

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0038893</u></p> <p>Facility Name: <u>Center Home for Hispanic Elderly</u></p> <p>Address: <u>1401 N. California</u> <u>Chicago</u> <u>60622</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>773-782-8700</u> Fax # <u>773-276-0465</u></p> <p>IDPA ID Number: <u>36-3527934001</u></p> <p>Date of Initial License for Current Owners: <u>02/18/82</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name <u>DAN MALONE</u> Telephone Number: <u>708-3614295</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501(c3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/99</u> to <u>06/30/2000</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name <u>Gilberto Torres</u>)</td> </tr> <tr> <td></td> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Daniel L. Malone</u></td> </tr> <tr> <td>(Firm Name & Address) <u>D.L.M. Financial Advisory Services</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>708-361-4295</u> Fax <u>708-448-3228</u></td> </tr> <tr> <td colspan="2"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name <u>Gilberto Torres</u>)		(Title) <u>Administrator</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Daniel L. Malone</u>	(Firm Name & Address) <u>D.L.M. Financial Advisory Services</u>		(Telephone) <u>708-361-4295</u> Fax <u>708-448-3228</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Center Home for Hispanic Elderly

0038893 Report Period Beginning: 07/01/99 Ending: 06/30/2000

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	91	Skilled (SNF)	91	33,306	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,228	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	149	TOTALS	149	54,534	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	9,603			9,603	8
9	SNF/PED					9
10	ICF	43,544	293		43,837	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,147	293		53,440	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 97.99%)

D. How many bed-hold days during this year were paid by Public Aid? 2,735 (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? No

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 02/18/82

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 _____ and days of care provided _____

Medicare Intermediary Not Applicable

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/99 Ending: 06/30/2000

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	276,568	81,618	13,672	371,858		371,858	0	371,858	1	
2	Food Purchase		263,184		263,184		263,184	0	263,184	2	
3	Housekeeping	55,152	1,667	982	57,801		57,801	0	57,801	3	
4	Laundry	82,226	20,925		103,151		103,151	0	103,151	4	
5	Heat and Other Utilities			147,998	147,998		147,998	0	147,998	5	
6	Maintenance	113,840		75,802	189,642		189,642	0	189,642	6	
7	Other (specify):*							0		7	
8	TOTAL General Services	527,786	367,394	238,454	1,133,634		1,133,634		1,133,634	8	
	B. Health Care and Programs										
9	Medical Director					2,751	2,751	0	2,751	9	
10	Nursing and Medical Records	1,583,836	210,041	248,964	2,042,841	(7,264)	2,035,577	0	2,035,577	10	
10a	Therapy	135,715			135,715		135,715	0	135,715	10a	
11	Activities	110,304	3,909		114,213		114,213	0	114,213	11	
12	Social Services	65,535			65,535		65,535	0	65,535	12	
13	Nurse Aide Training							0		13	
14	Program Transportation							0		14	
15	Other (specify):*							0		15	
16	TOTAL Health Care and Progra	1,895,390	213,950	248,964	2,358,304	(4,513)	2,353,791		2,353,791	16	
	C. General Administration										
17	Administrative	222,362		428,540	650,902		650,902	(428,540)	222,362	17	
18	Directors Fees							0		18	
19	Professional Services			54,251	54,251	4,513	58,764	0	58,764	19	
20	Dues, Fees, Subscriptions & Promotions			21,256	21,256		21,256	(437)	20,819	20	
21	Clerical & General Office Expense	197,990	22,055	118,201	338,246		338,246	(13,463)	324,783	21	
22	Employee Benefits & Payroll Taxes			469,437	469,437		469,437	0	469,437	22	
23	Inservice Training & Education			3,305	3,305		3,305	0	3,305	23	
24	Travel and Seminar			21,930	21,930		21,930	0	21,930	24	
25	Other Admin. Staff Transportation							0		25	
26	Insurance-Prop.Liab.Malpractice			32,197	32,197		32,197	0	32,197	26	
27	Other (specify):*							0		27	
28	TOTAL General Administration	420,352	22,055	1,149,117	1,591,524	4,513	1,596,037	(442,440)	1,153,597	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,843,528	603,399	1,636,535	5,083,462		5,083,462	(442,440)	4,641,022	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.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
D. Ownership											
30	Depreciation			117,794	117,794		117,794	(5,412)	112,382		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			39,482	39,482		39,482	0	39,482		32
33	Real Estate Taxes							0			33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles							0			35
36	Other (specify):*							0			36
37	TOTAL Ownership			157,276	157,276		157,276	(5,412)	151,864		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers							0			39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			86,112	86,112		86,112	0	86,112		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers			86,112	86,112		86,112		86,112		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,843,528	603,399	1,879,923	5,326,850	0	5,326,850	(447,852)	4,878,998		45

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

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning: 07/01/99

Ending: 6/30/2000

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	(5,412)	L30C7		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer:				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(437)	L20C7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>COMPENSATION FOR EARNFARE WORKERS</u>	(13,463)	L21 C3		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (19,312)		\$	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)	(428,540)	L17C3	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (428,540)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (447,852)		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

Print Preview

Detail Sheet 29 and 30 of Page 5 continuing in BSM. DO NOT DRAG AND DROP CELLS.

The amounts on column 1 will transfer to the Adj. Expenses column automatically.

STATE OF ILLINOIS
 Facility Name: Center Home for Speech Elderly Page 5A
 Report Period Beginning: 01/01/20
 Ending: 12/31/20

To Print the Other Adjustments you have entered:
 1. Highlight the other adjustments you have entered
 sitting at BSM and continue to your last entry.
 2. Press the printers highlighted on Form C.
 Print the Print Other Adjustments
 button.

NON-ALLOWABLE EXPENSES	Amount	Reference	LN	Adj. Expense
1 Day Care	0	0	Line 1	0
2 Other Care for Dependents	0	0	Line 2	0
3 Government Sponsored Special Programs	0	0	Line 3	0
4 Non-Patient Meals	0	0	Line 4	0
5 Long-term, TV & Radio in Resident Rooms	0	0	Line 5	0
6 Patient Facility Space	0	0	Line 6	0
7 Fuel or Supplies to Non-Patients	0	0	Line 7	0
8 Patient Facility Space	(5,812)	1,267	Line 8	0
9 Non-Resident Preparation	0	0	Line 9	0
10 Interest and Other Investment Income	0	0	Line 10	0
11 Dividends, Shareholders Returns & Refunds	0	0	Line 10a	0
12 Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13 Sales Tax	0	0	Line 11a	0
14 Non-Care Related Interest	0	0	Line 12	0
15 Non-Care Related Owner's Transactions	0	0	Line 13	0
16 Personal Expenses (Including Transportation)	0	0	Line 14	0
17 Non-Care Related Fees	0	0	Line 15	0
18 Home and Furniture	0	0	Line 16	0
19 Entertainment	0	0	Line 17	0
20 Contributions	0	0	Line 18	0
21 Owner or Non-Resident	0	0	Line 19	0
22 Special Legal Fees or Legal Expenses	0	0	Line 20	0
23 Mortgage Interest for Individuals	0	0	Line 21	0
24 Real Estate	0	0	Line 22	0
25 Bond Rating, Advertising and Promotional	(107)	1,267	Line 23	0
26 Interest & He Personal Property Replacement	0	0	Line 24	0
27 Owner Non-Training for Non-Employees	0	0	Line 25	0
28 Value-Added Advertising	0	0	Line 26	0
29 Non-Paid Vacation	0	0	Line 27	0
30 Discount Cards	0	0	Line 28	0
31 Amortization Expenses	0	0	Line 29	0
32			Line 30	
33			Line 31	
34			Line 32	
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336			Line 334	
337			Line 335	
338			Line 336	</

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Center Home for Hispanic Elderly

0038893 Report Period Beginning:

07/01/99

Ending: 06/30/2000

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

Print Summary
A

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	0	0	0	0	0	0	0	0	0	0	0	0 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	0	0	0	0	0	0	0	0	0	0	0	0 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 Program	0	0	0	0	0	0	0	0	0	0	0	0 16
C. General Administration													
17	Administrative	0	(428,540)	0	0	0	0	0	0	0	0	0	(428,540) 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0 19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0 20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28	TOTAL General Administration	0	(428,540)	0	0	0	0	0	0	0	0	0	(428,540) 28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	(428,540)	0	0	0	0	0	0	0	0	0	(428,540) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/99

Ending:

06/30/2000

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

Print Summary
B

	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	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	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	0	0	0	0	0	0	0	0	0	0	0	0 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 Cent	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	(428,540)	0	0	0	0	0	0	0	0	0	(428,540) 45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number: Country Home for Eligible Elders (Show Pg 6A thru 6) Report Period Beginning: 07/01/09 Facility: 00-00000 Page 6

VI. RELATED PARTIES (Show Pg 6A thru 6) (Show Pg 6B thru 6) (Hide Pg 6A thru 6)

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

OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				NON-PROFIT	CHI, AGY	NON-PROFIT
				PARTNER, CORP.	CHI, AGY	NON-PROFIT

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.

Schedule	Line	Item	Amount	Name of Related Organization	Percent of Related Organization	Operating Cost of Related Organization	Adjustment to Related Organization Costs	Difference
1	V	OTHER ADMINISTRATION	428,540	COUNTRY HOME FOR ELIGIBLE ELDERS	100%			428,540
2	V							
3	V							
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	V							
15	V							
16	V							
17	V							
18	V							
19	V							
20	V							
21	V							
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23	V							
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28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	V							
40	V							
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42	V							
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84	V							
85	V							
86	V							
87	V							
88	V							
89	V							
90	V							
91	V							
92	V							
93	V							
94	V							
95	V							
96	V							
97	V							
98	V							
99	V							
100	V							
Total			428,540					428,540

Sum 6
-428,540

- Print Preview
- Total must agree with the amount revealed on line 16 of Schedule V.
DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.
1. Enter the information on pages 5 and 5A.
 2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
 5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 2 3 4 5 6 7 9 10 10a 11 12 13 14 15 17 18 19 20 21 22 23 24 25 26 27 30 31 32 33 34 35 36 38 39 40 41 42 43

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.

Line	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	NOT APPLICABLE								\$ N/A	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 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 REI

** 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

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number Center Home for Hispanic Elderly

0038893 Report Period Beginning: 07/01/99

Ending: 5/30/2000

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 PADRES CORPORATION

Street Address _____

City / State / Zip Code CHICAGO, IL, 60622

Phone Number (773) 645-2300

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	AMERICAN NATIONAL BANK	X	BUILDING MORTGAGE	\$5,085.00		\$ 500,000	\$	07/06/05	9.500%	\$ 39,482	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related			\$5,085.00		\$ 500,000	\$			\$ 39,482	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 500,000	\$			\$ 39,482	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.)

Print Preview

Facility Name & ID Number: **Center Home for Hispanic Elderly**

0038893 Report Period Beginning: **07/01/99** Ending: **06/30/2000**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$		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.)	\$	Not Applicable	2
3. Under or (over) accrual (line 2 minus line 1).	\$	"" ""	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	"" ""	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 used previously to calculate a payment rate. 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 19 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	\$	"" ""	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	Not Applicable	8
	1996	"" "" ""	9
	1997	"" "" ""	10
	1998	"" "" ""	11
	1999	"" "" ""	12
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATIO \$	16

NOTES:

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

Print Preview

Facility Name & ID Number: Center Home for Hispanic Elderly

0038893 Report Period Beginning:

07/01/99 Ending: 06/30/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,149 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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).

Not 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	55,145	1981	\$ 45,000	1
2					2
3	TOTALS	55,145		\$ 45,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/99 Ending: 06/30/2000

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	149		1981		\$ 255,000	\$ 10,200	25	\$ 10,200	\$	\$ 188,700	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements		1982		2,251	90	25	90		1,665	9
10	Improvements		1983		205,573	8,223	25	8,223		143,901	10
11	Improvements		1984		72,587	2,904	25	2,904		47,911	11
12	Improvements		1985		41,435	1,657	25	1,657		26,487	12
13	Improvements		1986		236,110	9,444	25	9,444		136,941	13
14	Improvements		1988		3,850	154	25	154		1,817	14
15	Improvements		1991		79,623	5,308	15	5,308		50,335	15
16	Improvements		1992		10,325	688	15	688		5,562	16
17	Improvements		1993		67,891	4,527	15	4,527		32,795	17
18	Improvements		1994		41,040	3,136	15	3,136		20,680	18
19	Elevator Repairs		1995		39,924	2,662	15	2,662		15,245	19
20	Front Door		1995		11,843	789	15	789		4,531	20
21	Electrical Improvements		1995		213,730	14,289	15	14,289		85,574	21
22	Boiler Repairs		1995		15,681	1,045	15	1,045		5,688	22
23	Water Heater		1995		2,025	135	15	135		799	23
24	Plumbing Repairs		1995		1,550	103	15	103		584	24
25	Laundry and Kitchen Repairs		1996		17,500	1,167	15	1,167		5,252	25
26	4th Floor Construction		1996		7,500	500	15	500		2,382	26
27	Boiler Repairs		1996		2,180	145	15	145		702	27
28	Electric Upgrade		1996		5,245	350	15	350		1,322	28
29	Elevator Repairs		1996		9,800	654	15	654		2,453	29
30	Elevator Repairs		1997		14,390	959	15	959		3,232	30
31	Electrical Repairs		1997		1,885	126	15	126		430	31
32	Doors		1997		1,675	112	15	112		364	32
33	Boiler Repairs		1997		3,573	238	15	238		774	33
34						#	#	#			#
35											35
36	TOTAL (lines 4 thru 35)				\$ 1364186	\$ 69,605		\$ 69,605	\$	\$ 786,126	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/99 Ending: 06/30/2000

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		BATHROOM REMODELING	1998		96,661	6,444	15	6,444		16,012	9
10		ELEVATOR REPAIR	1998		3,000	200	15	200		483	10
11		LAUNDRY PUMPS	1998		4,422	295	15	295		700	11
12		ELECTRICAL WORK	1998		31,052	2,070	15	2,070		4,531	12
13		AIRCONDITIONER	1998		933	62	15	62		140	13
14		KITCHEN WORK	1998		3,903	260	15	260		542	14
15		BOILER REPAIRS	1998		1,875	125	15	125		260	15
16		DAMPERS	1998		6,220	415	15	415		865	16
17		DOORS AND FRAMES	1998		20,263	1,350	15	1,350		2,865	17
18		BUILDING IMPROVEMENTS: ELECTRICAL TRANSFRER	1999		9,591	586	15	586		1,225	18
19		KITCHEN FIRE EXTINGUISHING SYSTEM	1999		1,500	92	15	92		192	19
20		TOASTER WIRING	1999		1,370	76	15	76		213	20
21		BOILER REPAIRS	1999		2,977	149	15	149		199	21
22		BASE BOARD RADIATORS	1999		1,000	50	15	50		67	22
23		BASE BOARD RADIATORS	1999		800	40	15	40		53	23
24		ELECTRICAL TRANSFER SWITCHES	1999		3,500	156	15	156		214	24
25		ACCESS PANELS	1999		3,125	139	15	139		155	25
26		ACCESS PANELS	1999		1,025	40	15	40		40	26
27		FIRE DAMPERS	1999		1,550	60	15	60		60	27
28		ROOF REPAIRS	1999		1,000	39	15	39		39	28
29		ROOF REPAIRS	1999		1,000	39	15	39		39	29
30		WATER HEATER	1999		3,812	116	15	116		116	30
31		ELECTRICAL REPAIRS	1999		2,443	81	15	81		81	31
32		EXIT SIGNS	1999		1,089	30	15	30		30	32
33		WATER HEATERS	1999		1,490	25	15	25		25	33
34		METAL FENCING	1999		1,000	67	15	67		67	34
35		METAL FENCING	1999		800	53	15	53		53	35
36		TOTAL (lines 4 thru 35)			\$ 207,401	\$ 13,059		\$ 13,059	\$	\$ 29,266	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

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Facility Name & ID Numbe Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/99 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9		REPLACE HANDRAILS		1999	26,000	289	15	289		289	9
10		UPGRADE TELEPHONE SYSTEM		1999	3,772	42	15	42		42	10
11		BOILER AND GAS LINE REPLACEMENT AND REPAIR		1999	3,990	266	15	266		266	11
12		EMERGENCY SYSTEM UPGRADE		1999	6,425	229	15	229		229	12
13		OTHER IMPROVEMENTS		1999	9,897		15	0		0	13
14		COMPUTER WIRING		2000	4,958	116	15	116		116	14
15		WATER HEATER		2000	6,980	194	15	194		194	15
16		FLOOR TILE		2000	258	6	15	6		6	16
17		KITCHEN REHAB		2000	4,286	76	15	76		76	17
18		HANDRAILS		2000	13,500	225	15	225		225	18
19		ROOF REPAIRS		2000	27,600	460	15	460		460	19
20		EMERGENCY GENERATOR		2000	64,267	714	15	714		714	20
21		ROOF REPAIRS		2000	28,000	156	15	156		156	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)			\$ 199933	\$ 2,773		\$ 2,773	\$	\$ 2,773	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

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Report Period Beginning:

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07/01/99 Ending: 06/30/2000

Facility Name & ID Numbe Center Home for Hispanic Elderly

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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.

Print Preview

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/99 Ending: 06/30/2000

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	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 255,340	\$ 22,488	\$ 22,488	\$	3/10 YRS	\$ 153,501	37
38	Current Year Purchases	26,065	5,729	5,729			5,729	38
39	Fully Depreciated Assets							39
40		72,097					72,097	40
41	TOTALS	\$ 353,502	\$ 28,217	\$ 28,217	\$		\$ 231,327	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				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,170,022	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 97,822	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 97,822	49**
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 0	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,206,153	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.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipme \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

* 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.

Print Preview

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Facility Name & ID Number Center Home for Hispanic Elderly# 0038893 Report Period Beginning:07/01/99 Ending: 06/30/2000

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
									Units	Cost		
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$		1	
2	Licensed Speech and Language Development Therapist		hrs								2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist		hrs								4	
5	Physician Care		visits								5	
6	Dental Care		visits								6	
7	Work Related Program		hrs								7	
8	Habilitation		hrs								8	
9	Pharmacy		# of prescripts								9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Exceptional Care Program										12	
13	Other (specify):										13	
14	TOTAL			\$		\$	\$		\$		14	

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

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STATE OF ILLINOIS

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/99 Ending: 06/30/2000
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2000 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (1,078)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	725,114		3
4	Supply Inventory (priced at)	23,149		4
5	Short-Term Investments			5
6	Prepaid Insurance	88,934		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	450		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 836,569	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	45,000		13
14	Buildings, at Historical Cost	255,000		14
15	Leasehold Improvements, at Historical Cos	1,109,186		15
16	Equipment, at Historical Cost	353,502		16
17	Accumulated Depreciation (book methods)	(1,206,153)		17
18	Deferred Charges	793		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
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 557,328	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,393,897	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 243,170	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,508		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	OTHER CURRENT LIABILITIES	35,995		33
34	INTER COMPANY A/P PADRES CORP.	216,556		34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	AMERICAN NATIONAL BANK LINE OF CREDIT	350,000		36
37	DUE ILLINOIS DEPARTMENT OF PUBLIC AID	19,476		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,022,705	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	527,200		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)	\$ 527,200	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,549,905	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,885,325	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,435,230	\$	48

*(See instructions.)

Print Preview

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,070,777	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,070,777	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(185,452)	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)	\$ (185,452)	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)	\$ 1,885,325	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Center Home for Hispanic Elderly # 0038893

Report Period Beginning: 07/01/99

Ending: 06/30/2000

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	\$ 5,114,090	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,114,090	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,412	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)	\$ 5,412	23
D. Non-Operating Revenue			
24	Contributions	14,931	24
25	Interest and Other Investment Income***	6,965	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,896	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,141,398	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 1,133,634	31
32	Health Care	2,358,304	32
33	General Administration	1,591,524	33
B. Capital Expense			
34	Ownership	157,276	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	86,112	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,526,850	40
41	Income before Income Taxes (line 30 minus line 40)**	(185,452)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (185,452)	43

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

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

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

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

Print Preview

	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	1,952	2,160	\$ 59,320	\$ 27.46	1
2	Assistant Director of Nursing	829	948	20,729	21.87	2
3	Registered Nurses	10,635	11,983	234,953	19.61	3
4	Licensed Practical Nurses	24,482	29,139	479,909	16.47	4
5	Nurse Aides & Orderlies	26,581	95,243	741,612	7.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,396	12,518	135,715	10.84	8
9	Activity Director	1,504	1,564	17,423	11.14	9
10	Activity Assistants	21,262	23,316	92,881	3.98	10
11	Social Service Workers	4,567	5,039	65,535	13.01	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,120	25,481	12.02	13
14	Head Cook	5,579	6,211	51,000	8.21	14
15	Cook Helpers/Assistants	15,612	16,841	112,316	6.67	15
16	Dishwashers	13,385	14,530	87,771	6.04	16
17	Maintenance Workers	9,957	11,145	113,840	10.21	17
18	Housekeepers	25,637	27,652	55,152	1.99	18
19	Laundry	12,753	14,209	82,226	5.79	19
20	Administrator	1,912	2,160	91,677	42.44	20
21	Assistant Administrator	1,952	2,080	58,236	28.00	21
22	Other Administrative	1,040	1,040	72,449	69.66	22
23	Office Manager					23
24	Clerical	21,180	23,805	197,990	8.32	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	3,810	4,288	47,313	11.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	217,025	307,991	\$ 2,843,528 *	\$ 9.23	34

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

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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	\$ 12,441	L1COL3	35
36	Medical Director	2,751	L9COL3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	4,721	L10COL3	40
41	Occupational Therapy Consultant	4,848	L10aCOL3	41
42	Respiratory Therapy Consultant	54	L10aCOL3	42
43	Speech Therapy Consultant			43
44	Activity Consultant	316	L11COL3	44
45	Social Service Consultant	9,049	L12COL3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 34,180		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 50,218	L10-COL3	50
51	Licensed Practical Nurses	40,730	L10-COL3	51
52	Nurse Aides	121,494	L10-COL3	52
53	TOTAL (lines 50 - 52)	\$ 212,442		53