

		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>0032862</u></p> <p>Facility Name: <u>DANVILLE CARE CENTER</u></p> <p>Address: <u>1701 N. BOWMAN AVE.</u> <u>DANVILLE</u> <u>61832</u> <small>Number City Zip Code</small></p> <p>County: <u>VERMILLION</u></p> <p>Telephone Number: <u>(847) 674-4700</u> Fax # <u>(847) 674-4733</u></p> <p>IDPA ID Number: <u>36-3532095</u></p> <p>Date of Initial License for Current Owners: <u>10/01/87</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2000</u> to <u>12/31/2000</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" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____ (Type or Print Name) <u>BRADLEY ALTER</u></td> </tr> <tr> <td></td> <td>(Title) <u>SECRETARY</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA/PARTNER</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1</u> (Telephone) <u>(847) 675-3585</u> Fax <u>(847) 675-5777</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>BRADLEY ALTER</u>		(Title) <u>SECRETARY</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA/PARTNER</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1</u> (Telephone) <u>(847) 675-3585</u> Fax <u>(847) 675-5777</u>
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Print Previe

Facility Name & ID Number DANVILLE CARE CENTER

0032862 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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	118	Skilled (SNF)	118	43,188	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	30,012	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other		Total
8	SNF			2,409	2,409	8
9	SNF/PED					9
10	ICF	43,144	4,512	1,443	49,099	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,144	4,512	3,852	51,508	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 70.37%)

D. How many bed-hold days during this year were paid by Public Aid? 16 (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 10/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/87 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 24 and days of care provided 2409

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/00 Fiscal Year: 12/31/00
* All facilities other than governmental must report on the accrual basis.

Print Previe

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

Page 3

Facility Name & ID Number **DANVILLE CARE CENTER** # **0032862** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**
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	240,322	17,516	9,082	266,920		266,920	0	266,920		1
2	Food Purchase		260,802		260,802		260,802	(19,503)	241,299		2
3	Housekeeping	172,721	37,073	0	209,794		209,794	548	210,342		3
4	Laundry	115,521	22,566	1,941	140,028		140,028	0	140,028		4
5	Heat and Other Utilities			122,552	122,552		122,552	431	122,983		5
6	Maintenance	41,063	50,690	12,236	103,989		103,989	6,938	110,927		6
7	Other (specify):*			9,260	9,260		9,260	0	9,260		7
8	TOTAL General Services	569,627	388,647	155,071	1,113,345		1,113,345	(11,586)	1,101,759		8
	B. Health Care and Programs										
9	Medical Director			6,950	6,950		6,950	0	6,950		9
10	Nursing and Medical Records	1,692,341	98,422	47,519	1,838,282		1,838,282	8,797	1,847,079		10
10a	Therapy	89,537	2,793	2,564	94,894		94,894	(13,304)	81,590		10a
11	Activities	111,643	231	472	112,346		112,346	0	112,346		11
12	Social Services	53,495		2,592	56,087		56,087	0	56,087		12
13	Nurse Aide Training			1,210	1,210		1,210	0	1,210		13
14	Program Transportation			0				0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	1,947,016	101,446	61,307	2,109,769		2,109,769	(4,507)	2,105,262		16
	C. General Administration										
17	Administrative	127,750		41,400	169,150		169,150	6,469	175,619		17
18	Directors Fees			0				0			18
19	Professional Services			48,335	48,335		48,335	15,424	63,759		19
20	Dues, Fees, Subscriptions & Promotions			39,592	39,592		39,592	(10,083)	29,509		20
21	Clerical & General Office Expense	58,181	23,659	173,978	255,818		255,818	(67,881)	187,937		21
22	Employee Benefits & Payroll Taxes			344,540	344,540		344,540	0	344,540		22
23	Inservice Training & Education			1,125	1,125		1,125	0	1,125		23
24	Travel and Seminar			0				9,540	9,540		24
25	Other Admin. Staff Transportation			10,741	10,741		10,741	5,185	15,926		25
26	Insurance-Prop.Liab.Malpractice			60,021	60,021		60,021	2,829	62,850		26
27	Other (specify):*			0				49,012	49,012		27
28	TOTAL General Administration	185,931	23,659	719,732	929,322		929,322	10,495	939,817		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,702,574	513,752	936,110	4,152,436		4,152,436	(5,598)	4,146,838		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.

Facility Name & ID Number **DANVILLE CARE CENTER**

0032862

Report Period Beginning: **01/01/2000** Ending: **12/31/2000**

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
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			79,327	79,327		79,327	173,594	252,921		30
31	Amortization of Pre-Op. & Org.							26,680	26,680		31
32	Interest			58,148	58,148		58,148	584,566	642,714		32
33	Real Estate Taxes			64,253	64,253		64,253	0	64,253		33
34	Rent-Facility & Grounds			803,000	803,000		803,000	(796,386)	6,614		34
35	Rent-Equipment & Vehicles			7,364	7,364		7,364	6,394	13,758		35
36	Other (specify):*							0			36
37	TOTAL Ownership			1,012,092	1,012,092		1,012,092	(5,152)	1,006,940		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		72,256	138,723	210,979		210,979	0	210,979		39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			109,800	109,800		109,800	0	109,800		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers		72,256	248,523	320,779		320,779		320,779		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,702,574	586,008	2,196,725	5,485,307	0	5,485,307	(10,750)	5,474,557		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 **DANVILLE CARE CENTER**

0032862

Report Period Beginning: **01/01/2000**

Ending: **2/31/2000**

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 Program:				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(35,470)	30		9
10	Interest and Other Investment Income	0	32		10
11	Discounts, Allowances, Rebates & Refunds	(18,289)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,214)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(13,380)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(13,582)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(1,029)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	6,793	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (76,171)		\$	30

OHF USE ONLY							
48		49		50		51	

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)	65,421	SCHED	34
35	Other- Attach Schedule	0	TACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 65,421		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (10,750)		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 Previe

**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 DANVILLE CARE CENTER

0032862 Report Period Beginning:

01/01/2000

Ending: 12/31/2000

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

Print Summary

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	(19,503)	0	0	0	0	0	0	0	0	0	0	(19,503) 2
3	Housekeeping	0	0	548	0	0	0	0	0	0	0	0	548 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	431	0	0	0	0	0	0	0	0	431 5
6	Maintenance	6,793	0	145	0	0	0	0	0	0	0	0	6,938 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	(12,710)	0	1,124	0	0	0	0	0	0	0	0	(11,586) 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	8,797	0	0	0	0	0	0	0	0	8,797 10
10a	Therapy	0	(78,695)	0	65,391	0	0	0	0	0	0	0	(13,304) 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	(78,695)	8,797	65,391	0	(4,507) 16						
C. General Administration													
17	Administrative	0	(41,400)	47,869	0	0	0	0	0	0	0	0	6,469 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	0	14,826	598	0	0	0	0	0	0	0	15,424 19
20	Fees, Subscriptions & Promotions	(14,611)	0	4,528	0	0	0	0	0	0	0	0	(10,083) 20
21	Clerical & General Office Expenses	(13,380)	(131,183)	76,472	210	0	0	0	0	0	0	0	(67,881) 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	8,598	942	0	0	0	0	0	0	0	9,540 24
25	Other Admin. Staff Transportation	0	0	3,185	2,000	0	0	0	0	0	0	0	5,185 25
26	Insurance-Prop.Liab.Malpractice	0	0	2,829	0	0	0	0	0	0	0	0	2,829 26
27	Other (specify):*	0	0	40,875	8,137	0	0	0	0	0	0	0	49,012 27
28	TOTAL General Administration	(27,991)	(172,583)	199,182	11,887	0	10,495 28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(40,701)	(251,278)	209,103	77,278	0	(5,598) 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 Num: DANVILLE CARE CENTER

0032862

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

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

Print Summary

	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	(35,470)	205,136	3,928	0	0	0	0	0	0	0	0	173,594	30
31	Amortization of Pre-Op. & Org.	0	26,680	0	0	0	0	0	0	0	0	0	26,680	31
32	Interest	0	583,914	652	0	0	0	0	0	0	0	0	584,566	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(803,000)	6,614	0	0	0	0	0	0	0	0	(796,386)	34
35	Rent-Equipment & Vehicles	0	0	4,762	1,632	0	0	0	0	0	0	0	6,394	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(35,470)	12,730	15,956	1,632	0	(5,152)	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)	(76,171)	(238,548)	225,059	78,910	0	(10,750)	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.

VI. RELATED PARTIES (Show Pgs 6A thru 6) (Show Pgs 6A thru 6) (Hide Pgs 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	Type of Business
HOWARD ALDER	22%	SCHUBS (C) NURSING		MANAGEMENT	MANAGEMENT
HOWARD GELLER	48%				
SYNTHIA LEWIS	30%				

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 Ownership	Operational Cost of Related Organization	Adjustment to Related Organization Costs	Sum 5
V	1	MANAGEMENT FEES	47,300	CERTIFIED HEALTH MANAGEMENT				-47,300
V	2	MANAGEMENT FEES	12,000					-12,000
V	3	THE RCPY	9,200					-9,200
V	4							
V	5							
V	6							
V	7							
V	8							
V	9							
V	10							
V	11	RENT	303,400	DANVILLE CARE CENTER LLC				-303,400
V	12	PROPERTY TAXES	4,000					-4,000
V	13	PROPERTY TAXES	2,000					-2,000
V	14	PROPERTY TAXES	2,000					-2,000
V	15	PROPERTY TAXES	2,000					-2,000
V	16	PROPERTY TAXES	2,000					-2,000
V	17	PROPERTY TAXES	2,000					-2,000
V	18	PROPERTY TAXES	2,000					-2,000
V	19	PROPERTY TAXES	2,000					-2,000
V	20	PROPERTY TAXES	2,000					-2,000
V	21	PROPERTY TAXES	2,000					-2,000
V	22	PROPERTY TAXES	2,000					-2,000
V	23	PROPERTY TAXES	2,000					-2,000
V	24	PROPERTY TAXES	2,000					-2,000
V	25	PROPERTY TAXES	2,000					-2,000
V	26	PROPERTY TAXES	2,000					-2,000
V	27	PROPERTY TAXES	2,000					-2,000
V	28	PROPERTY TAXES	2,000					-2,000
V	29	PROPERTY TAXES	2,000					-2,000
V	30	PROPERTY TAXES	2,000					-2,000
V	31	PROPERTY TAXES	2,000					-2,000
V	32	PROPERTY TAXES	2,000					-2,000
V	33	PROPERTY TAXES	2,000					-2,000
V	34	PROPERTY TAXES	2,000					-2,000
V	35	PROPERTY TAXES	2,000					-2,000
V	36	PROPERTY TAXES	2,000					-2,000
V	37	PROPERTY TAXES	2,000					-2,000
V	38	PROPERTY TAXES	2,000					-2,000
V	39	PROPERTY TAXES	2,000					-2,000
V	40	PROPERTY TAXES	2,000					-2,000
V	41	PROPERTY TAXES	2,000					-2,000
V	42	PROPERTY TAXES	2,000					-2,000
V	43	PROPERTY TAXES	2,000					-2,000
V	44	PROPERTY TAXES	2,000					-2,000
V	45	PROPERTY TAXES	2,000					-2,000
V	46	PROPERTY TAXES	2,000					-2,000
V	47	PROPERTY TAXES	2,000					-2,000
V	48	PROPERTY TAXES	2,000					-2,000
V	49	PROPERTY TAXES	2,000					-2,000
V	50	PROPERTY TAXES	2,000					-2,000
V	51	PROPERTY TAXES	2,000					-2,000
V	52	PROPERTY TAXES	2,000					-2,000
V	53	PROPERTY TAXES	2,000					-2,000
V	54	PROPERTY TAXES	2,000					-2,000
V	55	PROPERTY TAXES	2,000					-2,000
V	56	PROPERTY TAXES	2,000					-2,000
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V	58	PROPERTY TAXES	2,000					-2,000
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V	61	PROPERTY TAXES	2,000					-2,000
V	62	PROPERTY TAXES	2,000					-2,000
V	63	PROPERTY TAXES	2,000					-2,000
V	64	PROPERTY TAXES	2,000					-2,000
V	65	PROPERTY TAXES	2,000					-2,000
V	66	PROPERTY TAXES	2,000					-2,000
V	67	PROPERTY TAXES	2,000					-2,000
V	68	PROPERTY TAXES	2,000					-2,000
V	69	PROPERTY TAXES	2,000					-2,000
V	70	PROPERTY TAXES	2,000					-2,000
V	71	PROPERTY TAXES	2,000					-2,000
V	72	PROPERTY TAXES	2,000					-2,000
V	73	PROPERTY TAXES	2,000					-2,000
V	74	PROPERTY TAXES	2,000					-2,000
V	75	PROPERTY TAXES	2,000					-2,000
V	76	PROPERTY TAXES	2,000					-2,000
V	77	PROPERTY TAXES	2,000					-2,000
V	78	PROPERTY TAXES	2,000					-2,000
V	79	PROPERTY TAXES	2,000					-2,000
V	80	PROPERTY TAXES	2,000					-2,000
V	81	PROPERTY TAXES	2,000					-2,000
V	82	PROPERTY TAXES	2,000					-2,000
V	83	PROPERTY TAXES	2,000					-2,000
V	84	PROPERTY TAXES	2,000					-2,000
V	85	PROPERTY TAXES	2,000					-2,000
V	86	PROPERTY TAXES	2,000					-2,000
V	87	PROPERTY TAXES	2,000					-2,000
V	88	PROPERTY TAXES	2,000					-2,000
V	89	PROPERTY TAXES	2,000					-2,000
V	90	PROPERTY TAXES	2,000					-2,000
V	91	PROPERTY TAXES	2,000					-2,000
V	92	PROPERTY TAXES	2,000					-2,000
V	93	PROPERTY TAXES	2,000					-2,000
V	94	PROPERTY TAXES	2,000					-2,000
V	95	PROPERTY TAXES	2,000					-2,000
V	96	PROPERTY TAXES	2,000					-2,000
V	97	PROPERTY TAXES	2,000					-2,000
V	98	PROPERTY TAXES	2,000					-2,000
V	99	PROPERTY TAXES	2,000					-2,000
V	100	PROPERTY TAXES	2,000					-2,000
V	101	PROPERTY TAXES	2,000					-2,000
V	102	PROPERTY TAXES	2,000					-2,000
V	103	PROPERTY TAXES	2,000					-2,000
V	104	PROPERTY TAXES	2,000					-2,000
V	105	PROPERTY TAXES	2,000					-2,000
V	106	PROPERTY TAXES	2,000					-2,000
V	107	PROPERTY TAXES	2,000					-2,000
V	108	PROPERTY TAXES	2,000					-2,000
V	109	PROPERTY TAXES	2,000					-2,000
V	110	PROPERTY TAXES	2,000					-2,000
V	111	PROPERTY TAXES	2,000					-2,000
V	112	PROPERTY TAXES	2,000					-2,000
V	113	PROPERTY TAXES	2,000					-2,000
V	114	PROPERTY TAXES	2,000					-2,000
V	115	PROPERTY TAXES	2,000					-2,000
V	116	PROPERTY TAXES	2,000					-2,000
V	117	PROPERTY TAXES	2,000					-2,000
V	118	PROPERTY TAXES	2,000					-2,000
V	119	PROPERTY TAXES	2,000					-2,000
V	120	PROPERTY TAXES	2,000					-2,000
V	121	PROPERTY TAXES	2,000					-2,000
V	122	PROPERTY TAXES	2,000					-2,000
V	123	PROPERTY TAXES	2,000					-2,000
V	124	PROPERTY TAXES	2,000					-2,000
V	125	PROPERTY TAXES	2,000					-2,000
V	126	PROPERTY TAXES	2,000					-2,000
V	127	PROPERTY TAXES	2,000					-2,000
V	128	PROPERTY TAXES	2,000					-2,000
V	129	PROPERTY TAXES	2,000					-2,000
V	130	PROPERTY TAXES	2,000					-2,000
V	131	PROPERTY TAXES	2,000					-2,000
V	132	PROPERTY TAXES	2,000					-2,000
V	133	PROPERTY TAXES	2,000					-2,000
V	134	PROPERTY TAXES	2,000					-2,000
V	135	PROPERTY TAXES	2,000					-2,000
V	136	PROPERTY TAXES	2,000					-2,000
V	137	PROPERTY TAXES	2,000					-2,000
V	138	PROPERTY TAXES	2,000					-2,000
V	139	PROPERTY TAXES	2,000					-2,000
V	140	PROPERTY TAXES	2,000					-2,000
V	141	PROPERTY TAXES	2,000					-2,000
V	142	PROPERTY TAXES	2,000					-2,000
V	143	PROPERTY TAXES	2,000					-2,000
V	144	PROPERTY TAXES	2,000					-2,000
V	145	PROPERTY TAXES	2,000					-2,000
V	146	PROPERTY TAXES	2,000					-2,000
V	147	PROPERTY TAXES	2,000					-2,000
V	148	PROPERTY TAXES	2,000					-2,000
V	149	PROPERTY TAXES	2,000					-2,000
V	150	PROPERTY TAXES	2,000					-2,000
V	151	PROPERTY TAXES	2,000					-2,000
V	152	PROPERTY TAXES	2,000					-2,000
V	153	PROPERTY TAXES	2,000					-2,000
V	154	PROPERTY TAXES	2,000					-2,000
V	155	PROPERTY TAXES	2,000					-2,000
V	156	PROPERTY TAXES	2,000					-2,000
V	157	PROPERTY TAXES	2,000					-2,000
V	158	PROPERTY TAXES	2,000					-2,000
V	159	PROPERTY TAXES	2,000					-2,000
V	160	PROPERTY TAXES	2,000					-2,000
V	161	PROPERTY TAXES	2,000					

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

Facility Name & ID Number DANVILLE CARE CENTER

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	3 HOUSEKEEPING	\$			\$ 548	\$ 548
16	V	5 ELECTRICITY & GAS				431	431
17	V	6 MAINTENANCE				145	145
18	V	10 NURSING & MEDICAL RECORDS				8,797	8,797
19	V	17 ADMIN SALARIES				47,869	47,869
20	V	19 PROFESSIONAL FEES				14,826	14,826
21	V	20 FEES, SUBSCRIPTION				4,528	4,528
22	V	21 OFFICE EXPENSE				76,472	76,472
23	V	27 EMPLOYEE BENEFITS				40,875	40,875
24	V	24 TRAVEL & SEMINAR				8,598	8,598
25	V	25 TRANSPORTATION				3,185	3,185
26	V	26 INSURANCE				2,829	2,829
27	V	30 DEPRECIATION				3,928	3,928
28	V	32 INTEREST				652	652
29	V	34 OFFICE RENT				6,614	6,614
30	V	35 EQUIPMENT RENT				4,762	4,762
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 225,059	\$ * 225,059

Sum_6A

548
431
145
8797
47869
14826
4528
76472
40875
8598
3185
2829
3928
652
6614
4762

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

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.

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 DANVILLE CARE CENTER # 0032862 Report Period Beginn 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6	7	8
Schedule V	Line	Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)
15	V 10a	THERAPY	\$			\$ 65,391	\$ 65,391
16	V 19	PROFESSIONAL FEE				598	598
17	V 21	OFFICE EXPENSE				210	210
18	V 27	EMPLOYEE BENEFITS				8,137	8,137
19	V 24	TRAVEL & SEMINARS				942	942
20	V 25	TRANSPORTATION				2,000	2,000
21	V 35	EQUIPMENT RENT				1,632	1,632
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 78,910	\$ * 78,910

Sum_6B

65391
598
210
8137
942
2000
1632

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

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.

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 DANVILLE CARE CENTER # 0032862 Report Period Beginn 01/01/2000 Ending: 12/31/2000

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.

Table with 8 columns: Schedule V Line, Cost Per General Ledger, Amount, Cost to Related Organization, Name of Related Organization, Percent of Ownership, Operating Cost of Related Organization, Adjustments for Related Organization Costs (7 minus 4). Rows 15-39.

Sum_6C

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

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

Page 6D

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginn 01/01/2000 Ending: 12/31/2000

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		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

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

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.

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	2	3	4	5	6		7		8	9		
					Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			Schedule V. Line & Column Reference	
						Hours	Percent	Description				Amount
Name	Title	Function	Ownership Interest									
1	BRADLEY ALTER		ADMINISTRATIVE	SCHEDULE ATTACHED				SALARY	\$ 30,554	17-7	1	
2	HOWARD GELLER		ADMINISTRATIVE	SCHEDULE ATTACHED				MGMT FEE	8,775	19-7	2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$ 39,329		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 DANVILLE CARE CENTER

0032862 Report Period Beginning: 01/01/2000

Ending: 1/31/2000

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: CERTIFIED HEALTH MANAGEMENT
 Street Address: 3856 OAKTON SUITE 200
 City / State / Zip Code: SKOKIE, IL 60076
 Phone Number: (847) 674-4700
 Fax Number: (847) 674-4733

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	3	HOUSEKEEPING	PATIENT DAYS	282,193	8	\$ 3,000	\$ 51,508	\$ 548	1
2	5	ELECTRICITY & GAS	" "	282,193	8	2,363	51,508	431	2
3	6	MAINTENANCE	" "	282,193	8	794	51,508	145	3
4	10	NURSING & MEDICAL REC	" "	282,193	8	48,193	51,508	8,797	4
5	17	ADMIN SALARIES	" "	282,193	8	262,258	51,508	47,869	5
6	19	PROFESSIONAL FEES	" "	282,193	8	103,352	51,508	14,826	6
7	20	FEES, SUBSCRIPTION	" "	282,193	8	24,805	51,508	4,528	7
8	21	OFFICE EXPENSE	" "	282,193	8	418,964	51,508	76,472	8
9	27	EMPLOYEE BENEFITS	" "	282,193	8	223,938	51,508	40,875	9
10	24	TRAVEL & SEMINAR	" "	282,193	8	47,103	51,508	8,598	10
11	25	TRANSPORTATION	" "	282,193	8	17,449	51,508	3,185	11
12	26	INSURANCE	" "	282,193	8	15,497	51,508	2,829	12
13	30	DEPRECIATION	" "	282,193	8	21,518	51,508	3,928	13
14	32	INTEREST	" "	282,193	8	3,570	51,508	652	14
15	34	OFFICE RENT	" "	282,193	8	36,234	51,508	6,614	15
16	35	EQUIPMENT RENT	" "	282,193	8	26,088	51,508	4,762	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,255,126	\$ 503,226	\$ 225,059	25

[Print Previe](#)

Facility Name & ID Number DANVILLE CARE CENTER

0032862 Report Period Beginning: 01/01/2000

Ending: 12/31/2000

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 CHM THERAPY
 Street Address 3856 OAKTON SUITE 200
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-4700
 Fax Number (847) 674-4733

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	10a	THERAPY	USAGE	100	5	\$ 237,623	\$ 237,623	28	\$ 65,391	1
2	19	PROFESSIONAL FEE	" "	100	5	2,171		28	598	2
3	21	OFFICE EXPENSE	" "	100	5	762		28	210	3
4	27	EMPLOYEE BENEFITS	" "	100	5	29,544		28	8,137	4
5	24	TRAVEL & SEMINARS	" "	100	5	3,419		28	942	5
6	25	TRANSPORTATION	" "	100	5	7,260		28	2,000	6
7	35	EQUIPMENT RENT	" "	100	5	5,926		28	1,632	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					\$ 286,705	\$ 237,623		\$ 78,910	25

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	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

Facility Name & ID Number DANVILLE CARE CENTER

0032862 Report Period Beginning: 01/01/2000

Ending: 12/31/2000

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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	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	BARRY KIRSCHENBAUM	X		MORTGAGE	\$52,439.00	01/01/98	\$ 6,300,000	\$ 6,072,624	1/1/23	8.9	\$ 583,914	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	OLD KENT BANK		X	WORKING CAPITAL DEMAND						PRIME +	58,148	6								
7												7								
8	RELATED PARTY	X									505	8								
9	TOTAL Facility Related				\$52,439.00		\$ 6,300,000	\$ 6,072,624			\$ 642,567	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 6,300,000	\$ 6,072,624			\$ 642,567	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	52,600	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.)	\$	57,848	2
3. Under or (over) accrual (line 2 minus line 1).	\$	5,248	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	59,005	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	\$	64,253	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	46,572	8		
	1996	48,421	9		
	1997	50,382	10		
	1998	51,543	11		
	1999	57,848	12		

	FOR OFF 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 CALCULATIC	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

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: DANVILLE CARE CENTER

0032862 Report Period Beginning:

01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 0 B. General Construction Type: Exterior Frame 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		1998	\$ 350,000	1
2					2
3	TOTALS			\$ 350,000	3

Print Preview

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

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

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Facility Name & ID Number DANVILLE CARE CENTER

0032862

Report Period Beginning:

01/01/200(Ending: 12/31/2000

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	200		1998		\$ 2,954,225	\$ 152,666	39	\$ 152,666	\$	\$ 458,004	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9		LEASEHOLD IMPROVEMENTS	1989		34,167	1,085	30	1,139	54	12,233	9
10		LEASEHOLD IMPROVEMENTS	1990		17,344	551	30	578	27	5,866	10
11		LEASEHOLD IMPROVEMENTS	1991		45,376	1,441	30	1,513	72	13,905	11
12		LEASEHOLD IMPROVEMENTS	1992		12,043	382	30	401	19	3,304	12
13		LEASEHOLD IMPROVEMENTS	1993		9,213	236	30	307	71	1,993	13
14		LEASEHOLD IMPROVEMENTS	1994		8,304	213	39	213		1,394	14
15		NURSING STATION	1995		14,331	367	39	367		1,943	15
16		DOORS & LIGHT FIXTURES	1995		17,592	451	39	451		2,386	16
17		FIRE ALARM & ELECTRICAL WORK	1995		2,420	62	39	62		328	17
18		SHOWER & BATH CONSTRUCTION	1995		4,704	121	39	121		640	18
19		NURSECALL REPAIR	1996		1,655	43	39	43		213	19
20		SMOKE DETECTORS, LIGHT FIXTURES, DOOR	1996		5,894	150	39	150		722	20
21		RESURFACE PARKING AREA	1996		12,910	861	15	861		3,874	21
22		ROOF REPAIR	1996		12,742	327	39	327		1,349	22
23		WARDROBE UNITS	1996		8,361	214	39	214		865	23
24		FLOORING	1996		2,444	63	39	63		254	24
25		CARPET, WALLPAPER, BUMPER GUARDS, COVE BASE	1997		19,014	488	39	488		1,746	25
26		PARKING LOT REPAIR	1997		1,500	100	15	100		350	26
27		PAVILION CONSTRUCTION	1997		8,297	212	39	212		780	27
28		THERAPY ROOM ADDITION	1998		320,230	8,211	39	8,211		16,765	28
29		NORTH WING RENOVATION	1998		65,143	1,670	39	1,670		3,410	29
30		BUMPER GUARDS	1998		9,285	238	39	238		705	30
31		CEILING REPAIR, DRYWALL, TILE	1999		17,083	438	39	438		480	31
32		NURSE CALL, FIRE ALARM SYSTEM	1999		5,616	144	39	144		224	32
33		ROOF REPAIR, AIR EXHAUSTS	1999		7,095	183	39	183		285	33
34		LANDSCAPING	1999		12,535	836	15	836		1,253	34
35											35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 171,753		\$ 171,996	\$ 243	\$ 535,271	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 Previe

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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0032862

Report Period Beginning:

01/01/200(Ending: 12/31/2000

Facility Name & ID Numbe DANVILLE CARE CENTER

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						441		441			8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		AIR CONDITIONER		2000	3,436	491	20	86	(405)	86	9
10		CARPET/COVE BASE/WALLPAPER		2000	9,734	1,391	20	243	(1,148)	243	10
11		BATHROOM REPAIR/REMODEL		2000	11,104	310	27.5	310		310	11
12		HOT TUB ROOM REPAIR/REMODEL		2000	6,700	182	27.5	182		182	12
13		ALARM SYSTEM/DOORS/CAMERAS		2000	15,171	418	27.5	418		418	13
14		NORTH WING RENOVATION		2000	4,809	128	27.5	128		128	14
15		WATER HEATER VALVE		2000	1,026	32	27.5	32		32	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!	\$ 3,393		\$ 1,840	\$ (1,553)	\$ 1,399	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 Previe

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

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Report Period Beginning:

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01/01/2000 Ending: 12/31/2000

Facility Name & ID Numbe DANVILLE CARE CENTER

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
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

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:

Page 12C

01/01/200(Ending: 12/31/2000

Facility Name & ID Numbe **DANVILLE CARE CENTER**

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
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 Previe

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

Page 12D

Facility Name & ID Numbe DANVILLE CARE CENTER

0032862

Report Period Beginning:

01/01/2000 Ending: 12/31/2000

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					\$	\$		\$	\$	\$
5										
6										
7										
8										
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9										
10										
11										
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27										
28										
29										
30										
31										
32										
33										
34										
35										
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$

*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 Previe

Facility Name & ID Number DANVILLE CARE CENTER

0032862

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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	\$ 423,852	\$ 46,138	\$ 40,112	\$ (6,026)		\$ 196,178	37
38	Current Year Purchases	36,173	6,769	1,809	(4,960)		1,809	38
39	Fully Depreciated Assets	41,241					41,241	39
40	RELATED PARTY	327,826	55,957	32,783	(23,174)			40
41	TOTALS	\$ 829,092	\$ 108,864	\$ 74,704	\$ (34,160)		\$ 239,228	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	MAINT DEPT	1995 DODGE VAN	1994	\$ 19,595	\$	\$	\$		\$ 19,595	42
43	PATIENT TRANS	1996 FORD WAGON	2000	21,907	4,381	4,381		5 YRS	4,381	43
44										44
45										45
46	TOTALS			\$ 41,502	\$ 4,381	\$ 4,381	\$		\$ 23,976	46

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 288,391	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 252,921	49**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (35,470)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 799,874	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 **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u> </u> /2001	\$ <u> </u>
13.	<u> </u> /2002	\$ <u> </u>
14.	<u> </u> /2003	\$ <u> </u>

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

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

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

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

16. Rental Amount for movable equipment: \$ **7,364** Description: **SEE SCHEDULE ATTACHED**
(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

* 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.

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Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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

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

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

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (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.

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Facility Name & ID Number DANVILLE CARE CENTER# 0032862 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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	39-3	hrs	\$		\$ 74,260	\$		\$	74,260	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,304				1,304	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs			63,143				63,143	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescripts					39,878		39,878	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): LAB	39-2&3				16		32,378		32,394	13
14	TOTAL			\$		\$ 138,723	\$	72,256	\$	210,979	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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Facility Name & ID Number DANVILLE CARE CENTER

0032862

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (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	\$ 32,656	\$ 1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 205,000)	775,932	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	124,437	6
7	Other Prepaid Expenses	24,523	7
8	Accounts Receivable (owners or related parties)	40,933	8
9	Other(specify): RE ESCROW	161,948	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,160,429	\$ 10
B. Long-Term Assets			
11	Long-Term Notes Receivable	314,164	11
12	Long-Term Investments		12
13	Land		13
14	Buildings, at Historical Cost		14
15	Leasehold Improvements, at Historical Cost	727,279	15
16	Equipment, at Historical Cost	520,861	16
17	Accumulated Depreciation (book methods)	(459,716)	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
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,102,588	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,263,017	\$ 25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 678,356	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	8,906	28
29	Short-Term Notes Payable	625,000	29
30	Accrued Salaries Payable	137,196	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,766	31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,005	32
33	Accrued Interest Payable	6,201	33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	DEFERRED INCOME	42,811	36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,564,241	\$ 38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	555,680	39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 555,680	\$ 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,119,921	\$ 46
47	TOTAL EQUITY(page 18, line 24)	\$ 143,096	\$ 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,263,017	\$ 48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 332,494	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	(7,757)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 324,737	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(181,641)	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)	\$ (181,641)	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)	\$ 143,096	24 *

* This must agree with page 17, line 47.

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STATE OF ILLINOIS

Facility Name & ID Number DANVILLE CARE CENTER

0032862

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

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	\$ 5,218,423	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,218,423	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	64,368	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 64,368	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	18,289	28
28a	VENDING COMMISSION	2,586	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,875	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,303,666	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 1,113,345	31
32	Health Care	2,109,769	32
33	General Administration	929,322	33
B. Capital Expense			
34	Ownership	1,012,092	34
C. Ancillary Expense			
35	Special Cost Centers	210,979	35
36	Provider Participation Fee	109,800	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,485,307	40
41	Income before Income Taxes (line 30 minus line 40)**	(181,641)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (181,641)	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.

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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	1,040	1,040	\$ 24,680	\$ 23.73	1
2	Assistant Director of Nursing	3,280	3,365	52,144	15.50	2
3	Registered Nurses	9,818	10,637	190,091	17.87	3
4	Licensed Practical Nurses	36,406	37,665	492,857	13.09	4
5	Nurse Aides & Orderlies	96,791	99,251	876,389	8.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,383	9,111	89,537	9.83	8
9	Activity Director	2,182	2,230	18,480	8.29	9
10	Activity Assistants	14,196	14,860	93,163	6.27	10
11	Social Service Workers	6,440	6,648	53,495	8.05	11
12	Dietician					12
13	Food Service Supervisor	3,920	4,160	31,300	7.52	13
14	Head Cook	14,894	14,905	104,657	7.02	14
15	Cook Helpers/Assistants	15,708	16,244	104,365	6.42	15
16	Dishwashers					16
17	Maintenance Workers	5,777	6,039	41,063	6.80	17
18	Housekeepers	20,692	21,326	172,721	8.10	18
19	Laundry	19,456	20,654	115,521	5.59	19
20	Administrator	2,460	2,500	47,071	18.83	20
21	Assistant Administrator	2,200	2,320	45,677	19.69	21
22	Other Administrative	1,960	2,080	35,002	16.83	22
23	Office Manager	2,076	2,220	30,361	13.68	23
24	Clerical	3,533	3,769	27,820	7.38	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	2,627	2,786	24,752	8.88	31
32	Other Health MED NURSE	320	320	3,998	12.49	32
33	Other(specify CARE PLAN	2,106	2,253	27,430	12.17	33
34	TOTAL (lines 1 - 33)	276,265	286,383	\$ 2,702,574 *	\$ 9.44	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	\$ 9,004	1-3	35
36	Medical Director	6,950	9-3	36
37	Medical Records Consultant	3,963	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	2,200	10-3	39
40	Physical Therapy Consultant	455	10a-3	40
41	Occupational Therapy Consultant	0	10a-3	41
42	Respiratory Therapy Consultant	1,239	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	472	11-3	44
45	Social Service Consultant	2,592	12-3	45
46	Other(specify)			46
47		0		47
48				48
49	TOTAL (lines 35 - 48)	\$ 26,875		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$ 60	1,506	10-3	50
51	Licensed Practical Nurses	541	11,361	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	601	\$ 12,867		53