

		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><b>I. IDPH Facility ID Number:</b> <u>0043141</u></p> <p><b>Facility Name:</b> <u>Dolton HealthCare Centre</u></p> <p><b>Address:</b> <u>14325 So. Blackstone Ave.</u> <u>Dolton</u> <u>60425</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(708)849-5000</u> Fax # <u>(708)849-5175</u></p> <p><b>IDPA ID Number:</b> <u>36-4184122</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>1-Oct-97</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  Name: <u>Christopher Vicere</u> Telephone Number: <u>(773)604-4416</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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1-Jan-01</u> to <u>31-Dec-01</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ <u>28-Mar-02</u> <small>(Date)</small></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>Christopher Vicere</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>Vice President - Finance</u></td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ <small>(Date)</small></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name &amp; Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) <u>( )</u> Fax # <u>( )</u></td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ <u>28-Mar-02</u> <small>(Date)</small>		(Type or Print Name) <u>Christopher Vicere</u>		(Title) <u>Vice President - Finance</u>	Paid Preparer	(Signed) _____ <small>(Date)</small>		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>( )</u> Fax # <u>( )</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name & ID Number Dolton HealthCare Centre

# 0043141 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

**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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>39</u>	Skilled (SNF)	<u>39</u>	<u>14,235</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>34</u>	Intermediate (ICF)	<u>34</u>	<u>12,410</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>73</u>	TOTALS	<u>73</u>	<u>26,645</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>3,405</u>	<u>182</u>	<u>2,610</u>	<u>6,197</u>	8
9	SNF/PED					9
10	ICF	<u>14,955</u>	<u>1,736</u>		<u>16,691</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,360</u>	<u>1,918</u>	<u>2,610</u>	<u>22,888</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.90%

D. How many bed-hold days during this year were paid by Public Aid? 47 (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 1-Oct-97

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1-Oct-97 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 39 and days of care provided 2,610

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 31-Dec-01 Fiscal Year: 31-Dec-01

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

STATE OF ILLINOIS

Facility Name & ID Number Dolton HealthCare Centre # 0043141 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

**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
<b>A. General Services</b>											
1	Dietary	113,544	20,125	5,099	138,768		138,768		138,768		1
2	Food Purchase		130,711		130,711	(13,651)	117,060	(104)	116,956		2
3	Housekeeping	68,131	20,654	2,843	91,628		91,628		91,628		3
4	Laundry	30,307	21,384		51,691		51,691		51,691		4
5	Heat and Other Utilities			67,853	67,853		67,853		67,853		5
6	Maintenance	32,803	11,052	55,830	99,685		99,685	(6,948)	92,737		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	244,785	203,926	131,625	580,336	(13,651)	566,685	(7,052)	559,633		8
<b>B. Health Care and Programs</b>											
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	789,848	52,990	5,360	848,198		848,198		848,198		10
10a	Therapy		2,474	11,578	14,052		14,052		14,052		10a
11	Activities	64,312	4,439	2,560	71,311		71,311		71,311		11
12	Social Services	42,337		2,090	44,427		44,427		44,427		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	896,497	59,903	25,788	982,188		982,188		982,188		16
<b>C. General Administration</b>											
17	Administrative	70,595		253,279	323,874		323,874	(166,150)	157,724		17
18	Directors Fees										18
19	Professional Services			16,270	16,270		16,270	12,255	28,525		19
20	Dues, Fees, Subscriptions & Promotions			50,746	50,746		50,746	(18,757)	31,989		20
21	Clerical & General Office Expenses	14,652	10,301	38,432	63,385		63,385	50,316	113,701		21
22	Employee Benefits & Payroll Taxes			165,331	165,331	13,651	178,982	25,978	204,960		22
23	Inservice Training & Education										23
24	Travel and Seminar			997	997		997	222	1,219		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			24,421	24,421		24,421	308	24,729		26
27	Other (specify):*							13,781	13,781		27
28	<b>TOTAL General Administration</b>	85,247	10,301	549,476	645,024	13,651	658,675	(82,047)	576,628		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,226,529	274,130	706,889	2,207,548		2,207,548	(89,099)	2,118,449		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Dolton HealthCare Centre

#0043141

Report Period Beginning:

1-Jan-01

Ending:

31-Dec-01

## 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	
	<b>D. Ownership</b>											
30	Depreciation			47,539	47,539		47,539	3,713	51,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,603	1,603		1,603	12,232	13,835			32
33	Real Estate Taxes			143,307	143,307		143,307		143,307			33
34	Rent-Facility & Grounds			339,865	339,865		339,865		339,865			34
35	Rent-Equipment & Vehicles			560	560		560		560			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			532,874	532,874		532,874	15,945	548,819			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		66,715	90,680	157,395		157,395		157,395			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,967	39,967		39,967		39,967			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		66,715	130,647	197,362		197,362		197,362			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,226,529	340,845	1,370,410	2,937,784		2,937,784	(73,154)	2,864,630			45

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

Facility Name & ID Number **Dolton HealthCare Centre**

# **0043141**

Report Period Beginning: **1-Jan-01**

Ending: **31-Dec-01**

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,820	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(104)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,902)	21		24
25	Fund Raising, Advertising and Promotional	(18,334)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,969)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,196)	20		28
29	Other-Attach Schedule <b>**Deferred Maint. Costs**</b>	(9,710)	6		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (56,395)		\$	30

OHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(16,759)	various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (16,759)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (73,154)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Dolton HealthCare Centre

ID# 0043141

Report Period Beginning: 1-Jan-01

Ending: 31-Dec-01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance Costs	\$ (9,710)	6
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(9,710)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **Dolton HealthCare Centre**# **0043141** Report Period Beginning:**1-Jan-01**

Ending:

**31-Dec-01****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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(104)	0	0	0	0	0	0	0	0	0	0	(104)	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	(9,710)	2,762	0	0	0	0	0	0	0	0	0	(6,948)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(9,814)</b>	<b>2,762</b>	<b>0</b>	<b>(7,052)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(166,150)	0	0	0	0	0	0	0	0	0	(166,150)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,255	0	0	0	0	0	0	0	0	0	12,255	19
20	Fees, Subscriptions & Promotions	(25,530)	6,773	0	0	0	0	0	0	0	0	0	(18,757)	20
21	Clerical & General Office Expenses	(23,871)	74,187	0	0	0	0	0	0	0	0	0	50,316	21
22	Employee Benefits & Payroll Taxes	0	25,978	0	0	0	0	0	0	0	0	0	25,978	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	222	0	0	0	0	0	0	0	0	0	222	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	308	0	0	0	0	0	0	0	0	0	308	26
27	Other (specify):*	0	13,781	0	0	0	0	0	0	0	0	0	13,781	27
28	<b>TOTAL General Administration</b>	<b>(49,401)</b>	<b>(32,646)</b>	<b>0</b>	<b>(82,047)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(59,215)</b>	<b>(29,884)</b>	<b>0</b>	<b>(89,099)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Dolton HealthCare Centre# 0043141

Report Period Beginning:

1-Jan-01

Ending:

31-Dec-01

## 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)
	<b>D. Ownership</b>												
30	Depreciation	2,820	893	0	0	0	0	0	0	0	0	0	3,713 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	12,232	0	0	0	0	0	0	0	0	0	12,232 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>2,820</b>	<b>13,125</b>	<b>0</b>	<b>15,945 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(56,395)</b>	<b>(16,759)</b>	<b>0</b>	<b>(73,154) 45</b>								

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

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	17 Salary-Cynthia and Laurence	\$	Lancaster, Ltd.	100.00%	\$ 18,692	\$ 18,692 1
2	V	27 Payroll Taxes		Lancaster, Ltd.	100.00%	13,781	13,781 2
3	V	17 Management Fee Income	201,900	Lancaster, Ltd.	100.00%		(201,900) 3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	12,255	12,255 4
5	V	21 Office Expenses		Lancaster, Ltd.	100.00%	74,187	74,187 5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	25,978	25,978 6
7	V	24 Education and Seminars		Lancaster, Ltd.	100.00%	222	222 7
8	V	17 Administrative Consultant		Lancaster, Ltd.	100.00%	17,058	17,058 8
9	V	20 Fees and Marketing		Lancaster, Ltd.	100.00%	6,773	6,773 9
10	V	32 Interest	837	Lancaster, Ltd.	100.00%	13,069	12,232 10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	893	893 11
12	V	6 Maintenance		Lancaster, Ltd.	100.00%	2,762	2,762 12
13	V	26 Professional Liability Ins.		Lancaster, Ltd.	100.00%	308	308 13
14	Total		\$ 202,737			\$ 185,978	\$ * (16,759) 14

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

Facility Name & ID Number      **Dolton HealthCare Centre**      #      **0043141**      Report Period Beginning:      **1-Jan-01**      Ending:      **31-Dec-01**

## 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	Cynthia Chow	Officer	Administrative	50.00%	see attached	2	3.00%	Lancaster	\$ 3,692	17-7	1
2	Laurence Zung	Officer	Administrative	50.00%	see attached	2	4.17%	Lancaster	15,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 18,692		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 Dolton HealthCare Centre # 0043141 Report Period Beginning: 1-Jan-01 Ending: 1-Dec-01

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 Lancaster, Ltd.  
 Street Address 5061 N. Pulaski Road  
 City / State / Zip Code Chicago, IL. 60630  
 Phone Number ( 773)478-3699  
 Fax Number ( 773)478-1192

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)		
1	17	Cynthia Chow	Hours Worked	65	7	\$ 120,000	\$ 120,000	2	\$ 3,692	1
2	27	Cynthia Chow	Hours Worked	65	7	6,835	0	2	210	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	2	15,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,315	0	2	430	4
5										5
6										6
7	19	Professional Services	Management Fees	1,697,900	7	103,061	0	201,900	12,255	7
8	21	Office Expenses	Management Fees	1,697,900	7	27,792	0	201,900	3,305	8
9	22	Employee Benefits	Management Fees	1,697,900	7	218,469	0	201,900	25,978	9
10	24	Education and Seminars	Management Fees	1,697,900	7	1,868	0	201,900	222	10
11	17	Administrative Consultant	Management Fees	1,697,900	7	143,451	0	201,900	17,058	11
12	20	Marketing	Management Fees	1,697,900	7	54,625	0	201,900	6,496	12
13	32	Interest	Management Fees	1,697,900	7	109,907	0	201,900	13,069	13
14	30	Depreciation	Management Fees	1,697,900	7	7,511	0	201,900	893	14
15	26	Professional Liability Ins.	Management Fees	1,697,900	7	2,588	0	201,900	308	15
16	20	Licenses and Fees	Management Fees	1,697,900	7	2,330	0	201,900	277	16
17	6	Maintenance	Management Fees	1,697,900	7	23,228	0	201,900	2,762	17
18	21	Salary-Clerical	Management Fees	1,697,900	7	596,087	596,087	201,900	70,882	18
19	27	P/R Taxes-Clerical	Management Fees	1,697,900	7	110,511	0	201,900	13,141	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,898,578	\$ 1,076,087		\$ 185,978	25

Facility Name & ID Number Dolton HealthCare Centre# 0043141

Report Period Beginning:

1-Jan-01

Ending:

31-Dec-01

## 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				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6	Lancaster	X		Working Capital							836	6
7	A-1 Crdeit		X	Insurance Premium Finance							767	7
8	Lancaster Allocation	X									12,232	8
9	TOTAL Facility Related						\$	\$			\$ 13,835	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$ 13,835	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 **Dolton HealthCare Centre**# **0043141** Report Period Beginning: **1-Jan-01** Ending: **31-Dec-01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2000 report.	\$			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.)	\$	143,307		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	143,307		3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$			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. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	143,307		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996	150,421	8	
		1997	138,243	9	
		1998	141,376	10	
		1999	144,398	11	
		2000	152,961	12	
<b>FOR OHF USE ONLY</b>					
		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, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Dolton HealthCare Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0043141

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773)604-4416 FAX #: (773)478-1192

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be 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>29-02-422-001-0000</u>	<u>Long-Term HealthCare</u>	\$ <u>17,471.99</u>	\$ <u>17,471.99</u>
2. <u>29-02-414-056-0000</u>	<u>Long-Term HealthCare</u>	\$ <u>135,488.54</u>	\$ <u>135,488.54</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>152,960.53</u>	\$ <u>152,960.53</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly 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 home. (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.

Facility Name & ID Number Dolton HealthCare Centre

# 0043141 Report Period Beginning:

1-Jan-01 Ending:

31-Dec-01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,952 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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

\*\*\*NONE\*\*\*

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Dolton HealthCare Centre

# 0043141

Report Period Beginning:

1-Jan-01

Ending:

31-Dec-01

**XL OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Excavation and Site Work	2000		36,732	3,490	20	3,490		5,327	9
10	Concrete Work	2000		23,650	606	20	606		934	10
11	Masonry Work	2000		35,757	917	20	917		1,414	11
12	Steel and Erection	2000		24,818	636	20	636		981	12
13	Roofing	2000		15,130	388	20	388		598	13
14	Storm Drainage	2000		15,740	1,495	20	1,495		2,282	14
15	Plumbing	2000		38,800	995	20	995		1,534	15
16	Fire Alarm System & Protection	2000		33,664	863	20	863		1,330	16
17	Heating & Cooling	2000		26,640	683	20	683		1,053	17
18	Electrical	2000		58,592	1,502	20	1,502		2,316	18
19	Nurses' Call System	2000		12,691	325	20	325		501	19
20	Phase I Expansion	2000		257,605	6,605	20	6,605		10,183	20
21	Hand Rails	2001		5,424	75	20	75		75	21
22	Alarm Systems	2001		3,734	52	20	52		52	22
23	Electrical	2001		2,149	30	20	30		30	23
24	Wall Coverings	2001		7,602	106	20	106		106	24
25	Fire Proofing	2001		4,301	60	20	60		60	25
26	Construction	2001		125,945	1,749	20	1,749		1,749	26
27	Interior Design	2001		22,500	313	20	313		313	27
28	Architectual	2001		40,401	561	20	561		561	28
29	Flooring	2001		4,478	62	20	62		62	29
30	Signage	2001		3,832	53	20	53		53	30
31	Plumbing	2001		2,400	34	20	34		34	31
32	Fire Dampers	2001		8,462	27	20	27		27	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

Facility Name & ID Number Dolton HealthCare Centre

# 0043141

Report Period Beginning:

1-Jan-01

Ending:

31-Dec-01

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 811,047	\$ 21,627		\$ 21,627	\$	\$ 31,575	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 132,796	\$ 20,890	\$ 23,710	\$ 2,820	10	\$ 76,996	71
72	Current Year Purchases	34,217	5,915	5,915		10	5,915	72
73	Fully Depreciated Assets	14,179				10	14,179	73
74								74
75	TOTALS	\$ 181,192	\$ 26,805	\$ 29,625	\$ 2,820		\$ 97,090	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	2	
	Reference	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)	\$ 992,239	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,432	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,252	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,820	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 128,665	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: Dolton Associates \*\*an unrelated entity\*\*

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>1-Oct-97</u>	\$ <u>337,785</u>			3
4	Additions							4
5		<u>**off-site public storage space**</u>			<u>2,080</u>			5
6								6
7	<b>TOTAL</b>				\$ <u>339,865</u>			7

10. Effective dates of current rental agreement:

Beginning 1-Oct-97  
Ending 30-Sept-2022

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2002</u>	\$ <u>342,370</u>
13.	<u>/2003</u>	\$ <u>342,370</u>
14.	<u>/2004</u>	\$ <u>342,370</u>

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

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 560 Description: dish washing machine

(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	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

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

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

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	45,357	\$		\$	45,357	1		
2	Licensed Speech and Language Development Therapist	39-3	hrs				1,355				1,355	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39-3	hrs				43,968				43,968	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy	39-2	# of prescripts						46,859		46,859	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Exceptional Care Program											12		
13	Other (specify): <b>Med. Supply/Sp. Bed</b>	39-2							19,856		19,856	13		
14	<b>TOTAL</b>			\$		\$	90,680	\$	66,715	\$	157,395	14		

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

Facility Name &amp; ID Number      Dolton HealthCare Centre

#      0043141

Report Period Beginning:    1-Jan-01

Ending:

31-Dec-01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of    31-Dec-01

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (34,547)	\$	1
2	Cash-Patient Deposits	9,526		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	997,208		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,152		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	5,687		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 992,026	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	811,048		15
16	Equipment, at Historical Cost	181,191		16
17	Accumulated Depreciation (book methods)	(154,221)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 838,018	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,830,044	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 72,898	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,526		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,792		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,372		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
	<b>Other Current Liabilities(specify):</b>			
36	<b>**401(k) Contributions**</b>	1,932		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 247,520	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 247,520	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,582,524	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,830,044	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,046,942</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,046,942</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	535,582	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>535,582</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,582,524</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number Dolton HealthCare Centre

# 0043141

Report Period Beginning: 1-Jan-01

Ending: 31-Dec-01

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,611,883	1
2	Discounts and Allowances for all Levels	(514,015)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,097,868	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	280,548	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 280,548	8
<b>C. Other Operating Revenue</b>			
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	38,170	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,750	19
20	Radiology and X-Ray	2,190	20
21	Other Medical Services	42,840	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 94,950	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,473,366	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	580,336	31
32	Health Care	982,188	32
33	General Administration	645,024	33
<b>B. Capital Expense</b>			
34	Ownership	532,874	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	157,395	35
36	Provider Participation Fee	39,967	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,937,784	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	535,582	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 535,582	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 **Dolton HealthCare Centre**# **0043141**Report Period Beginning: **1-Jan-01**Ending: **31-Dec-01****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,813	\$ 68,185	\$ 32.69	1
2	Assistant Director of Nursing				2
3	Registered Nurses	9,382	210,040	20.43	3
4	Licensed Practical Nurses	11,104	201,842	17.19	4
5	Nurse Aides & Orderlies	37,982	309,781	7.89	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,670	22,138	11.81	9
10	Activity Assistants	5,816	42,174	6.78	10
11	Social Service Workers	3,863	42,337	10.29	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	12,916	113,544	8.25	15
16	Dishwashers				16
17	Maintenance Workers	2,018	32,803	14.57	17
18	Housekeepers	9,649	68,131	6.62	18
19	Laundry	3,877	30,307	7.28	19
20	Administrator	1,869	70,595	33.84	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	1,832	14,652	7.83	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	103,791	\$ 1,226,529 *	\$ 11.15	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	107	\$ 5,099	1-3	35
36	Medical Director	120	4,200	9-3	36
37	Medical Records Consultant	42	2,064	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	660	10-3	39
40	Physical Therapy Consultant	119	7,782	10a-3	40
41	Occupational Therapy Consultant	59	3,548	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	248	10a-3	43
44	Activity Consultant	51	2,560	11-3	44
45	Social Service Consultant	44	2,090	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	667	\$ 28,251		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	207	2,636	10-3	52
53	TOTAL (lines 50 - 52)	207	\$ 2,636		53



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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & Decorating	\$ 11,652	3	\$	\$	\$	\$ 1,942	\$ 3,884	\$ 3,884	\$ 1,942	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$ 11,652		\$	\$	\$	\$ 1,942	\$ 3,884	\$ 3,884	\$ 1,942	\$	\$

Facility Name & ID Number Dolton HealthCare Centre# 0043141

Report Period Beginning:

1-Jan-01

Ending:

31-Dec-01**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. II. Council on Long-Term Care=\$3,323
- (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? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,591 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 39,967  
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. \$ 13,651 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.