

		FOR OHF USE				

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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>0043489</u></p> <p>Facility Name: <u>ALDERWOOD HEALTH CARE CENTER</u></p> <p>Address: <u>746 WEST SPRING STREET</u> <u>SOUTH ELGIN</u> <u>60177</u> <small>Number City Zip Code</small></p> <p>County: <u>KANE</u></p> <p>Telephone Number: <u>(847) 697-0565</u> Fax # <u>(847) 697-0568</u></p> <p>IDPA ID Number: <u>830320180004</u></p> <p>Date of Initial License for Current Owners: <u>02/07/98</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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" 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>William H. Keys</u> Telephone Number: <u>(317) 208-2740</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 type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) <u>Larry Bonds</u></td> </tr> <tr> <td></td> <td data-bbox="1291 803 1950 868">(Title) <u>President</u></td> </tr> <tr> <td data-bbox="1155 868 1291 1031">Paid Preparer</td> <td data-bbox="1291 868 1950 933">(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td data-bbox="1291 933 1950 998">(Print Name and Title) _____</td> </tr> <tr> <td></td> <td data-bbox="1291 998 1950 1063">(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td data-bbox="1291 1063 1950 1123">(Telephone) _____ Fax # () _____</td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Larry Bonds</u>		(Title) <u>President</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Print Name and Title) _____																																						
	(Firm Name & Address) _____																																						
	(Telephone) _____ Fax # () _____																																						

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER

0043489 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

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	14	Skilled (SNF)	14	5,110	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	76	Intermediate (ICF)	76	27,740	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Public Aid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF	266	21	
9	SNF/PED	0	0	0		9
10	ICF	14,969	4,952	0	19,921	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	15,235	4,973	1,601	21,809	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.39%

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)
N/A - 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 02/07/98

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/07/98 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 14 and days of care provided 1,601

Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2001 Ending: 12/31/2001**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	95,078	6,973	15,859	117,910		117,910		117,910		1
2	Food Purchase		89,721		89,721		89,721		89,721		2
3	Housekeeping	88,138	6,675		94,813		94,813		94,813		3
4	Laundry	20,426	7,069		27,495		27,495		27,495		4
5	Heat and Other Utilities			33,228	33,228		33,228	53	33,281		5
6	Maintenance	16,882	4,994	26,822	48,698		48,698	144	48,842		6
7	Other (specify):* Waste Removal			8,054	8,054		8,054		8,054		7
8	TOTAL General Services	220,524	115,432	83,963	419,919		419,919	197	420,116		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	755,536	47,482	59,416	862,434		862,434		862,434		10
10a	Therapy		21,699	98,800	120,499		120,499	6	120,505		10a
11	Activities	44,064	557	2,346	46,967		46,967		46,967		11
12	Social Services	39,251		1,130	40,381		40,381		40,381		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	838,851	69,738	161,692	1,070,281		1,070,281	6	1,070,287		16
	C. General Administration										
17	Administrative	57,477			57,477		57,477		57,477		17
18	Directors Fees										18
19	Professional Services			69,635	69,635		69,635	107,701	177,336		19
20	Dues, Fees, Subscriptions & Promotions			17,024	17,024		17,024	397	17,421		20
21	Clerical & General Office Expenses	51,578	44,314	166,149	262,041		262,041	37,191	299,232		21
22	Employee Benefits & Payroll Taxes			206,112	206,112		206,112	7	206,119		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,051	13,051		13,051	4,331	17,382		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			72,611	72,611		72,611	45,186	117,797		26
27	Other (specify):*										27
28	TOTAL General Administration	109,055	44,314	544,582	697,951		697,951	194,813	892,764		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,168,430	229,484	790,237	2,188,151		2,188,151	195,016	2,383,167		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			72,667	72,667		72,667		72,667			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			207,891	207,891		207,891	1,921	209,812			32
33	Real Estate Taxes			46,543	46,543		46,543	67	46,610			33
34	Rent-Facility & Grounds							2,196	2,196			34
35	Rent-Equipment & Vehicles			8,588	8,588		8,588	417	9,005			35
36	Other (specify):* See Attached			44,479	44,479		44,479	(17,982)	26,497			36
37	TOTAL Ownership			380,168	380,168		380,168	(13,381)	366,787			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,441	1,441		1,441		1,441			38
39	Ancillary Service Centers		33,874	(418)	33,456		33,456		33,456			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,695	61,695		61,695		61,695			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		33,874	62,718	96,592		96,592		96,592			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,168,430	263,358	1,233,123	2,664,911		2,664,911	181,635	2,846,546			45

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

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	\$ #VALUE!	#####	\$	1
2	Other Care for Outpatients	#VALUE!	#####		2
3	Governmental Sponsored Special Programs	#VALUE!	#####		3
4	Non-Patient Meals	#VALUE!	#####		4
5	Telephone, TV & Radio in Resident Rooms	#VALUE!	#####		5
6	Rented Facility Space	#VALUE!	#####		6
7	Sale of Supplies to Non-Patients	#VALUE!	#####		7
8	Laundry for Non-Patients	#VALUE!	#####		8
9	Non-Straightline Depreciation	#VALUE!	#####		9
10	Interest and Other Investment Income	#VALUE!	#####		10
11	Discounts, Allowances, Rebates & Refunds	#VALUE!	#####		11
12	Non-Working Officer's or Owner's Salary	#VALUE!	#####		12
13	Sales Tax	#VALUE!	#####		13
14	Non-Care Related Interest	#VALUE!	#####		14
15	Non-Care Related Owner's Transactions	#VALUE!	#####		15
16	Personal Expenses (Including Transportation)	#VALUE!	#####		16
17	Non-Care Related Fees	#VALUE!	#####		17
18	Fines and Penalties	#VALUE!	#####		18
19	Entertainment	#VALUE!	#####		19
20	Contributions	#VALUE!	#####		20
21	Owner or Key-Man Insurance	#VALUE!	#####		21
22	Special Legal Fees & Legal Retainers	#VALUE!	#####		22
23	Malpractice Insurance for Individuals	#VALUE!	#####		23
24	Bad Debt	#VALUE!	#####		24
25	Fund Raising, Advertising and Promotional	#VALUE!	#####		25
26	Income Taxes and Illinois Personal Property Replacement Tax	#VALUE!	#####		26
27	Nurse Aide Training for Non-Employees	#VALUE!	#####		27
28	Yellow Page Advertising	#VALUE!	#####		28
29	Other-Attach Schedule (See page 5a)	#VALUE!	#####		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ #VALUE!		\$	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*	\$ #VALUE!	#####	31
32	Donated Goods-Attach Schedule*	#VALUE!	#####	32
33	Amortization of Organization & Pre-Operating Expense	#VALUE!	#####	33
34	Adjustments for Related Organization Costs (Schedule VII)	#VALUE!	#####	34
35	Other- Attach Schedule	#VALUE!	#####	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ #VALUE!		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ #VALUE!		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			X			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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
ALDERWOOD HEALTH CARE CENTER

ID# 0043489

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	#VALUE!	\$ #VALUE!	#VALUE!	1
2	#VALUE!	#VALUE!	#VALUE!	2
3	#VALUE!	#VALUE!	#VALUE!	3
4	#VALUE!	#VALUE!	#VALUE!	4
5	#VALUE!	#VALUE!	#VALUE!	5
6	#VALUE!	#VALUE!	#VALUE!	6
7	#VALUE!	#VALUE!	#VALUE!	7
8	#VALUE!	#VALUE!	#VALUE!	8
9	#VALUE!	#VALUE!	#VALUE!	9
10	#VALUE!	#VALUE!	#VALUE!	10
11	#VALUE!	#VALUE!	#VALUE!	11
12	#VALUE!	#VALUE!	#VALUE!	12
13	#VALUE!	#VALUE!	#VALUE!	13
14	#VALUE!	#VALUE!	#VALUE!	14
15	#VALUE!	#VALUE!	#VALUE!	15
16	#VALUE!	#VALUE!	#VALUE!	16
17	#VALUE!	#VALUE!	#VALUE!	17
18	#VALUE!	#VALUE!	#VALUE!	18
19	#VALUE!	#VALUE!	#VALUE!	19
20	#VALUE!	#VALUE!	#VALUE!	20
21	#VALUE!	#VALUE!	#VALUE!	21
22	#VALUE!	#VALUE!	#VALUE!	22
23	#VALUE!	#VALUE!	#VALUE!	23
24	#VALUE!	#VALUE!	#VALUE!	24
25	#VALUE!	#VALUE!	#VALUE!	25
26				26
27	#VALUE!	#VALUE!	#VALUE!	27
28	#VALUE!	#VALUE!	#VALUE!	28
29	#VALUE!	#VALUE!	#VALUE!	29
30	Other - Goodwill	(44,479)	36	30
31				31
32	Vending revenue	(588)	21	32
33				33
34				34
35				35
36				36
37				37
38				38
39	Subtotal Line 29	(45,067)	#VALUE!	39
40			#VALUE!	40
41	#VALUE!	#VALUE!	#VALUE!	41
42	#VALUE!	#VALUE!	#VALUE!	42
43				43
44	#VALUE!	#VALUE!	#VALUE!	44
45				45
46	#VALUE!	#VALUE!	#VALUE!	46
47	#VALUE!	#VALUE!	#VALUE!	47
48				48
49	Total	#VALUE!		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489

Report Period Beginning:

1/1/2001

Ending:

12/31/2001**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	53	0	0	0	0	0	0	0	0	0	53	5
6	Maintenance	0	144	0	0	0	0	0	0	0	0	0	144	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	197	0	0	0	0	0	0	0	0	0	197	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	6	0	0	0	0	0	0	0	0	0	6	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	6	0	0	0	0	0	0	0	0	0	6	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	107,701	0	0	0	0	0	0	0	0	0	107,701	19
20	Fees, Subscriptions & Promotions	0	397	0	0	0	0	0	0	0	0	0	397	20
21	Clerical & General Office Expenses	(588)	37,779	0	0	0	0	0	0	0	0	0	37,191	21
22	Employee Benefits & Payroll Taxes	0	7	0	0	0	0	0	0	0	0	0	7	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,331	0	0	0	0	0	0	0	0	0	4,331	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	45,186	0	0	0	0	0	0	0	0	0	45,186	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(588)	195,401	0	0	0	0	0	0	0	0	0	194,813	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(588)	195,604	0	0	0	0	0	0	0	0	0	195,016	29

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER

0043489

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

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 Organizational Structure Description						

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Food Purchase	\$	Senior Living Properties, LLC	100.00%	\$ 0	\$ 1
2	V	5 Heat and Other Utilities		Senior Living Properties, LLC	100.00%	53	53 2
3	V	6 Maintenance		Senior Living Properties, LLC	100.00%	144	144 3
4	V	7 Waste Removal		Senior Living Properties, LLC	100.00%	0	4
5	V	10 Nursing & Medical Records		Senior Living Properties, LLC	100.00%	0	5
6	V	10a Therapy		Senior Living Properties, LLC	100.00%	6	6 6
7	V	19 Professional Services		Senior Living Properties, LLC	100.00%	107,701	107,701 7
8	V	20 Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	397	397 8
9	V	21 Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	37,779	37,779 9
10	V	22 Employee Benefits & Payroll Taxes		Senior Living Properties, LLC	100.00%	7	7 10
11	V	24 Travel and Seminar		Senior Living Properties, LLC	100.00%	4,331	4,331 11
12	V	26 Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	45,186	45,186 12
13	V	32 Interest		Senior Living Properties, LLC	100.00%	1,921	1,921 13
14	Total		\$			\$ 197,525	\$ * 197,525 14

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

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	33	Real Estate Taxes	\$	Senior Living Properties, LLC	100.00%	\$ 67	\$ 67	15	
16	V	34	Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	2,196	2,196	16	
17	V	35	Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	417	417	17	
18	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	26,497	26,497	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			\$			\$ 29,177	\$ * 29,177	39	

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

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

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

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

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 Senior Living Properties, LLC
 Street Address 12400 N. Meridian Street, Suite 180
 City / State / Zip Code Carmel, Indiana 46032
 Phone Number (317) 208-2740
 Fax Number (317) 575-2562

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food Purchase	See attachment	See attachment	\$ 0	\$	See attachment	\$ 0	1
2	5	Heat and Other Utilities	See attachment	See attachment	2,029		See attachment	53	2
3	6	Maintenance	See attachment	See attachment	10,713		See attachment	144	3
4	7	Waste Removal	See attachment	See attachment	6		See attachment	0	4
5	10	Nursing & Medical Records	See attachment	See attachment	0		See attachment	0	5
6	10a	Therapy	See attachment	See attachment	452		See attachment	6	6
7	19	Professional Services	See attachment	See attachment	7,709,475		See attachment	107,701	7
8	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	17,834		See attachment	397	8
9	21	Clerical & General Office Expens	See attachment	See attachment	2,749,973		See attachment	37,779	9
10	22	Employee Benefits & Payroll Tax	See attachment	See attachment	508		See attachment	7	10
11	24	Travel and Seminar	See attachment	See attachment	837,931		See attachment	4,331	11
12	26	Insurance - Prop Liab Malpractic	See attachment	See attachment	1,271,868		See attachment	45,186	12
13	32	Interest	See attachment	See attachment	53,649		See attachment	1,921	13
14	33	Real Estate Taxes	See attachment	See attachment	4,962		See attachment	67	14
15	34	Rent-Facility & Grounds	See attachment	See attachment	162,698		See attachment	2,196	15
16	35	Rent-Equipment & Vehicles	See attachment	See attachment	31,048		See attachment	417	16
17	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	1,962,703		See attachment	26,497	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 14,815,849	\$		\$ 226,702	25

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10	
						Original	Balance					
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO									
	A. Directly Facility Related											
	Long-Term											
1	GMAC Comm Mort Corp		X	Acquisition	\$15,846.00	02/06/98	\$ 1,817,718	\$ 1,817,673	02/01/08	0.0681	\$ 132,282	1
2	Complete Care Services		X	Acquisition	\$469.00	02/06/98	80,430	84,966	02/06/08	N/A - None	N/A - None	2
3	Manager Note		X	Acquisition	\$469.00	02/06/98	80,430	84,966	02/06/08	N/A - None	N/A - None	3
4												4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital	None	02/06/98	Various	488,596	Demand	Prime + 2%	47,543	6
7	Other Interest										23,689	7
8												8
9	TOTAL Facility Related				\$16,784.00		\$ 1,978,578	\$ 2,476,201			\$ 203,514	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 1,978,578	\$ 2,476,201			\$ 203,514	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 **ALDERWOOD HEALTH CARE CENTER**

0043489

Report Period Beginning: **1/1/2001**

Ending: **12/31/2001**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2000 report.		\$ 27,236	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.)		\$ 27,236	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 46,543	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. 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.		\$ 46,543	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996	38,587	8
	1997	38,312	9
	1998	39,305	10
	1999	42,271	11
	2000	27,236	12
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2000 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDERWOOD HEALTH CARE CENTER COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0043489

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 208-2740 FAX #: (317)581-9513

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-34-226-014-8</u>	<u>See Attachment</u>	<u>\$ 43,534.88</u>	<u>\$ 43,534.88</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 43,534.88</u>	<u>\$ 43,534.88</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,169 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	131,116	1998	\$ 77,477	1
2					2
3	TOTALS	131,116		\$ 77,477	3

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER

0043489

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

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	90	1998	1970	\$ 982,687	\$ 32,756	30	\$ 32,756	\$	\$ 128,295	4
5						-				5
6						-				6
7						-				7
8						-				8
Improvement Type**										
9	Paint Materials	1998		80	16	5	16		49	9
10	Surface Mount	1998		1,022	51	20	51		166	10
11	Bathroom Tile	1998		1,624	81	20	81		270	11
12	Repair Window	1998		2,000	133	15	133		433	12
13	Borders - Remodeling	1998		2,036	407	5	407		1,289	13
14	Copper Piping	1998		2,043	82	25	82		266	14
15	Sprinkler System	1998		2,232	89	25	89		342	15
16	Cove Base	1998		2,289	114	20	114		352	16
17	Remodel Nursing	1998		2,498	166	15	166		556	17
18	Handrails	1998		4,062	271	15	271		835	18
19	Water Softener	1998		4,150	415	10	415		1,487	19
20	Paint for Dining Room	1998		4,300	860	5	860		2,723	20
21	Repair Paint Walls	1998		7,400	1,480	5	1,480		4,563	21
22	Tile Kitchen	1998		8,168	408	20	408		1,293	22
23	Remove Wallpaper	1998		9,300	1,860	5	1,860		5,890	23
24	Signage	1998		464	46	10	46		166	24
25	Land Improvements	1999		32,329	2,155	15	2,155		8,441	25
26	Phase IV Paint Halls	1999		8,000	1,600	5	1,600		4,800	26
27	Repair Paint RM 405 & 406	1999		682	136	5	136		397	27
28	Hallway 200 & 400	1999		1,575	105	15	105		306	28
29	Painting Materials for hallway	1999		198	40	5	40		119	29
30	Paint for Halls 100 & 300	1999		461	92	5	92		261	30
31	Building Improvements	2000		2,000	133	15	133		166	31
32	Design for Laundry RM Additions	2000		1,302	87	15	87		159	32
33										33
34										34
35										35
36										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

See Page 12A, Line 70 for total

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		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37	Sliding Door	2000	\$ 1,186	\$ 79	15	\$ 79	\$ 0	\$ 104	37	
38	Sprinkler System	2001	6,019	201	25	201		201	38	
39					-				39	
40					-				40	
41					-				41	
42					-				42	
43					-				43	
44					-				44	
45					-				45	
46					-				46	
47					-				47	
48					-				48	
49					-				49	
50					-				50	
51					-				51	
52					-				52	
53					-				53	
54					-				54	
55					-				55	
56					-				56	
57					-				57	
58					-				58	
59					-				59	
60					-				60	
61					-				61	
62					-				62	
63	(DON'T ENTER BELOW THIS LINE)									63
64	Total (This Page)									64
65									65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 1,090,107	\$ 43,863		\$ 43,863	\$ 0	\$ 163,929	70	

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

Facility Name & ID Number **ALDERWOOD HEALTH CARE CENTER** # **0043489** Report Period Beginning: **1/1/2001** Ending: **12/31/2001**

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	
71	Purchased in Prior Years	\$ 203,939	\$ 28,091	\$ 28,091	\$	Various	\$ 165,156	71
72	Current Year Purchases	4,752	713	713		Various	713	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 208,691	\$ 28,804	\$ 28,804	\$		\$ 165,869	75

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	
76			-	\$	\$	\$	\$		\$	76
77			-							77
78			-							78
79			-							79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,376,275	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,667	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,667	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 329,798	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* 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: 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:	<u>N/A</u>			\$			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>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</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: N/A*

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: \$ 8,588 Description: Nursing - 286, Central Supply - 3,208, Dietary - 562, Plant - 2450, Administrative - 2082
 (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	<u>N/A</u>		\$	\$	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>Training was not necessary for aides, as the facility only hired aides who were already trained. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist	10a, 3	hrs	\$	493	\$	30,554	\$	2,928	493	\$	33,482	1	
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		121		6,153		-	121		6,153	2	
3	Licensed Recreational Therapist	10a, 3	hrs		-		-		15,671			15,671	3	
4	Licensed Physical Therapist	10a, 3	hrs		1,048		62,092		3,100	1,048		65,192	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			\$	1,662	\$	98,799	\$	21,699	1,662	\$	120,498	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.

STATE OF ILLINOIS

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Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER

0043489

Report Period Beginning: 1/1/2001

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001

(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	\$ 29,911	\$	1
2	Cash-Patient Deposits	9,730		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	375,939		3
4	Supply Inventory (priced at)	10,080		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 425,660	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	77,477		13
14	Buildings, at Historical Cost	1,079,959		14
15	Leasehold Improvements, at Historical Cost	32,793		15
16	Equipment, at Historical Cost	186,047		16
17	Accumulated Depreciation (book methods)	(329,798)		17
18	Deferred Charges	524,861		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Rec / (Pay)</u>	(695,768)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 875,571	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,301,231	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 201,501	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,841		28
29	Short-Term Notes Payable	241,406		29
30	Accrued Salaries Payable	144,727		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other accrued expenses</u>	(29,821)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 577,654	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,948,508		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,948,508	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,526,162	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,224,931)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,301,231	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,092,192)	1
2	Restatements (describe):		2
3	Restatements of Prior Year to allow rollforward	244,453	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (847,739)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(377,192)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (377,192)	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)	\$ (1,224,931)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER

0043489

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

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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	\$ 2,404,715	1
2	Discounts and Allowances for all Levels	(437,986)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,966,729	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	176,838	6
7	Oxygen	19,042	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 195,880	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	849	13
14	Non-Patient Meals	620	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	66,206	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,836	19
20	Radiology and X-Ray		20
21	Other Medical Services	48,011	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 124,522	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Vending	588	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 588	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,287,719	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	419,919	31
32	Health Care	1,070,281	32
33	General Administration	697,951	33
B. Capital Expense			
34	Ownership	380,168	34
C. Ancillary Expense			
35	Special Cost Centers	34,897	35
36	Provider Participation Fee	61,695	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,664,911	40
41	Income before Income Taxes (line 30 minus line 40)**	(377,192)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (377,192)	43

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

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

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

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

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER

0043489

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

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	4,433	4,433	\$ 71,806	\$ 16.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,866	9,866	201,085	20.38	3
4	Licensed Practical Nurses	6,285	6,285	108,298	17.23	4
5	Nurse Aides & Orderlies	32,255	32,255	361,490	11.21	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,156	2,156	24,545	11.38	9
10	Activity Assistants	2,507	2,507	19,519	7.79	10
11	Social Service Workers	2,652	2,652	39,251	14.80	11
12	Dietician					12
13	Food Service Supervisor	1,225	1,225	12,331	10.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,676	10,676	82,747	7.75	15
16	Dishwashers					16
17	Maintenance Workers	1,517	1,517	16,882	11.13	17
18	Housekeepers	9,230	9,230	88,138	9.55	18
19	Laundry	2,972	2,972	20,426	6.87	19
20	Administrator	1,858	1,858	57,477	30.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,678	3,678	51,578	14.02	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	1,115	1,115	12,857	11.53	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	92,425	92,425	\$ 1,168,430 *	\$ 12.64	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	89	\$ 11,173	1, 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	75	330	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,984	11, 3	44
45	Social Service Consultant	44	2,602	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	240	\$ 16,089		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,867	\$ 55,725	10, 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	53	1,011	10, 3	52
53	TOTAL (lines 50 - 52)	1,920	\$ 56,736		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. 5515 - Illinois Health Care Assoc.
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (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? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over 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. \$ 61,695
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 benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 620
- (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? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.