

		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>0042853</u></p> <p>Facility Name: <u>Highland Health Care Center</u></p> <p>Address: <u>1450 26th Street</u> <u>Highland</u> <u>62249</u> Number City Zip Code</p> <p>County: <u>Madison</u></p> <p>Telephone Number: <u>(618)654-2368</u> Fax # <u>(618)654-4741</u></p> <p>IDPA ID Number: <u>33-0748151003</u></p> <p>Date of Initial License for Current Owners: <u>06/01/92</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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 checked="" 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>Julian Ahumada</u> Telephone Number: <u>(909)312-3518</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 checked="" 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>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"> <tr> <td data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 722">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 722 1281 828"></td> <td data-bbox="1281 722 1921 755">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1144 755 1281 828"></td> <td data-bbox="1281 755 1921 803">(Title) _____</td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 876">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 876 1281 1039"></td> <td data-bbox="1281 876 1921 933">(Print Name and Title) <u>Julian Ahumada</u> <u>Reimbursement Consultant</u></td> </tr> <tr> <td data-bbox="1144 933 1281 1039"></td> <td data-bbox="1281 933 1921 1015">(Firm Name & Address) <u>Julian Ahumada</u> <u>10803 South Oleander Ave. Fontana, CA 92337</u></td> </tr> <tr> <td data-bbox="1144 1015 1281 1039"></td> <td data-bbox="1281 1015 1921 1039">(Telephone) <u>(909)312-3518</u> Fax # <u>(909)356-7983</u></td> </tr> </table> <p>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) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) <u>Julian Ahumada</u> <u>Reimbursement Consultant</u>		(Firm Name & Address) <u>Julian Ahumada</u> <u>10803 South Oleander Ave. Fontana, CA 92337</u>		(Telephone) <u>(909)312-3518</u> Fax # <u>(909)356-7983</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name & ID Number Highland Health Care Center

0042853 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	<u>128</u>	Skilled (SNF)	<u>128</u>	<u>46,720</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>128</u>	TOTALS	<u>128</u>	<u>46,720</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	<u>26,581</u>	<u>12,432</u>	<u>5,747</u>	<u>44,760</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,581</u>	<u>12,432</u>	<u>5,747</u>	<u>44,760</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.80%

D. How many bed-hold days during this year were paid by Public Aid? 305 (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) n/a

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 02/01/64

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/97 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 5,747

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

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

STATE OF ILLINOIS

Facility Name & ID Number Highland Health Care Center # 0042853 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				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	232,932	21,225	16,187	270,344		270,344		270,344		1
2	Food Purchase		163,330		163,330		163,330		163,330		2
3	Housekeeping	102,217	14,455	13,113	129,785		129,785		129,785		3
4	Laundry	91,656	10,575	8,172	110,403		110,403		110,403		4
5	Heat and Other Utilities										5
6	Maintenance	55,194	23,727	110,471	189,392		189,392		189,392		6
7	Other (specify):*										7
8	TOTAL General Services	481,999	233,312	147,943	863,254		863,254		863,254		8
	B. Health Care and Programs										
9	Medical Director			12,041	12,041		12,041		12,041		9
10	Nursing and Medical Records	1,765,900	65,490	5,036	1,836,426		1,836,426		1,836,426		10
10a	Therapy										10a
11	Activities	62,713	3,803	2,575	69,091		69,091		69,091		11
12	Social Services	27,857		2,855	30,712		30,712		30,712		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							52,677	52,677		15
16	TOTAL Health Care and Programs	1,856,470	69,293	22,507	1,948,270		1,948,270	52,677	2,000,947		16
	C. General Administration										
17	Administrative	61,664		199,548	261,212		261,212	96,387	357,599		17
18	Directors Fees										18
19	Professional Services			9,657	9,657		9,657		9,657		19
20	Dues, Fees, Subscriptions & Promotions			11,770	11,770		11,770	(5,355)	6,415		20
21	Clerical & General Office Expenses	133,834	15,160	32,346	181,340		181,340		181,340		21
22	Employee Benefits & Payroll Taxes			385,147	385,147		385,147		385,147		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,672	9,672		9,672	(44)	9,628		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,376	47,376		47,376		47,376		26
27	Other (specify):*			54,827	54,827		54,827	(40,333)	14,494		27
28	TOTAL General Administration	195,498	15,160	750,343	961,001		961,001	50,655	1,011,656		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,533,967	317,765	920,793	3,772,525		3,772,525	103,332	3,875,857		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.

Facility Name & ID Number

Highland Health Care Center

#0042853

Report Period Beginning:

01/01/2000

Ending:

12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			62,764	62,764		62,764		62,764		30
31	Amortization of Pre-Op. & Org.			14,352	14,352		14,352	(14,352)			31
32	Interest			65,318	65,318		65,318	(57,970)	7,348		32
33	Real Estate Taxes			48,770	48,770		48,770		48,770		33
34	Rent-Facility & Grounds			454,965	454,965		454,965	189,327	644,292		34
35	Rent-Equipment & Vehicles			10,034	10,034		10,034		10,034		35
36	Other (specify):*							40,263	40,263		36
37	TOTAL Ownership			656,203	656,203		656,203	157,268	813,471		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		156,873	304,311	461,184		461,184		461,184		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			70,604	70,604		70,604		70,604		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		156,873	374,915	531,788		531,788		531,788		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,533,967	474,638	1,951,911	4,960,516		4,960,516	260,600	5,221,116		45

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

Facility Name & ID Number Highland Health Care Center

0042853

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

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 Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(57,970)	32		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	(44)	24		19
20	Contributions	(315)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,018)	27		24
25	Fund Raising, Advertising and Promotional	(5,355)	20		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 Goodwill Amortization	(14,352)	31		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (118,054)		\$	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)	189,327	34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 189,327		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 71,273		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

ID# 0042853
 Report Period Beginning: 01/01/2000
 Ending: 12/31/2000

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Goodwill Amortization	\$ (14,352)	31
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
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19			19
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76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(14,352)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Highland Health Care Center# 0042853

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

	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	52,677	0	0	0	0	0	0	0	0	0	52,677	15
16	TOTAL Health Care and Programs	0	52,677	0	0	0	0	0	0	0	0	0	52,677	16
	C. General Administration													
17	Administrative	0	96,387	0	0	0	0	0	0	0	0	0	96,387	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	(5,355)	0	0	0	0	0	0	0	0	0	0	(5,355)	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	(44)	0	0	0	0	0	0	0	0	0	0	(44)	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):*	(40,333)	0	0	0	0	0	0	0	0	0	0	(40,333)	27
28	TOTAL General Administration	(45,732)	96,387	0	0	0	0	0	0	0	0	0	50,655	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,732)	149,064	0	0	0	0	0	0	0	0	0	103,332	29

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Care Inc.	100	See List	Aliso Viejo, CA	See list		Health Care

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	15 Home Office Allocation Health C	\$	Covenant Care Inc.	100.00%	\$ 52,677	\$	52,677	1
2	V	17 Home Office Allocation Gen Adm	199,548	Covenant Care Inc.	100.00%	295,935		96,387	2
3	V	36 Home Office Allocation Capital		Covenant Care Inc.	100.00%	40,263		40,263	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 199,548			\$ 388,875	\$ *	189,327	14

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	none								\$	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 the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

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

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

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 Covenant Care Inc.
 Street Address 27071 Aliso Creek Road
 City / State / Zip Code Aliso Viejo, California 92656
 Phone Number (949)349-1100
 Fax Number (949)349-1200

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	15	Home Office Alloc. - Direct Care	Accum Costs	1	\$ 52,677	\$	1	\$ 52,677	1
2	17	Home Office Alloc. - Admin & Ge	Accum Costs	1	295,935		1	295,935	2
3	36	Home Office Alloc. - Capital Costs	Accum Costs	1	40,263		1	40,263	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				\$ 388,875	\$		\$ 388,875	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		Banque Paribas		X	Purchase Of facility		02/03/98	\$ 752,000	\$ 658,000	04/30/01	0.0750	\$ 65,318	1						
2													2						
3													3						
4													4						
5													5						
		Working Capital																	
6													6						
7													7						
8													8						
9		TOTAL Facility Related						\$ 752,000	\$ 658,000			\$ 65,318	9						
		B. Non-Facility Related*																	
10													10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$	14						
15		TOTALS (line 9+line14)						\$ 752,000	\$ 658,000			\$ 65,318	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.)

Facility Name & ID Number **Highland Health Care Center**# **0042853** Report Period Beginning: **01/01/2000** Ending: **12/31/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	44,504	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.)	\$	44,504	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.)	\$	48,770	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.	\$	48,770	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	45,688	8
	1996	47,837	9
	1997	2,563	10
	1998	39,788	11
	1999	44,504	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 CALCULATION \$	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.

Facility Name & ID Number Highland Health Care Center

0042853 Report Period Beginning:

01/01/2000 Ending:

12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,432 B. General Construction Type: Exterior Frame Number of Stories 1C. 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: 357,777 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 14,352 4. Dates Incurred: 04/01/97Nature of Costs: Goodwill & Covenant not to compete
(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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Highland Health Care Center

0042853

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements See Fixed Asset Schedule				196,258	34,578	15	34,578	0	59,735	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	TOTAL (lines 4 thru 35)				\$ 196,258	\$ 34,578		\$ 34,578	\$ 0	\$ 59,735	36

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

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

Facility Name & ID Number Highland Health Care Center

0042853

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	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 174,468	\$ 27,529	\$ 27,529	\$ 0	5	\$ 99,222	37
38	Current Year Purchases	12,614	657	657	(0)	5	657	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 187,082	\$ 28,186	\$ 28,186	\$ 0		\$ 99,879	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	Transportation	1994 Ford Wagon	1994	\$ 26,845	\$	\$	\$		\$ 26,845	42
43										43
44										44
45										45
46	TOTALS			\$ 26,845	\$	\$	\$		\$ 26,845	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)	\$ 410,185	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 62,764	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 62,764	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)	\$ 186,459	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.

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:	1963			\$			3
4	Additions	1967						4
5		1971	130	05/01/92	454,965	13	n/a	5
6								6
7	TOTAL		130		\$ 454,965			7

10. Effective dates of current rental agreement:
 Beginning 04/01/1997
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/31/2001</u>	\$ <u>464,064</u>
13.	<u>12/31/2002</u>	\$ <u>442,400</u>
14.	_____	\$ _____

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 n/a n/a.

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: \$ n/a 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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39.3	hrs	\$	2,721	\$ 119,289	\$ 8,060	2,721	\$ 127,349	1				
2	Licensed Speech and Language Development Therapist	39.3	hrs		530	23,828	91	530	23,919	2				
3	Licensed Recreational Therapist	39.3	hrs		2,542	91,044	2,585	2,542	93,629	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			\$	5,792	\$ 234,161	\$ 10,736	5,792	\$ 244,897	14				

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

Facility Name & ID Number Highland Health Care Center

0042853

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	\$ 211,047	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 225,409)	(64,318)		3
4 Supply Inventory (priced at)	56,331		4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	711		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):	1,509,001		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,712,772	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cost	196,258		15
16 Equipment, at Historical Cost	213,927		16
17 Accumulated Depreciation (book methods)	(186,458)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	316,055		19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): Deposits & CIP	50,389		23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 590,171	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,302,943	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 51,484	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	27,852		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 Intercompany	2,161,704		36
37 Deposits Res Care	21,340		37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,262,380	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	658,000		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)	\$ 658,000	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,920,380	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ (617,437)	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,302,943	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (653,545)	1
2	Restatements (describe):		2
3	Prior Period Adjustment		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (653,545)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	36,105	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)	\$ 36,105	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22	Rounding	3	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 3	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (617,437)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Highland Health Care Center

0042853

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	\$ 5,554,564	1
2	Discounts and Allowances for all Levels	(1,666,461)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,888,103	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	667,450	6
7	Oxygen	1,690	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 669,140	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	1,768	13
14	Non-Patient Meals	94	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	173,337	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	90,372	19
20	Radiology and X-Ray	57,257	20
21	Other Medical Services	121,786	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 444,614	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	83	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 83	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		(16,439)	28
28a		11,126	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (5,313)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,996,627	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	863,254	31
32	Health Care	1,948,270	32
33	General Administration	961,001	33
B. Capital Expense			
34	Ownership	656,203	34
C. Ancillary Expense			
35	Special Cost Centers	461,184	35
36	Provider Participation Fee	70,604	36
D. Other Expenses (specify):			
37	Rounding Variance	6	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,960,522	40
41	Income before Income Taxes (line 30 minus line 40)**	36,105	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 36,105	43

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

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

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

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

Facility Name & ID Number Highland Health Care Center

0042853

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

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	3,630	3,702	\$ 95,927	\$ 25.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,815	26,997	595,427	22.06	3
4	Licensed Practical Nurses	17,209	17,209	253,165	14.71	4
5	Nurse Aides & Orderlies	78,736	78,736	783,198	9.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,825	1,825	21,400	11.73	9
10	Activity Assistants	3,678	3,837	41,312	10.77	10
11	Social Service Workers	1,825	1,858	27,858	14.99	11
12	Dietician					12
13	Food Service Supervisor	275	275	3,514	12.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,105	28,472	229,418	8.06	15
16	Dishwashers					16
17	Maintenance Workers	3,717	3,842	55,195	14.37	17
18	Housekeepers	12,561	12,768	102,217	8.01	18
19	Laundry	10,379	10,445	91,657	8.78	19
20	Administrator	1,741	1,741	61,861	35.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,871	1,871	34,014	18.18	23
24	Clerical	7,824	8,013	99,820	12.46	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	1,493	1,536	16,174	10.53	31
32	Other Health Care(specify)	1,909	1,948	21,810	11.20	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	201,593	205,075	\$ 2,533,967 *	\$ 12.36	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	428	\$ 7,487	1.3	35
36	Medical Director	80	12,000	9.3	36
37	Medical Records Consultant	77	1,920	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	146	2,910	17.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	97	1,752	11.3	44
45	Social Service Consultant	235	4,696	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,063	\$ 30,765		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	0	\$		50
51	Licensed Practical Nurses	0			51
52	Nurse Aides	0			52
53	TOTAL (lines 50 - 52)		\$		53

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Karole Reed	Administrator	0	\$ 61,664	Workers' Compensation Insurance	\$ 36,925	IDPH License Fee	\$	
				Unemployment Compensation Insurance	45,310	Advertising: Employee Recruitment		
				FICA Taxes	187,453	Health Care Worker Background Check		
				Employee Health Insurance	96,207	(Indicate # of checks performed _____)		
				Employee Meals		Public Relations	2,254	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising - Informational	2,608	
				Other Benefits	5,784	Advertising - Marketing	493	
				Group Life	3,062	Dues and Subscriptions	6,120	
				401 K Contribution	6,643	Publications and Manuals	295	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 61,664			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount	Emp Physical	963	Yellow page advertising	()	
Management Fee			\$ 199,548					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 199,548	TOTAL (agree to Schedule V, line 22, col.8)		\$ 382,347	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,770
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Pharmacy Consultant	Pharm Consulting		\$ 3,120			\$	Out-of-State Travel	\$
Various	Legal Fees		237				Airfare and Lodging	2,009
Various Vendors	A & G Purchased Serv		6,300				In-State Travel	
							Gas/Oils, Auto, Mileage	6,020
							Meals and Others	732
							Seminar Expense	912
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 9,657	TOTAL		\$	Entertainment Expense	(44)
							(agree to Sch. V, line 24, col. 8)	\$ 9,628

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Highland Health Care Center# 0042853Report Period Beginning: 01/01/2000Ending: 12/31/2000**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,683 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. n/a
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 70,604
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? n/a Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? yes
If YES, attach a complete explanation. CEO and DON travel to corporate office
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. audit not specific to facility
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.