2,309	462	5	462		1,308	13
14		Incorporation(kickplates & larone)	1998		4,547	909	5	909		2,501	14
15		Shine Rite Maintenance (strip and refinish 30 rooms)	1998		6,480	1,296	5	1,296		3,564	15
16		Star Contractors (install locks)	1998		5,581	558	10	558		1,581	16
17		Supreme Sheet Metal (Fire dampers)	1998		10,000	667	15	667		1,667	17
18		CSI (replace fan coil units)	1998		6,340	423	15	423		986	18
19		Atash Fire & Safety (install annunciator panel)	1998		5,890	393	15	393		1,014	19
20		CSI (rebuild compressor)	1998		7,056	470	15	470		1,098	20
21		Supreme Sheet Metal (install fire dampers)	1998		11,680	1,168	10	1,168		2,628	21
22		Alden Bennett Construction (plan of correction)	1998		2,222	222	10	222		481	22
23		Supreme Sheet Metal (install fire dampers)	1998		7,750	775	10	775		1,615	23
24		Supreme Sheet Metal (install fire dampers)	1999		9,475	948	10	948		1,895	24
25		Patton (repair generator)	1999		1,702	114	15	114		227	25
26		Alden Bennett Construction(general)	1999		11,471	1,147	10	1,147		1,625	26
27		Welding Supply(oxygen piping installed)	1999		13,176	659	20	659		824	27
28		ISS/Chicago Sound & Comm.(call system)	1999		28,500	1,900	15	1,900		2,217	28
29		Alden Bennett Construction(general)	1999		23,289	1,571	15	1,571		1,702	29
30		Alden Bennet Construction- oxygen tank	1999		9,475	474	20	474		474	30
31		Alden Bennett Construction(oxyg tank	1999		35,016	1,751	20	1,751		1,897	31
32		Supreme sheet metal-install fire dampers-delete duplicate	2000		(9,475)	(948)	10	(948)		(948)	32
33		Climate Service, Inc (repair boiler)	2000		4,892	204	20	204		204	33
34		A&B custom cable-install cable tv	2000		13,824	1,037	10	1,037		1,037	34
35		Fox Valley-install new fire safety pump	2000		4,423	166	20	166		166	35
36		TOTAL (lines 4 thru 35)			\$ 225,182	\$ 17,682		\$ 17,682	\$	\$ 33,677	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.

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Fox Valley-repair hvac pump	2000		1,969	74	20	74		74	9
10		System electric-circuit for sump pump	2000		2,361	79	20	79		79	10
11		System electric-emergency lighting	2000		5,190	202	15	202		202	11
12		System Electric-install circuits	2000		1,570	39	20	39		39	12
13		Fox Valley-install tank system	2000		1,755	35	25	35		35	13
14		GT Mechanical-repair boiler	2000		2,698	67	20	67		67	14
15		ABC-fireproofing	2000		2,503	42	20	42		42	15
16		ABC-seal & stripe parking lot	2000		977	16	10	16		16	16
17		Richard G. Radke-color rendering	1993		6,620		5			6,620	17
18		ABC-oxygen tank wiring	2000		9,475	1,842	3	1,842		1,842	18
19		ABC-oxygen tank wiring	2000		26,715	5,195	3	5,195		5,195	19
20		ABC-wallpapering	2000		3,543	197	3	197		197	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		TOTAL (lines 4 thru 35)			\$ 65,376	\$ 7,788		\$ 7,788	\$	\$ 14,408	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.

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	Related Party		1978	\$ 12,184	\$ 554	22	\$ 554	\$	\$ 11,565	4
5	Related Party		1978	5,953	271	32	271		4,767	5
6	(FORUM)									6
7										7
8										8
Improvement Type**										
9	Related Party - AMS:									9
10	Leasehold Improvement - Remodeling		1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling		1994	2,663	407	various	407		55,299	11
12										12
13	Related Party - Forum:									13
14	Leasehold Improvement - Remodeling		1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling		1980	113		10			113	15
16	Leasehold Improvement - Remodeling		1986	32		6			32	16
17	Leasehold Improvement - Remodeling		1990	51		5			51	17
18	Leasehold Improvement - Remodeling		1991	12		5			12	18
19	Leasehold Improvement - Remodeling		1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling		1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN		1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT		1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC		1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof		1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof		1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof		1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof		1999	1,373	92	15	92		198	27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)			\$ 58,177	\$ 3,514		\$ 3,514	\$	\$ 215,231	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.

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	
37	Purchased in Prior Years	\$ 2,055,878	\$ 164,327	\$ 164,327	\$	varies	\$ 1,284,355	37
38	Current Year Purchases	86,842	5,828	5,828		varies	5,828	38
39	Fully Depreciated Assets	136,487	1,214	1,214		varies	136,487	39
40								40
41	TOTALS	\$ 2,279,207	\$ 171,369	\$ 171,369	\$		\$ 1,426,670	41

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	
42	VARIOUS	VANS, ENGINES, BUSES	1998-2000	\$ 26,682	\$ 2,494	\$ 2,494	\$	3	\$ 3,030	42
43										43
44										44
45										45
46	TOTALS			\$ 26,682	\$ 2,494	\$ 2,494	\$		\$ 3,030	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 15,539,213	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 523,364	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 610,855	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 87,491	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 4,378,337	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* 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 ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/00

Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party-Lawrence Ave. Partnership

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:				\$ <u>related party- cost eliminated...</u>			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. _____ /2001 \$ _____

13. _____ /2002 \$ _____

14. _____ /2003 \$ _____

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: \$ 12,041

Description: copy machine rental

(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>related party-various</u>	<u>various</u>	\$ <u>2267</u>	\$ <u>27,201</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>27,201</u>	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.

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. SKILLED NURSING IS ALREADY ON SITE</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.

\$ N/A

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.)

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 314,843	\$		\$ 314,843	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			61,376			61,376	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			324,913			324,913	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PG 16A...	# of prescripts			100,158			100,158	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-1	95480	1,758,055				95,480	1,758,055	12
13	Other (specify):	SEE PG 16A...				1,149,894			1,149,894	13
14	TOTAL			\$ 1,758,055		\$ 1,951,184	\$	95,480	\$ 3,709,239	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.

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	\$ 206,633	\$ 212,337	1
2 Cash-Patient Deposits	1,500	1,500	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,879,160	3,879,160	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	57,412	197,162	6
7 Other Prepaid Expenses		14,640	7
8 Accounts Receivable (owners or related parties)	288	1,065,714	8
9 Other(specify): <u>escrows</u>		381,423	9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,144,993	\$ 5,751,936	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		1,040,001	13
14 Buildings, at Historical Cost		8,884,435	14
15 Leasehold Improvements, at Historical Cos	1,375,953	3,744,549	15
16 Equipment, at Historical Cost	798,476	2,209,686	16
17 Accumulated Depreciation (book methods)	(977,295)	(3,390,903)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,197,135	\$ 12,487,769	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,342,128	\$ 18,239,705	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 5,262,750	\$ 5,262,750	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	47,323	47,323	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	313,053	313,053	30
31 Accrued Taxes Payable (excluding real estate taxes)	108,133	108,133	31
32 Accrued Real Estate Taxes(Sch.IX-B)		391,000	32
33 Accrued Interest Payable		163,342	33
34 Deferred Compensation			34
35 Federal and State Income Taxes	(2,257,607)	(2,257,607)	35
Other Current Liabilities(specify):			
36 <u>third party</u>	7,704,825	7,704,825	36
37 <u>accrued expenses/due idpa/misc</u>	797,121	891,171	37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,975,597	\$ 12,623,989	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable		11,704,638	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,704,638	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,975,597	\$ 24,328,627	46
47 TOTAL EQUITY (page 18, line 24)	\$ (7,491,934)	\$ (6,947,387)	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,483,663	\$ 17,381,240	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,629,047)	1
2	Restatements (describe):		2
3	external auditors' adjustments made after 1999 cost report		3
4	was filed. The adjustments had no effect on reimbursable		4
5	costs: bad debt expense and medicare revenues were adjusted:	(193,601)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,822,648)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,669,287)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,669,287)	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)	\$ (7,491,934)	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	\$ 10,047,071	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,047,071	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	480,577	6
7	Oxygen	488,441	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 969,018	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	8	13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		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	693,220	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 693,228	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	34	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	adjust prior year accounts	65,622	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 65,622	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,774,973	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,031,963	31
32	Health Care	2,599,363	32
33	General Administration	1,998,548	33
B. Capital Expense			
34	Ownership	1,663,808	34
C. Ancillary Expense			
35	Special Cost Centers	4,985,878	35
36	Provider Participation Fee	164,700	36
D. Other Expenses (specify):			
37	Note: this will not balance to pages 3 & 4 due to related		37
38	party amounts being entered to pages 3 & 4.		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,444,260	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,669,287)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,669,287)	43

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

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

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

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

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	1,912	2,096	\$ 71,115	\$ 33.93	1
2	Assistant Director of Nursing	2,256	2,521	79,734	31.63	2
3	Registered Nurses	68,926	72,502	1,781,738	24.58	3
4	Licensed Practical Nurses	19,778	21,166	371,460	17.55	4
5	Nurse Aides & Orderlies	117,726	123,890	1,180,908	9.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,302	2,358	21,393	9.07	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,870	1,918	25,810	13.46	9
10	Activity Assistants	7,236	7,687	67,283	8.75	10
11	Social Service Workers	2,159	2,223	33,139	14.91	11
12	Dietician	1,960	2,080	34,016	16.35	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,334	37,940	300,000	7.91	15
16	Dishwashers					16
17	Maintenance Workers	1,751	1,889	43,696	23.13	17
18	Housekeepers	4,907	5,144	42,111	8.19	18
19	Laundry	10,562	11,326	86,048	7.60	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	6,417	6,673	132,182	19.81	22
23	Office Manager					23
24	Clerical	12,179	12,685	154,315	12.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,460	3,597	91,440	25.42	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,951	4,029	31,016	7.70	31
32	Other Health C: S.A.C./C.S.S.	3,336	3,520	105,485	29.97	32
33	Other(specify) SECURITY	4,431	4,610	59,399	12.88	33
34	TOTAL (lines 1 - 33)	313,453	329,854	\$ 4,712,288 *	\$ 14.29	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			35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	48	2,472	11-3 44
45	Social Service Consultant	16	824	12-3 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	64	\$ 3,296	49

C. CONTRACT NURSES

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

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	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	hvac/pipes/pumps/repairs	1/88	\$ 3,500	5	\$	\$	\$	\$	\$	\$	\$	\$
2	hvac/pipes/pumps/repairs	2/88	2,444	5								
3	hvac/pipes/pumps/repairs	3/88	2,385	5								
4	hvac/pipes/pumps/repairs	7/88	1,766	5								
5	hvac/pipes/pumps/repairs	10/88	3,200	5								
6	hvac/pipes/pumps/repairs	12/88	2,510	5								
7	boiler/hvac repair	6/89	5,114	5								
8	fan/pump/boiler repairs	10/90	4,240	5								
9	fan/pump/boiler repairs	11/90	3,482	5								
10	fan/pump/boiler repairs	12/90	2,233	5								
11	see page 22a	1991-1995	220,093	5-20	37,461	35,018	32,213	2,100	1,540	1,540	1,540	1,540
12	see page 22b	1996	41,372	3-20	9,649	9,648	5,956	2,976	1,566	696	696	696
13	see page 22c	1997	16,366	3	2,984	5,455	5,455	2,471	0			
14	see page 22d	1998	103,843	3	0	24,921	34,614	34,614	9,693	0		
15	see page 22e	1999	18,157	3			3,032	6,052	6,052	3,021	0	
16	painting>\$1,500 ytd 1999	7/99	12,619	3			2,103	4,206	4,206	2,103	0	
17	see page 22f	2000	13,803	3				2,166	4,601	4,601	2,436	0
18												
19												
20	TOTALS		\$ 457,127		\$ 50,094	\$ 75,042	\$ 83,373	\$ 54,585	\$ 27,658	\$ 11,961	\$ 4,672	\$ 2,236

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning: 01/01/00

Ending: 12/31/00

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. Health Care Ass., \$9864.
- (3) Did the nursing home make political contributions or payments to a political 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? 14
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,535 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES _____ NO x
- (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. \$ 164,700
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? n/a 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 benefit on Schedule V. \$ 44,358 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? n/a 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? n/a
d. Have vehicle usage logs been maintained? n/a
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
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? yes
Firm Name: Blackman Kallick Bartlestein-in progress 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.