

		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>0041418</u></p> <p>Facility Name: <u>The Abbey of Carbondale</u></p> <p>Address: <u>120 Tower Road</u> <u>Carbondale</u> <u>62901</u> Number City Zip Code</p> <p>County: <u>Jackson</u></p> <p>Telephone Number: <u>618-549-3355</u> Fax # ()</p> <p>IDPA ID Number: <u>36-4031855</u></p> <p>Date of Initial License for Current Owners: <u>07/01/95</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 type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mendel S. Schneider</u> Telephone Number: <u>847-675-9311</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said content 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 609 1312 771">Officer or Administrator of Provider</td> <td data-bbox="1312 609 1995 771">(Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td data-bbox="1155 771 1312 998">Paid Preparer</td> <td data-bbox="1312 771 1995 998">(Signed) <u>See Attached Accountant's Report</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Mendel S. Schneider & Associates, C.P.A., P.C.</u> <u>6600 Lincoln Ave., Suite 330, Lincolnwood, IL 60712</u> (Telephone) <u>847-675-9311</u> Fax # <u>847-675-9343</u></td> </tr> </table> <p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>See Attached Accountant's Report</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Mendel S. Schneider & Associates, C.P.A., P.C.</u> <u>6600 Lincoln Ave., Suite 330, Lincolnwood, IL 60712</u> (Telephone) <u>847-675-9311</u> Fax # <u>847-675-9343</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name & ID Number The Abbey of Carbondale

0041418 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	127	Skilled (SNF)	127	46,482	1
2	108	Skilled Pediatric (SNF/PED)	108	39,528	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	235	TOTALS	235	86,010	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	2,405	996	2,842	6,243	8
9	SNF/PED	12,196			12,196	9
10	ICF	21,643	8,960		30,603	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,244	9,956	2,842	49,042	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.02%

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 07/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/95 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 30 and days of care provided 2,842

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

The Abbey of Carbondale

0041418

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				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	137,371	14,248	7,600	159,219		159,219		159,219		1
2	Food Purchase		171,605		171,605	(5,500)	166,105	(250)	165,855		2
3	Housekeeping	146,008	35,426		181,434		181,434		181,434		3
4	Laundry	30,559	34,327		64,886		64,886		64,886		4
5	Heat and Other Utilities			164,367	164,367		164,367	1,836	166,203		5
6	Maintenance	44,140		60,083	104,223		104,223	2,914	107,137		6
7	Other (specify):*										7
8	TOTAL General Services	358,078	255,606	232,050	845,734	(5,500)	840,234	4,500	844,734		8
	B. Health Care and Programs										
9	Medical Director			19,170	19,170		19,170		19,170		9
10	Nursing and Medical Records	1,391,158	241,111	4,914	1,637,183		1,637,183		1,637,183		10
10a	Therapy	47,703		27,898	75,601		75,601		75,601		10a
11	Activities	34,082	4,395		38,477		38,477		38,477		11
12	Social Services	16,395		4,284	20,679		20,679		20,679		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,489,338	245,506	56,266	1,791,110		1,791,110		1,791,110		16
	C. General Administration										
17	Administrative	119,310			119,310		119,310	56,618	175,928		17
18	Directors Fees										18
19	Professional Services			345,051	345,051		345,051	(290,412)	54,639		19
20	Dues, Fees, Subscriptions & Promotions			28,013	28,013	10,337	38,350	(12,569)	25,781		20
21	Clerical & General Office Expenses	70,490	21,258	48,927	140,675		140,675	87,086	227,761		21
22	Employee Benefits & Payroll Taxes			363,857	363,857	(4,837)	359,020	20,571	379,591		22
23	Inservice Training & Education										23
24	Travel and Seminar			831	831		831		831		24
25	Other Admin. Staff Transportation			6,774	6,774		6,774	10,193	16,967		25
26	Insurance-Prop.Liab.Malpractice			61,846	61,846		61,846	3,077	64,923		26
27	Other (specify):*										27
28	TOTAL General Administration	189,800	21,258	855,299	1,066,357	5,500	1,071,857	(125,436)	946,421		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,037,216	522,370	1,143,615	3,703,201		3,703,201	(120,936)	3,582,265		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

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			32,537	32,537		32,537	137,814	170,351			30
31	Amortization of Pre-Op. & Org.			15,256	15,256		15,256	1,048	16,304			31
32	Interest			71,185	71,185		71,185	423,597	494,782			32
33	Real Estate Taxes							31,397	31,397			33
34	Rent-Facility & Grounds			671,000	671,000		671,000	(658,975)	12,025			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			789,978	789,978		789,978	(65,119)	724,859			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,920	71,920		71,920		71,920			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			71,920	71,920		71,920		71,920			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,037,216	522,370	2,005,513	4,565,099		4,565,099	(186,055)	4,379,044			45

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

The Abbey of Carbondale

ID# 0041418

Report Period Beginning: 01/01/00

Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
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87				87
88				88
89				89
90	Total		0	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Abbey of Carbondale# 0041418

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	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(250)	0	0	0	0	0	0	0	0	0	0	(250)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(250)	0	(250)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(12,569)	0	0	0	0	0	0	0	0	0	0	(12,569)	20
21	Clerical & General Office Expenses	(623)	0	0	0	0	0	0	0	0	0	0	(623)	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	(13,192)	0	(13,192)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,442)	0	(13,442)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Abbey of Carbondale# 0041418

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	(21,396)	125,885	0	0	0	0	0	0	0	0	0	104,489	30
31	Amortization of Pre-Op. & Org.	0	34,381	0	0	0	0	0	0	0	0	0	34,381	31
32	Interest	(5,179)	428,776	0	0	0	0	0	0	0	0	0	423,597	32
33	Real Estate Taxes	0	31,397	0	0	0	0	0	0	0	0	0	31,397	33
34	Rent-Facility & Grounds	0	(671,000)	0	0	0	0	0	0	0	0	0	(671,000)	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	(26,575)	(50,561)	0	(77,136)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(40,017)	(50,561)	0	0	0	0	0	0	0	0	0	(90,578)	45

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
See Attached Schedule		See Attached Schedule		Abbey, LLC.	Carbondale	Bldg. Rental
				ABS Mgmt.	Chicago	Management

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	34 Rent	\$ 671,000	Abbey of Carbondale, LLC.	100.00%	\$	\$ (671,000)	1
2	V	32 Interest		Abbey of Carbondale, LLC.		428,776	428,776	2
3	V	33 Real Estate Tax		Abbey of Carbondale, LLC.		31,397	31,397	3
4	V	30 Depreciation		Abbey of Carbondale, LLC.		125,885	125,885	4
5	V	31 Amortization		Abbey of Carbondale, LLC.		34,381	34,381	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		\$ 671,000			\$ 620,439	\$ * (50,561)	14

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sam Brandman		Administrative	9.00	29,514	7.5	15.00	ABS Salary	\$ 12,656	17-1	1
2	David Abell		Administrative	9.50	44,092	9	18.00	ABS Salary	18,908	17-1	2
3	Tamar Abell		Administrative	9.50	19,596	6.5	13.25	ABS Salary	8,404		3
4	Joseph Brandman		Administrative	19.00	38,825	7.5	15.00	ABS Salary	16,650		4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 56,618		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 The Abbey of Carbondale # 0041418 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 ABS Management
 Street Address 2711 W. Howard
 City / State / Zip Code Chicago, IL 60645
 Phone Number (773-338-4400
 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	17	Sam Brandman	783		\$ 42,170	\$ 42,170	235	12,656	1
2	17	David Abell	783		63,000	63,000	235	18,908	2
3	17	Tamar Abell	783		28,000	28,000	235	8,404	3
4	17	Joseph Brandman	783		55,475	55,475	235	16,650	4
5	21	Clerical	783		188,161	188,161	235	56,472	5
6	6	Repairs & Maintenance	783		9,709		235	2,914	6
7	34	Rent	783		40,065		235	12,025	7
8	22	Health & Welfare	783		34,572		235	10,376	8
9	26	Insurance	783		10,252		235	3,077	9
10	21	Office	783		104,052		235	31,229	10
11	19	Professional Fees	783		12,963		235	3,891	11
12	22	Payroll Taxes	783		33,968		235	10,195	12
13	5	Utilities	783		6,118		235	1,836	13
14	25	Auto & Travel	783		33,961		235	10,193	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 662,466	\$ 376,806		\$ 198,826	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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
A. Directly Facility Related												
Long-Term												
1	American National Bank		X	Mortgage	\$18,352.00	08/01/95	\$ 3,100,000	\$ 3,322,185	11/17/15	8.2500	\$ 241,988	1
2	American National Bank		X	Second Mortgage	\$26,514.00	09/01/97	2,450,000	2,102,917		8.4700	186,788	2
3	American National Bank		X	Working Capital		01/01/99	100,000	0		9.0000	8,185	3
4												4
5												5
Working Capital												
6	S Hakkian & G Mandelbaum	X		Working Capital		08/01/95	260,000	260,000		9.0000	22,500	6
7	Schneider Children & Solomon	X		Working Capital		08/01/95	200,000	200,000		9.0000	18,000	7
8	Wolfe, Brandman, Shabat	X		Working Capital		08/01/95	260,000	260,000		9.0000	22,500	8
9	TOTAL Facility Related				\$44,866.00		\$ 6,370,000	\$ 6,145,102			\$ 499,961	9
B. Non-Facility Related*												
10	Interest Income		X								(5,179)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			(5,179)	14
15	TOTALS (line 9+line14)						\$ 6,370,000	\$ 6,145,102			\$ 494,782	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 The Abbey of Carbondale

0041418

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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: 91,994 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 16,304 4. Dates Incurred: 07/01/95

Nature of Costs: Goodwill, Building Purchase

(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>1995</u>	<u>\$ 500,000</u>	1
2					2
3	TOTALS			\$ 500,000	3

Facility Name & ID Number The Abbey of Carbondale

0041418

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	235	1995		\$ 3,500,000	\$ 110,256	39	\$ 89,744	\$ (20,512)	\$ 435,899	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Engineering Evaluation & Study	1996		44,451	1,140	39	1,140		4,560	9
10	Painting & Decorating	1996		53,121	1,362	39	1,362		5,448	10
11	Roof Work	1996		52,008	1,334	39	1,334		5,336	11
12	Plumbing Repair	1996		55,427	1,421	39	1,421		5,684	12
13	Hot Water Heater	1996		5,847	150	39	150		600	13
14	HVAC Systems & Room Units	1996		77,612	1,990	39	1,990		7,960	14
15	Electrical Work	1996		62,356	1,599	39	1,599		6,396	15
16	Nurses Call System	1996		34,894	895	39	895		3,580	16
17	Security System, Sign & Telephone System	1996		8,788	225	39	225		900	17
18	Built in Cabinets	1996		28,280	725	39	725		2,900	18
19	Flooring	1996		33,593	861	39	861		3,444	19
20	Hand Rails	1996		12,770	327	39	327		1,308	20
21	Ceiling System	1996		36,565	938	39	938		3,752	21
22	Landscaping	1996		8,768	225	39	225		900	22
23	Paving	1996		11,490	295	39	295		1,180	23
24	Tuckpointing	1996		16,600	426	39	426		1,704	24
25	Windows & Glazing	1996		27,958	717	39	717		2,868	25
26	Wallpaper & PVL Covering	1996		24,423	626	39	626		2,504	26
27	Window Treatment	1996		7,529	193	39	193		772	27
28	Elevator Repair	1996		2,960	76	39	76		304	28
29	New Walls/Repair Existing Walls	1996		49,733	1,275	39	1,275		5,100	29
30	Sprinkler	1996		30,000	769	39	769		3,076	30
31	Hardware	1996		7,299	187	39	187		748	31
32	Supervision & General	1996		120,993	3,102	39	3,102		12,408	32
33	Redecorating	1996		291,706	7,821	39	7,821		30,943	33
34	Windows	1999		7,331	180	39	180		360	34
35	Roof Repair	2000		22,000	423	39	423		423	35
36	TOTAL (lines 4 thru 35)			\$ 4,634,502	\$ 139,538		\$ 119,026	\$ (20,512)	\$ 551,057	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

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	\$ 513,258	\$ 52,209	\$ 51,325	\$ (884)	10	\$ 252,186	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 513,258	\$ 52,209	\$ 51,325	\$ (884)		\$ 252,186	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)	\$ 5,647,760	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 191,747	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 170,351	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (21,396)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 803,243	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.

Facility Name & ID Number The Abbey of Carbondale

0041418

Report Period Beginning: 01/01/00

Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from ABS Management				12,025			5
6								6
7	TOTAL				\$ 12,025			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: \$ _____

Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

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

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

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

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

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

		1 2 3 4			
		Facility		Contract	Total
		Drop-outs	Completed		
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		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 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		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts									9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify):											13
14	TOTAL			\$		\$		\$		\$		14

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

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (127,104)	\$ (100,454)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	630,172	630,172	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,022	93,022	6
7	Other Prepaid Expenses	74,617	74,617	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Others</u>	231,943	239,943	9
TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$ 902,650	\$ 937,300	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		3,500,000	14
15	Leasehold Improvements, at Historical Cost	1,134,502	1,134,502	15
16	Equipment, at Historical Cost	13,258	513,258	16
17	Accumulated Depreciation (book methods)	(106,137)	(1,126,753)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	76,280	91,994	19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs	(66,053)	(71,731)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$ 1,051,850	\$ 4,541,270	24
TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$ 1,954,500	\$ 5,478,570	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 162,072	\$ 162,072	26
27	Officer's Accounts Payable		849,043	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	148,937	148,937	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	21,558	21,558	31
32	Accrued Real Estate Taxes(Sch.IX-B)		31,997	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to LLC.</u>	2,391,436		36
37				37
TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$ 2,724,003	\$ 1,213,607	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,425,102	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	\$ 5,425,102	45
TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$ 2,724,003	\$ 6,638,709	46
TOTAL EQUITY(page 18, line 24)				
47		\$ (769,503)	\$ (1,158,139)	47
TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$ 1,954,500	\$ 5,480,570	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (597,312)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (597,312)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(92,191)	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	(80,000)	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)	\$ (172,191)	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)	\$ (769,503)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Abbey of Carbondale# 0041418Report Period Beginning: 01/01/00Ending: 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	\$ 4,470,382 1
2	Discounts and Allowances for all Levels	() 2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,470,382 3
B. Ancillary Revenue		
4	Day Care	4
5	Other Care for Outpatients	5
6	Therapy	6
7	Oxygen	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8 8
C. Other Operating Revenue		
9	Payments for Education	9
10	Other Government Grants	10
11	Nurses Aide Training Reimbursements	11
12	Gift and Coffee Shop	12
13	Barber and Beauty Care	13
14	Non-Patient Meals	14
15	Telephone, Television and Radio	15
16	Rental of Facility Space	16
17	Sale of Drugs	17
18	Sale of Supplies to Non-Patients	18
19	Laboratory	19
20	Radiology and X-Ray	20
21	Other Medical Services	21
22	Laundry	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 23 23
D. Non-Operating Revenue		
24	Contributions	24
25	Interest and Other Investment Income***	2,526 25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,526 26
E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	27
28		28
28a		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29 29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,472,908 30

2		
	Expenses	Amount
A. Operating Expenses		
31	General Services	845,734 31
32	Health Care	1,791,110 32
33	General Administration	1,066,357 33
B. Capital Expense		
34	Ownership	789,978 34
C. Ancillary Expense		
35	Special Cost Centers	35 35
36	Provider Participation Fee	71,920 36
D. Other Expenses (specify):		
37		37
38		38
39		39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,565,099 40
41	Income before Income Taxes (line 30 minus line 40)**	(92,191) 41
42	Income Taxes	42 42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (92,191) 43

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

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

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

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

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	4,141	4,353	68,772	15.80	1
2	Assistant Director of Nursing	1,110	1,398	14,671	10.49	2
3	Registered Nurses	14,052	14,722	207,668	14.11	3
4	Licensed Practical Nurses	28,907	30,761	345,060	11.22	4
5	Nurse Aides & Orderlies	105,925	110,450	740,174	6.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,672	2,672	47,703	17.85	8
9	Activity Director	5,112	5,401	34,082	6.31	9
10	Activity Assistants					10
11	Social Service Workers	2,441	2,561	16,395	6.40	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,160	21,484	9.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,730	20,036	115,887	5.78	15
16	Dishwashers					16
17	Maintenance Workers	5,515	5,935	44,140	7.44	17
18	Housekeepers	24,164	25,167	146,008	5.80	18
19	Laundry	4,762	4,999	30,559	6.11	19
20	Administrator	6,240	6,448	119,310	18.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,998	8,502	70,490	8.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,855	1,952	14,813	7.59	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	235,704	247,517	2,037,216 *	8.23	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	155	7,600	1-3	35
36	Medical Director	192	19,170	9-3	36
37	Medical Records Consultant	65	1,944	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	85	2,970	10-3	39
40	Physical Therapy Consultant	465	27,898	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	96	4,284	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,058	63,866		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

A. Administrative Salaries	Function	Ownership %	Amount
Debby Dillon	Administrator	0	\$ 53,583
Tammy Heard	Administrator-Ped	0	39,250
Rena Brookshire	Administrator-Ped	0	26,477
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 119,310

B. Administrative - Other	Description	Amount
		\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$

C. Professional Services	Vendor/Payee	Type	Amount
	Mendel S. Schneider	Accounting	\$ 8,300
	Frost, Rутtenberg, Rothblatt	Accounting	18,064
	Bennbrook	Quality Assurance	2,074
	Personnel Planners	UC Consultant	1,365
	ABS Management	Home Office	294,303
	Systematic Mgmt	Medicare Cons	2,836
	Gardner & Carton	Medicare Cons	3,000
	Laner, Muchin, Dumbrow	Legal	9,630
	Sachnoff & Weaver	Legal	4,655
	Donald Brandon	Legal	824
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 345,051

D. Employee Benefits and Payroll Taxes	Description	Amount
	Workers' Compensation Insurance	\$ 116,423
	Unemployment Compensation Insurance	48,288
	FICA Taxes	187,378
	Employee Health Insurance	22,002
	Employee Meals	5,500
	Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 379,591

E. Schedule of Non-Cash Compensation Paid to Owners or Employees	Description	Line #	Amount
			\$
TOTAL			\$

F. Dues, Fees, Subscriptions and Promotions	Description	Amount
	IDPH License Fee	\$ 200
	Advertising: Employee Recruitment	10,337
	Health Care Worker Background Check (Indicate # of checks performed 140)	1,428
	Advertising	12,569
	ICLTC-Dues	5,451
	Il. Health Care-Dues	5,502
	UHC/Accu-Med	1,770
	Comm. Readers-Subs	449
	Misc Subs	644
	Less: Public Relations Expense	()
	Non-allowable advertising	(12,569)
	Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 25,781

G. Schedule of Travel and Seminar**	Description	Amount
	Out-of-State Travel	\$
	In-State Travel	
	Seminar Expense	
	Il Health Care	441
	Osha-guard	195
	St Anthony Publishing	195
	Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)		\$ 831

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Abbey of Carbondale

0041418

Report Period Beginning: 01/01/00

Ending: 12/31/00

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. ICLTC-5451/II Health Care-5502
- (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? 39
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,000 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.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 71,920
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. \$ 5,500 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A 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.