

Facility Name & ID Number ST VINCENTS HOME

0036723 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	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	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other		Total
8	SNF	15,822	1,779	1,348	18,949	8
9	SNF/PED					9
10	ICF		9,717		9,717	10
11	ICF/DD	1,737			1,737	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,559	11,496	1,348	30,403	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.91%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 11/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/90 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 6 and days of care provided 1,348

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 2000 Fiscal Year: _____

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

STATE OF ILLINOIS

Facility Name & ID Number ST VINCENTS HOME # 0036723 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				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	142,594	12,206	4,002	158,802		158,802		158,802		1
2	Food Purchase		146,568		146,568		146,568	(6,097)	140,471		2
3	Housekeeping	69,438	10,065		79,503		79,503		79,503		3
4	Laundry	57,576	17,391		74,967		74,967		74,967		4
5	Heat and Other Utilities			78,754	78,754		78,754		78,754		5
6	Maintenance	76,567	22,193	32,636	131,396		131,396	(6,000)	125,396		6
7	Other (specify):*										7
8	TOTAL General Services	346,175	208,423	115,392	669,990		669,990	(12,097)	657,893		8
	B. Health Care and Programs										
9	Medical Director			12,164	12,164		12,164		12,164		9
10	Nursing and Medical Records	932,355	67,767	987	1,001,109		1,001,109	(4,300)	996,809		10
10a	Therapy	31,902	8,943	49,565	90,410		90,410		90,410		10a
11	Activities	29,488	1,013	17,228	47,729		47,729		47,729		11
12	Social Services	39,869	893	1,592	42,354		42,354		42,354		12
13	Nurse Aide Training										13
14	Program Transportation		4,150		4,150		4,150	(178)	3,972		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,033,614	82,766	81,536	1,197,916		1,197,916	(4,478)	1,193,438		16
	C. General Administration										
17	Administrative	39,083			39,083		39,083		39,083		17
18	Directors Fees										18
19	Professional Services			268,090	268,090		268,090	(262,806)	5,284		19
20	Dues, Fees, Subscriptions & Promotions			33,503	33,503		33,503	(21,900)	11,603		20
21	Clerical & General Office Expenses	43,493	13,528	17,090	74,111		74,111		74,111		21
22	Employee Benefits & Payroll Taxes			151,327	151,327		151,327		151,327		22
23	Inservice Training & Education			1,132	1,132		1,132		1,132		23
24	Travel and Seminar			6,438	6,438		6,438		6,438		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			11,484	11,484		11,484		11,484		26
27	Other (specify):*										27
28	TOTAL General Administration	82,576	13,528	489,064	585,168		585,168	(284,706)	300,462		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,462,365	304,717	685,992	2,453,074		2,453,074	(301,281)	2,151,793		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

ST VINCENTS HOME

#0036723

Report Period Beginning:

01/01/00

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			129,663	129,663		129,663	2,174	131,837		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			176,367	176,367		176,367	(139)	176,228		32
33	Real Estate Taxes			36,985	36,985		36,985		36,985		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			1,210	1,210		1,210		1,210		35
36	Other (specify):* BAD DEBTS			12,013	12,013		12,013	(12,013)			36
37	TOTAL Ownership			356,238	356,238		356,238	(9,978)	346,260		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation		4,150		4,150		4,150		4,150		38
39	Ancillary Service Centers			2,716	2,716		2,716		2,716		39
40	Barber and Beauty Shops	938	307	6,223	7,468		7,468		7,468		40
41	Coffee and Gift Shops		3,311		3,311		3,311		3,311		41
42	Provider Participation Fee			54,727	54,727		54,727		54,727		42
43	Other (specify):* PENALTY			2,507	2,507		2,507	(2,507)			43
44	TOTAL Special Cost Centers	938	7,768	66,173	74,879		74,879	(2,507)	72,372		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,463,303	312,485	1,108,403	2,884,191		2,884,191	(313,766)	2,570,425		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 ST VINCENTS HOME

0036723

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,079)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(4,300)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(143)	32		10
11	Discounts, Allowances, Rebates & Refunds	(18)	2		11
12	Non-Working Officer's or Owner's Salary	(262,806)	19		12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(178)	14		16
17	Non-Care Related Fees	(6,000)	6		17
18	Fines and Penalties	(2,507)	43		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	(12,013)	36		24
25	Fund Raising, Advertising and Promotional	(21,900)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (315,944)		\$	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)	2,178		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,178		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (313,766)		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

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 Report Period Beginning: 01/01/00
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1			1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
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26			26
27			27
28			28
29			29
30			30
31			31
32			32
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35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			49
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51			51
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67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
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		0	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST VINCENTS HOME

0036723 Report Period Beginning:

01/01/00

Ending:

12/31/00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,097)	0	0	0	0	0	0	0	0	0	0	(6,097)	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	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,097)	0	0	0	0	0	0	0	0	0	0	(12,097)	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	(4,300)	0	0	0	0	0	0	0	0	0	0	(4,300)	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	(178)	0	0	0	0	0	0	0	0	0	0	(178)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,478)	0	0	0	0	0	0	0	0	0	0	(4,478)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(262,806)	0	0	0	0	0	0	0	0	0	0	(262,806)	19
20	Fees, Subscriptions & Promotions	(21,900)	0	0	0	0	0	0	0	0	0	0	(21,900)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(284,706)	0	0	0	0	0	0	0	0	0	0	(284,706)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(301,281)	0	0	0	0	0	0	0	0	0	0	(301,281)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST VINCENTS HOME# 0036723 Report Period Beginning:01/01/00 Ending:12/31/00

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	2,174	0	0	0	0	0	0	0	0	0	2,174 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(143)	4	0	0	0	0	0	0	0	0	0	(139) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	(12,013)	0	0	0	0	0	0	0	0	0	0	(12,013) 36
37	TOTAL Ownership	(12,156)	2,178	0	(9,978) 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(2,507)	0	0	0	0	0	0	0	0	0	0	(2,507) 43
44	TOTAL Special Cost Centers	(2,507)	0	0	0	0	0	0	0	0	0	0	(2,507) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(315,944)	2,178	0	(313,766) 45								

Facility Name & ID Number ST VINCENTS HOME

0036723

Report Period Beginning: 01/01/00

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
CARLYLE HEALTHCARE INC	100	CARLYLE HEALTHCARE INC	CARLYLE	WDM HEALTHCARE	QUINCY	LEASING
		CLINTON MANOR	NEW BADEN			

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	30 DEPRECIATION	\$	WDM HEALTHCARE/LEASING		\$ 2,174	\$	2,174
2	V	32 INTEREST		CAPITALIZED LEASES		4		4
3	V							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		\$			\$ 2,178	\$ *	2,178

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

Facility Name & ID Number ST VINCENTS HOME # 0036723 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	DOROTHY MESSICK	PRESIDENT	ST VINCENTS			20	50.00		\$ 0	1
2	ANN REIS	SECRETARY	ST VINCENTS			19	48.00		0	2
3	SUE GRAY	TREAS	ST VINCENTS			20	50.00		0	3
4	DOROTHY MESSICK	PRESIDENT	CARLYLE	51.00	100,000	20	50.00			4
5	ANN REIS	SECRETARY	CARLYLE	24.00	28,000	19	48.00			5
6	SUE GRAY	TREAS	CARLYLE	24.00	28,000	20	50.00			6
7	CARLYLE HEALTHCARE	OWNS ST VINCENTS		100.00						7
8										8
9	ANN REIS		CLINTON MANO	25.00		2	4.00			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 ST VINCENTS HOME # 0036723 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	Purpose of Loan	4	Monthly Payment Required	5	Date of Note	6		7	8	Maturity Date	9	Interest Rate (4 Digits)	10	Reporting Period Interest Expense
			Related**								Original	Balance							
			YES	NO															
		A. Directly Facility Related																	
		Long-Term																	
1		FIRST BANKERS TRUST		X	MORTGAGE	\$27,847.00	04/01/99	\$ 3,500,000	\$ 3,352,124	04/01/2019	7.2500	\$ 175,321	1						
2													2						
3													3						
4													4						
5													5						
		Working Capital																	
6		FIRST BANKERS TRUST		X	HANDICAPE VAN LOAN	\$745.12	08/07/00	36,000	34,066	08/07/2005	8.7500	1,046	6						
7		CAPITALIZED LEASE	X		INTEREST							4	7						
8													8						
9		TOTAL Facility Related				\$28,592.12		\$ 3,536,000	\$ 3,386,190			\$ 176,371	9						
		B. Non-Facility Related*																	
10													10						
11		INVESTMENT INTEREST										(143)	11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$ (143)	14						
15		TOTALS (line 9+line14)						\$ 3,536,000	\$ 3,386,190			\$ 176,228	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 **ST VINCENTS HOME**# **0036723** Report Period Beginning: **01/01/00** 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.	\$	26,307	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.)	\$	36,985	2
3. Under or (over) accrual (line 2 minus line 1).	\$	10,678	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	26,306	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.	\$	36,984	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	31,308	8
	1996	28,645	9
	1997	29,025	10
	1998	33,197	11
	1999	36,984	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 ST VINCENTS HOME# 0036723 Report Period Beginning:01/01/00 Ending:12/31/00**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 38,103 B. General Construction Type: Exterior BRICK Frame STEEL/CONCRE Number of Stories 2C. 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).

10 DUPLUXES OR 20 INDEPENDENT LIVIND UNITS-VILLA C THERINE1 COMMUNITY /ACTIVITY CENTER10 ASSISSITED LIVING UNITS-CASSITA CATHERINE ASSISSTED LIVINGNO EXPENSES ON SCHEDULE 5 AS THSE ARE SEPARATE DIVISIONSF. 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	<u>FACILITY</u>	<u>114,177</u>	<u>1990</u>	<u>\$ 61,500</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>114,177</u>		<u>\$ 61,500</u>	<u>3</u>

Facility Name & ID Number ST VINCENTS HOME

0036723

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	76		1990	1976	\$ 963,000	\$ 32,099	30	\$ 32,099		\$ 326,358	4
5	23		1998	1998	878,056	31,538	30	31,538		65,706	5
6											6
7											7
8											8
	Improvement Type**										
9	LAUNDRY RM		1999		68,109						9
10	GLASS ENCLOSER		1990		2,972	149	20	149		1,511	10
11	DINNING RM ADTN		1991		86,996	4,335	20	4,335		42,203	11
12	GARAGE		1991		35,000	2,333	15	2,333		22,558	12
13	LAND IMPVMTS		1991		13,130	1,298	10	1,298		12,698	13
14	CONCRETE DVWY LOT 1		1993		10,580	711	15	711		5,014	14
15	FIREWALL CONCRETE		1993		1,808	91	20	91		718	15
16	CONCRETE DVWY LOT 2		1997		83,961	5,598	15	5,598		18,358	16
17	NEW ROOF		1997		141,503	4,717	30	4,717		14,543	17
18	LANDSCAPING		1997		10,358	691	15	691		2,129	18
19	ROOFTOP A/C UNITS		1997		6,995	987	7	987		3,540	19
20	HANDRAILS		1998		11,165	744	15	744		2,233	20
21	WALKIN FREEZOR		1998		10,485	1,413	8	1,413		3,063	21
22	REMODELING/HALLWAY		1998		26,569	2,657	10	2,657		5,535	22
23	FIRE DAMPERS		1999		7,122	712	10	712		830	23
24	8 PATIENT RMS REMODELING		1999		11,018	735	15	735		796	24
25	LEVEL BUILDING		2000		74,150	2,471	20	2,471		2,471	25
26	DOOR CLOSERS,NEW VENTILATION,ELECTRICAL		2000		15,450	797	15	797		797	26
27	RAILING		2000		2,997	156	8	156		156	27
28	WATER HEATER		2000		4,851	606	8	606		606	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 2,466,275	\$ 94,838		\$ 94,838	\$	\$ 531,823	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 ST VINCENTS HOME

0036723

Report Period Beginning:

01/01/00

Ending:

12/31/00

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	\$ 510,533	\$ 26,734	\$ 28,908	\$ 2,174	8	\$ 381,958	37
38	Current Year Purchases	32,135	2,352	2,352		8	2,352	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 542,668	\$ 29,086	\$ 31,260	\$ 2,174		\$ 384,310	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	facility auto	1995 SUNDANCE	1997	\$ 4,733	\$	\$	\$	3	\$ 4,733	42
43	FACILITY TRUCK	1994GMCTRUCKPLOW	1999	12,000	2,400	2,400		5	3,000	43
44	FACILITY HANDI VAN	2000 CHEV VAN/LIFT	2000	40,067	3,339	3,339		5	3,339	44
45										45
46	TOTALS			\$ 56,800	\$ 5,739	\$ 5,739	\$		\$ 11,072	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)	\$ 3,127,243	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 129,663	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 131,837	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 2,174	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 927,205	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? YES NO
 If NO, see instructions.

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

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

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

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 1,210 Description: DISHWASHER

(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.

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)	\$			

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	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$								1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care	39-3	visits				2,716						2,716	5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescrpts											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			\$		\$	2,716	\$		\$		\$	2,716	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 ST VINCENTS HOME

0036723

Report Period Beginning: 01/01/00

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	\$ 185,516	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	291,635		3
4	Supply Inventory (priced at FIFO)	10,574		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,893		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 492,618	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	619,490		12
13	Land	380,171		13
14	Buildings, at Historical Cost	3,398,628		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	746,162		16
17	Accumulated Depreciation (book methods)	(1,239,173)		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 (spe CONST IN PRO	13,617		22
23	Other(specify): GOODWILL	46,126		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,965,021	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,457,639	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 70,925	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	178,306		29
30	Accrued Salaries Payable	83,406		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,498		32
33	Accrued Interest Payable	(28,822)		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 320,313	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,352,124		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED INCOME TRUSTS	621,345		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,973,469	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,293,782	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 163,857	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,457,639	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 108,748	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 108,748	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,005	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) VILLA CATHERINE COTTAGES	26,104	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 55,109	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)	\$ 163,857	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ST VINCENTS HOME

0036723

Report Period Beginning: 01/01/00

Ending:

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	\$ 2,684,428	1
2	Discounts and Allowances for all Levels	15,006	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,699,434	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	139,884	6
7	Oxygen	1,322	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 141,206	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	969	12
13	Barber and Beauty Care	8,617	13
14	Non-Patient Meals	6,079	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	4,300	18
19	Laboratory	42,744	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 62,709	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	143	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 143	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE ATTACHED LIST	15,754	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,754	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,919,246	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	669,990	31
32	Health Care	1,197,916	32
33	General Administration	585,168	33
B. Capital Expense			
34	Ownership	356,238	34
C. Ancillary Expense			
35	Special Cost Centers	20,152	35
36	Provider Participation Fee	54,727	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,884,191	40
41	Income before Income Taxes (line 30 minus line 40)**	35,055	41
42	Income Taxes	(6,050)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 29,005	43

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

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

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

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

Facility Name & ID Number ST VINCENTS HOME

0036723

Report Period Beginning: 01/01/00

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	2,088	\$ 38,495	\$ 18.44	1
2	Assistant Director of Nursing	490	9,883	17.34	2
3	Registered Nurses	7,455	125,830	16.09	3
4	Licensed Practical Nurses	25,613	313,708	11.65	4
5	Nurse Aides & Orderlies	53,317	444,439	7.90	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	2,026	31,902	15.23	8
9	Activity Director	2,040	16,008	7.67	9
10	Activity Assistants	2,138	13,480	6.06	10
11	Social Service Workers	3,930	39,869	9.64	11
12	Dietician				12
13	Food Service Supervisor	2,080	21,253	10.18	13
14	Head Cook				14
15	Cook Helpers/Assistants	8,232	70,305	8.33	15
16	Dishwashers	10,192	51,036	4.70	16
17	Maintenance Workers	8,225	76,567	8.97	17
18	Housekeepers	10,068	69,438	6.48	18
19	Laundry	7,938	57,576	6.87	19
20	Administrator	2,088	39,083	18.72	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	5,291	43,493	7.78	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) <u>B&B</u>	117	938	8.02	33
34	TOTAL (lines 1 - 33)	153,328	\$ 1,463,303 *	\$ 9.09	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	160	\$ 4,002	1-3	35
36	Medical Director		12,164	9-3	36
37	Medical Records Consultant	16	750	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	237	10-3	39
40	Physical Therapy Consultant	513	26,032	10a-3	40
41	Occupational Therapy Consultant	317	21,439	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	84	2,094	10a-3	43
44	Activity Consultant	16	1,592	11-3	44
45	Social Service Consultant	16	1,592	12-3	45
46	Other(specify)				46
47	<u>RELIGIOUS</u>		15,636	11-3	47
48					48
49	TOTAL (lines 35 - 48)	1,134	\$ 85,538		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)	\$ 0		53

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. ILL HEALTHCARE 4398
- (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? _____
- (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? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 173 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. \$ 54,727
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? YES Indicate the amount. \$ 3,567
- (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? 50
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? N
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? N
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.