

		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>0037929</u></p> <p>Facility Name: <u>LAKWOOD CENTER</u></p> <p>Address: <u>1112 NORTH EASTERN AVENUE</u> <u>PLAINFIELD</u> <u>60544</u> <small>Number City Zip Code</small></p> <p>County: <u>WILL</u></p> <p>Telephone Number: <u>(815) 436-3400</u> Fax # <u>(815) 436-1357</u></p> <p>IDPA ID Number: <u>22-3152459001</u></p> <p>Date of Initial License for Current Owners: <u>5/1/92</u></p> <p>Type of Ownership:</p> <table border="0"> <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 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>SKANDER NASSER, III</u> Telephone Number: <u>(317) 237-5500</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 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>1/1/00</u> to <u>12/31/00</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="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date)</td> </tr> <tr> <td></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) <u>DEBBIE MCLARTY</u></td> </tr> <tr> <td></td> <td data-bbox="1291 803 1950 868">(Title) <u>VP OF REIMBURSEMENT</u></td> </tr> <tr> <td data-bbox="1155 868 1291 1031">Paid Preparer</td> <td data-bbox="1291 868 1950 933">(Signed) _____ (Date)</td> </tr> <tr> <td></td> <td data-bbox="1291 933 1950 998">(Print Name and Title) <u>SKANDER NASSER, III - PARTNER</u></td> </tr> <tr> <td></td> <td data-bbox="1291 998 1950 1063">(Firm Name & Address) <u>BRADLEY & ASSOCIATES, 201 S. CAPITOL, SUITE 910 INDIANAPOLIS, IN 46225</u></td> </tr> <tr> <td></td> <td data-bbox="1291 1063 1950 1123">(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u></td> </tr> </table> <p align="right">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>DEBBIE MCLARTY</u>		(Title) <u>VP OF REIMBURSEMENT</u>	Paid Preparer	(Signed) _____ (Date)		(Print Name and Title) <u>SKANDER NASSER, III - PARTNER</u>		(Firm Name & Address) <u>BRADLEY & ASSOCIATES, 201 S. CAPITOL, SUITE 910 INDIANAPOLIS, IN 46225</u>		(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>
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SEE ACCOUNTANT'S COMPILATION REPORT

Facility Name & ID Number LAKEWOOD CENTER

0037929 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 4/1/00 & 10/1/00

	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>4</u>	Skilled (SNF)	<u>15</u>	<u>3,208</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>46</u>	Intermediate (ICF)	<u>78</u>	<u>30,830</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>50</u>	TOTALS	<u>93</u>	<u>34,038</u>	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Public Aid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF	<u>35</u>	<u>88</u>	
9	SNF/PED					9
10	ICF	<u>8,184</u>	<u>15,995</u>	<u>256</u>	<u>24,435</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,219</u>	<u>16,083</u>	<u>2,788</u>	<u>27,090</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.59%

D. How many bed-hold days during this year were paid by Public Aid? 41 (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 5/1/92

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/1/92 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 15 and days of care provided 2,393

Medicare Intermediary RIVERBEND GOVERNMENT BENEFITS ADMINISTRATOR

IV. ACCOUNTING BASIS

ACCRUAL 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.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

LAKEWOOD CENTER

0037929

Report Period Beginning:

1/1/00

Ending:

12/31/00

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	184,318	14,004	34,490	232,812		232,812	(3,002)	229,810		1
2	Food Purchase		99,606		99,606		99,606	(2,719)	96,887		2
3	Housekeeping	59,746	9,953		69,699		69,699	72,735	142,434		3
4	Laundry	4,045	11,537	17,296	32,878		32,878	(15,629)	17,249		4
5	Heat and Other Utilities			112,267	112,267		112,267		112,267		5
6	Maintenance	34,453	15,979	43,881	94,313		94,313		94,313		6
7	Other (specify):*										7
8	TOTAL General Services	282,562	151,079	207,934	641,575		641,575	51,385	692,960		8
B. Health Care and Programs											
9	Medical Director			2,600	2,600		2,600		2,600		9
10	Nursing and Medical Records	1,060,336	51,792	239,764	1,351,892	(2,795)	1,349,097	(2,227)	1,346,870		10
10a	Therapy		2,784	208,585	211,369		211,369	(6,286)	205,083		10a
11	Activities	33,596	5,280	511	39,387		39,387		39,387		11
12	Social Services	43,383	140		43,523		43,523		43,523		12
13	Nurse Aide Training										13
14	Program Transportation					1,904	1,904		1,904		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,137,315	59,996	451,460	1,648,771	(891)	1,647,880	(8,513)	1,639,367		16
C. General Administration											
17	Administrative	92,571			92,571	(21,666)	70,905	285,525	356,430		17
18	Directors Fees										18
19	Professional Services			4,895	4,895		4,895	(3,000)	1,895		19
20	Dues, Fees, Subscriptions & Promotions			1,771	1,771	2,795	4,566	(422)	4,144		20
21	Clerical & General Office Expenses	48,683	10,510	35,569	94,762	21,666	116,428		116,428		21
22	Employee Benefits & Payroll Taxes			284,669	284,669		284,669		284,669		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,292	12,292	(1,904)	10,388		10,388		24
25	Other Admin. Staff Transportation			1,364	1,364		1,364		1,364		25
26	Insurance-Prop.Liab.Malpractice			12,471	12,471		12,471		12,471		26
27	Other (specify):* MISC EXPENSE			45,385	45,385		45,385	(43,602)	1,783		27
28	TOTAL General Administration	141,254	10,510	398,416	550,180	891	551,071	238,501	789,572		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,561,131	221,585	1,057,810	2,840,526		2,840,526	281,373	3,121,899		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

LAKEWOOD CENTER

#0037929

Report Period Beginning:

1/1/00

Ending:

12/31/00

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			25,433	25,433		25,433	35,432	60,865			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			15,708	15,708		15,708	32,870	48,578			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,107	16,107		16,107		16,107			35
36	Other (specify):*											36
37	TOTAL Ownership			57,248	57,248		57,248	68,302	125,550			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			155,361	155,361		155,361	(4,901)	150,460			39
40	Barber and Beauty Shops			16,372	16,372		16,372		16,372			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,891	63,891		63,891		63,891			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			235,624	235,624		235,624	(4,901)	230,723			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,561,131	221,585	1,350,682	3,133,398		3,133,398	344,774	3,478,172			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(2,128)	2		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	(15,629)	4		8
9	Non-Straightline Depreciation	20,154	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(591)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,905)	27		24
25	Fund Raising, Advertising and Promotional	(5,697)	27		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 See page 5a	29,448			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,348)		\$	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)	357,122		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 357,122		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 344,774		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0037929
Report Period Beginning: 1/1/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
			Reference
1	PROPERTY TAX ADJUSTMENT	\$ 21,870	13 1
2	NON ALLOWABLE LEGAL FEES	(3,000)	19 2
3	PAC DUES	(422)	20 3
4			4
5			5
6			6
7			7
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85			85
86			86
87			87
88			88
89			89
90	Total	29,448	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEWOOD CENTER

0037929

Report Period Beginning:

1/1/00

Ending:

12/31/00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(3,002)	0	0	0	0	0	0	0	0	0	(3,002)	1
2	Food Purchase	(2,719)	0	0	0	0	0	0	0	0	0	0	(2,719)	2
3	Housekeeping	0	72,735	0	0	0	0	0	0	0	0	0	72,735	3
4	Laundry	(15,629)	0	0	0	0	0	0	0	0	0	0	(15,629)	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	(18,348)	69,733	0	51,385	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	(2,227)	0	0	0	0	0	0	0	0	0	(2,227)	10
10a	Therapy	0	(6,286)	0	0	0	0	0	0	0	0	0	(6,286)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(8,513)	0	(8,513)	16								
	C. General Administration													
17	Administrative	0	285,525	0	0	0	0	0	0	0	0	0	285,525	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,000)	0	0	0	0	0	0	0	0	0	0	(3,000)	19
20	Fees, Subscriptions & Promotions	(422)	0	0	0	0	0	0	0	0	0	0	(422)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(43,602)	0	0	0	0	0	0	0	0	0	0	(43,602)	27
28	TOTAL General Administration	(47,024)	285,525	0	238,501	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(65,372)	346,745	0	281,373	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKWOOD CENTER

0037929

Report Period Beginning:

1/1/00

Ending:

12/31/00

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	20,154	15,278	0	0	0	0	0	0	0	0	0	35,432	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	32,870	0	0	0	0	0	0	0	0	0	0	32,870	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	53,024	15,278	0	68,302	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	(4,901)	0	0	0	0	0	0	0	0	0	(4,901)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	(4,901)	0	(4,901)	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(12,348)	357,122	0	344,774	45								

Facility Name & ID Number LAKWOOD CENTER

0037929

Report Period Beginning: 1/1/00

Ending: 12/31/00

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
GENESIS HEALTH VENTURES	100	SEE ATTACHED LIST		LWR, Inc.	Hackensack, NJ	Property Owner
				Neighborcare	Willowbrook, NJ	Pharmacy
				Genesis Rehab	Kennett Square, PA	Therapy
				Genesis Hospitality	Kennett Square, PA	Dietary

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	30 Depreciation	\$	LWR, Inc.		\$ 15,278	\$	15,278	1
2	V	3 Interest		LWR, Inc.		72,735		72,735	2
3	V	17 Administrative		Genesis Health Ventures	100.00%	285,525		285,525	3
4	V	10 Related Party Markup	2,227	Neighborcare				(2,227)	4
5	V	10A Related Party Markup	42	Neighborcare				(42)	5
6	V	39 Related Party Markup	4,901	Neighborcare				(4,901)	6
7	V	10A Related Party Markup	6,244	Genesis Rehab				(6,244)	7
8	V	1 Related Party Markup	3,002	Genesis Hospitality				(3,002)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 16,416			\$ 373,538	\$ *	357,122	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKWOOD CENTER # 0037929 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Facility is owned by a public company								\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKEWOOD CENTER # 0037929 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Genesis Health Ventures, Inc.
 Street Address 101 E. State Street
 City / State / Zip Code Kennett Square, PA 19348
 Phone Number (610) 925-4076
 Fax Number ()

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	58	\$ 19,764,727	\$		\$ 285,525	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				\$ 19,764,727	\$		\$ 285,525	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **LAKWOOD CENTER**# **0037929**

Report Period Beginning:

1/1/00

Ending:

12/31/00**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			
						Original	Balance							
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												
A. Directly Facility Related														
Long-Term														
1	Mellon Bank Revolving Credit		x			\$	722,651	\$	476,302		0.0850	\$	62,341	1
2	Mellon Bank Revolving Credit		x				103,269		103,269		0.0850		10,394	2
3														3
4														4
5														5
Working Capital														
6														6
7														7
8														8
9	TOTAL Facility Related					\$	825,920	\$	579,571			\$	72,735	9
B. Non-Facility Related*														
10														10
11														11
12														12
13														13
14	TOTAL Non-Facility Related					\$		\$				\$		14
15	TOTALS (line 9+line14)					\$	825,920	\$	579,571			\$	72,735	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **LAKEWOOD CENTER**

0037929 Report Period Beginning: **1/1/00** Ending: **12/31/00**

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	1,085	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.)	\$	49,663	2
3. Under or (over) accrual (line 2 minus line 1).	\$	48,578	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	48,578	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	13,590	8
	1996	13,408	9
	1997	13,730	10
	1998	13,481	11
	1999	49,663	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.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,925 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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 ground: (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	Facility	273,121	1992	\$ 20,000	1
2					2
3	TOTALS	273,121		\$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKEWOOD CENTER# 0037929

Report Period Beginning:

1/1/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	50		1992	1971	\$ 500,000	\$	30	\$ 15,278	\$ 15,278	\$ 145,834	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Leasehold Improvements	1993		27,756	780	20	1,391	611	10,103	9
10		Leasehold Improvements	1994		88,634	2,493	20	4,432	1,939	28,806	10
11		Leasehold Improvements	1995		6,745	181	20	321	140	1,778	11
12		Security & Communications	1997		1,515	40	20	68	28	273	12
13		Fire Protection	1997		1,775	44	20	80	36	288	13
14		Plumbing & Heating	1997		725	18	20	33	15	119	14
15		Painting Services	1997		1,550	23	35	40	17	123	15
16		Kitchen Exhaust Repairs	1998		1,018	24	35	24		72	16
17		Plumbing & Heating	1999		725	21	35	21		42	17
18		Conduit & Wiring for Sanitizer	1999		918	26	35	26		52	18
19		Annual Test on Generator	1999		1,430	41	35	41		82	19
20		Generator Pad Replacement	1999		3,688	105	35	105		210	20
21		Dampers	1999		542	15	35	15		30	21
22		Smoke Detector Panels	1999		961	27	35	27		54	22
23		Stripper & Floor Finish	1999		798	23	35	23		46	23
24		Fix Phone Line	1999		338	10	35	10		20	24
25		Service alarm system	1999		468	13	35	13		26	25
26		Electric	1999		663	19	35	19		38	26
27		Install Conduit & Wiring for outlets	1999		1,316	38	35	38		76	27
28		Concrete sealer	1999		922	26	35	26		52	28
29		Fire sprinkler inspection	1999		430	12	35	12		24	29
30		Exit alarms	1999		521	15	35	15		30	30
31		Picket fence	2000		1,328	38	35	38		38	31
32		New wing	2000		9,624	275	35	275		275	32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 654,390	\$ 4,307		\$ 22,371	\$ 18,064	\$ 188,491	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 224,114	\$ 18,679	\$ 33,789	\$ 15,110	5-7	\$ 227,172	37
38	Current Year Purchases	32,932	4,705	4,705		7	4,705	38
39	Fully Depreciated Assets	76,982						39
40								40
41	TOTALS	\$ 334,028	\$ 23,384	\$ 38,494	\$ 15,110		\$ 231,877	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,008,418	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 27,691	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 60,865	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 33,174	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 420,368	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized
 by the length of the lease _____

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

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

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

16. Rental Amount for movable equipment: \$ 11,199 Description: Nrsg \$7,254, Maint \$259, Dietary \$1500, Laundry \$209, Admin \$1977

(Attach a schedule detailing the breakdown of movable equipment)

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

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

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____
 13. _____/2002 \$ _____
 14. _____/2003 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	1999 Plymouth Voyager	\$ 409.00	\$ 4,908	17
18					18
19					19
20					20
21	TOTAL		\$ 409.00	\$ 4,908	21

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><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)	\$			

- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist	10a, 2 & 3	hrs	\$	1,698	\$	93,404	\$	555	1,698	\$	93,959	1	
2	Licensed Speech and Language Development Therapist	10a, 2 & 3	hrs		225		12,372		112	225		12,484	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10a, 2 & 3	hrs		1,857		102,158		2,117	1,857		104,275	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39, 3	# of prescripts						90,098			90,098	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			\$	3,780	\$	207,934	\$	92,882	3,780	\$	300,816	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number LAKEWOOD CENTER

0037929

Report Period Beginning: 1/1/00

Ending:

12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(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	\$ 61,983	\$ 61,983	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	419,744	419,744	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,802	3,802	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 485,529	\$ 485,529	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,000	13
14	Buildings, at Historical Cost		500,000	14
15	Leasehold Improvements, at Historical Cost	159,411	159,411	15
16	Equipment, at Historical Cost	344,631	344,631	16
17	Accumulated Depreciation (book methods)	(244,927)	(392,149)	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): other assets	62,578	62,578	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 321,693	\$ 694,471	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 807,222	\$ 1,180,000	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 231,322	\$ 231,322	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,075	91,075	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,341	25,341	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	other liab	89,247	89,247	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 436,985	\$ 436,985	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		476,302	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	due to related party	(2,218,507)	(2,218,507)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (2,218,507)	\$ (1,742,205)	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (1,781,522)	\$ (1,305,220)	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,588,744	\$ 2,485,220	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 807,222	\$ 1,180,000	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,857,411	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,857,411	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	731,333	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)	\$ 731,333	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,588,744	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number LAKEWOOD CENTER

0037929

Report Period Beginning: 1/1/00

Ending:

Page 19
12/31/00

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	\$ 3,355,133	1
2	Discounts and Allowances for all Levels	141,139	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,496,272	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	149,484	6
7	Oxygen	4	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 149,488	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	19,296	13
14	Non-Patient Meals	2,128	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	37,264	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	468	19
20	Radiology and X-Ray	38,798	20
21	Other Medical Services	105,869	21
22	Laundry	15,630	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 219,453	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	20	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Dental svcs	(502)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (502)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,864,731	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	641,575	31
32	Health Care	1,648,771	32
33	General Administration	550,180	33
B. Capital Expense			
34	Ownership	57,248	34
C. Ancillary Expense			
35	Special Cost Centers	171,733	35
36	Provider Participation Fee	63,891	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,133,398	40
41	Income before Income Taxes (line 30 minus line 40)**	731,333	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 731,333	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **LAKWOOD CENTER**

0037929

Report Period Beginning: **1/1/00**

Ending:

12/31/00

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	1,131	1,191	\$ 31,269	\$ 26.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	73,910	77,800	1,029,067	13.23	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,945	3,249	33,596	10.34	10
11	Social Service Workers	2,886	3,127	43,383	13.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,499	18,463	184,318	9.98	15
16	Dishwashers					16
17	Maintenance Workers	2,783	3,093	34,453	11.14	17
18	Housekeepers	6,300	7,147	59,746	8.36	18
19	Laundry	467	519	4,045	7.79	19
20	Administrator	2,146	2,325	70,905	30.50	20
21	Assistant Administrator					21
22	Other Administrative	5,252	5,691	70,349	12.36	22
23	Office Manager					23
24	Clerical					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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,319	122,605	\$ 1,561,131 *	\$ 12.73	34

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director			36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	per bed charge	4,263	10, 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			44	
45	Social Service Consultant			45	
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	\$	4,263	49	

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kathy Dychouse	Administrator	0	\$ 70,905	Workers' Compensation Insurance	\$ 56,909	IDPH License Fee	\$	
				Unemployment Compensation Insurance	26,334	Advertising: Employee Recruitment		
				FICA Taxes	115,652	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	61,906	IL Hlth Care Assoc	3,125	
				Employee Meals		Other Misc	1,019	
				Illinois Municipal Retirement Fund (IMRF)*				
				Other misc	12,880			
				Recruiting	5,974			
				Retirement	5,014			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,905	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,144		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	8,539
							Detail to be forwarded by provider under separate cover	
							Seminar Expense	1,849
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
C. Professional Services							TOTAL	
Vendor/Payee	Type	Amount					\$ 10,388	
Various	Accounting	\$ 1,895						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 1,895					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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? YES
If YES, give association name and amount. IL Hlth Care Assoc \$3125
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,582 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES 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. \$ 63,891
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.
- SEE ACCOUNTANTS' COMPILATION REPORT**
- (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 benefit: on Schedule V. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,128
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? NA
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG Peat Marwick The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. NOT YET AVAILABLE
- (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? NA
Attach invoices and a summary of services for all architect and appraisal fees.