

		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>0039669</u></p> <p><b>Facility Name:</b> <u>LAKE COOK TERRACE NURSING CE</u></p> <p><b>Address:</b> <u>263 SKOKIE BOULEVARD</u> <u>NORTHBROOK</u> <u>60062</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>(847) 564-0505</u> <b>Fax #</b> <u>(847) 564-3775</u></p> <p><b>IDPA ID Number:</b> <u>363962479001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>09/28/81</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <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><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</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	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><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>01/01/01</u> to <u>12/31/01</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%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) <u>See Accountants' Compilation Report Attached</u> (Date) _____ (Print Name and Title) <u>GARRY S. CHANKIN, C.P.A.</u> (Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax# <u>(847) 236-1155</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____	<b>Paid Preparer</b>	(Signed) <u>See Accountants' Compilation Report Attached</u> (Date) _____ (Print Name and Title) <u>GARRY S. CHANKIN, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax# <u>(847) 236-1155</u>
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Facility Name & ID Number LAKE COOK TERRACE NURSING CE

# 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

**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 \_\_\_\_\_

	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	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	1,203	373	1,821	3,397	8
9	SNF/PED					9
10	ICF	37,067	2,258	732	40,057	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,270	2,631	2,553	43,454	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.04%

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

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 8/1/1993

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 8/1/1993 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 10 and days of care provided 1821

Medicare Intermediary AdminaStar Federal

**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 LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

**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	164,866	23,265	13,115	201,246		201,246		201,246		1
2	Food Purchase		167,726		167,726	(19,385)	148,341	(101)	148,240		2
3	Housekeeping	185,335	10,694		196,029		196,029		196,029		3
4	Laundry	80,975	23,957		104,932		104,932		104,932		4
5	Heat and Other Utilities			113,165	113,165		113,165		113,165		5
6	Maintenance	85,057	31,911	57,526	174,494		174,494	(19,681)	154,813		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	516,233	257,553	183,806	957,592	(19,385)	938,207	(19,782)	918,425		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,300	3,300		3,300		3,300		9
10	Nursing and Medical Records	1,427,161	67,896	23,914	1,518,971		1,518,971	(1,533)	1,517,438		10
10a	Therapy	106,457	75		106,532		106,532		106,532		10a
11	Activities	86,856	9,188	2,708	98,752		98,752		98,752		11
12	Social Services	176,793		7,488	184,281		184,281		184,281		12
13	Nurse Aide Training			4,760	4,760		4,760		4,760		13
14	Program Transportation			1,383	1,383		1,383		1,383		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,797,267	77,159	43,553	1,917,979		1,917,979	(1,533)	1,916,446		16
	<b>C. General Administration</b>										
17	Administrative	83,899		247,246	331,145		331,145	(112,924)	218,221		17
18	Directors Fees										18
19	Professional Services			48,884	48,884	(3,500)	45,384	(4,135)	41,249		19
20	Dues, Fees, Subscriptions & Promotions			36,702	36,702		36,702	(22,052)	14,650		20
21	Clerical & General Office Expenses	62,734	1,106	658,249	722,089		722,089	(520,051)	202,038		21
22	Employee Benefits & Payroll Taxes			448,542	448,542	19,385	467,927	(8,288)	459,639		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,466	3,466		3,466	(720)	2,746		24
25	Other Admin. Staff Transportation			608	608		608		608		25
26	Insurance-Prop.Liab.Malpractice			48,461	48,461		48,461		48,461		26
27	Other (specify):*							6,311	6,311		27
28	<b>TOTAL General Administration</b>	146,633	1,106	1,492,158	1,639,897	15,885	1,655,782	(661,859)	993,923		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,460,133	335,818	1,719,517	4,515,468	(3,500)	4,511,968	(683,174)	3,828,794		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	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			62,871	62,871		62,871	155,691	218,562		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			21,934	21,934		21,934	118,441	140,375		32
33	Real Estate Taxes			152,967	152,967	3,500	156,467		156,467		33
34	Rent-Facility & Grounds			362,100	362,100		362,100	(362,100)			34
35	Rent-Equipment & Vehicles			20,734	20,734		20,734		20,734		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			620,606	620,606	3,500	624,106	(87,968)	536,138		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		73,547	145,684	219,231		219,231		219,231		39
40	Barber and Beauty Shops			303	303		303		303		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			76,650	76,650		76,650		76,650		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		73,547	222,637	296,184		296,184		296,184		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,460,133	409,365	2,562,760	5,432,258		5,432,258	(771,142)	4,661,116		45

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

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	87,616	30		9
10	Interest and Other Investment Income	(66)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(101)	02		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	(6,275)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,148)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,799)	20		28
29	Other-Attach Schedule	(560,636)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (491,409)		\$	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)	(279,733)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (279,733)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (771,142)		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

NON-ALLOWABLE EXPENSES	Amount	Reference	Sch. V Line
1 Bad Debts	\$ (519,363)	21	1
2 Bank Charges	(573)	21	2
3 Veterans Expenses	(444)	10	3
4 Officers Life Insurance	(7,644)	22	4
5 Resident Clothing	(1,089)	10	5
6 Collections	(4,135)	19	6
7 Vending Income	(114)	21	7
8 C/CPD Dues	(3,383)	20	8
9 Vendor Gifts	(644)	22	9
10 V2002 Seminar	(650)	24	10
11 Non-allowable Advertising	(443)	20	11
12 Capitalized R&M	(19,681)	06	12
13 Building Co - State Replacement Tax	(2,383)	21	13
14 Building Co - Franchise Tax	(23)	21	14
15 Non-allowable seminar	(70)	24	15
16			16
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## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning:

01/01/01

Ending:

12/31/01

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(101)											(101)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(19,681)											(19,681)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(19,782)</b>											<b>(19,782)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(1,533)											(1,533)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,533)</b>											<b>(1,533)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(45,324)		(67,600)							(112,924)	17
18	Directors Fees													18
19	Professional Services	(4,135)											(4,135)	19
20	Fees, Subscriptions & Promotions	(22,052)											(22,052)	20
21	Clerical & General Office Expenses	(522,449)	2,398										(520,051)	21
22	Employee Benefits & Payroll Taxes	(8,288)											(8,288)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(720)											(720)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			3,776		2,535							6,311	27
28	<b>TOTAL General Administration</b>	<b>(557,644)</b>	<b>2,398</b>	<b>(41,548)</b>		<b>(65,065)</b>							<b>(661,859)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(578,959)</b>	<b>2,398</b>	<b>(41,548)</b>		<b>(65,065)</b>							<b>(683,174)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE COOK TERRACE NURSING CE# 0039669

Report Period Beginning:

01/01/01

Ending:

12/31/01

## 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	87,616	68,075										155,691	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(66)	118,507										118,441	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(362,100)										(362,100)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>87,550</b>	<b>(175,518)</b>										<b>(87,968)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(491,409)</b>	<b>(173,120)</b>	<b>(41,548)</b>		<b>(65,065)</b>							<b>(771,142)</b>	<b>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
SEE ATTACHED		SEE ATTACHED	SEE ATTACHED			
					GAF PARTNERSHIP	BLDG. PTSHP

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENTAL INCOME	\$ 362,100	GAF PARTNERSHIP	100.00%	\$	\$ (362,100)	1
2	V	32 INTEREST INCOME	11,354	GAF PARTNERSHIP	100.00%		(11,354)	2
3	V	32 MORTGAGE INTEREST		GAF PARTNERSHIP	100.00%	129,861	129,861	3
4	V	30 DEPRECIATION		GAF PARTNERSHIP	100.00%	68,075	68,075	4
5	V	21 STATE REPLACEMENT TAX		GAF PARTNERSHIP	100.00%	2,383	2,383	5
6	V	21 FRANCHISE TAX		GAF PARTNERSHIP	100.00%	15	15	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 373,454			\$ 200,334	\$ * (173,120)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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)	
15	V	17 SALARY - STAN ARON	\$	PRO HEALTH CARE, INC.	100.00%	\$ 101,922	\$ 101,922	15
16	V	27 PAYROLL TAXES				3,776	3,776	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V	17 MNGMNT. FEES - GAF, LTD.	100,000				(100,000)	23
24	V	17 MNGMNT. FEES - PRO HEALTH	47,246				(47,246)	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		\$ 147,246			\$ 105,698	\$ * (41,548)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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)	
15	V		\$	<u>GAF, LTD.</u>	<u>100.00%</u>	\$	\$	15
16	V	<u>17 MANAGEMENT FEES</u>	<u>200,000</u>				<u>(200,000)</u>	16
17	V	<u>17 MNGMNT. FEES - FINN CONS.</u>				<u>100,000</u>	<u>100,000</u>	17
18	V	<u>17 MNGMNT. FEES - PRO HEALTH</u>				<u>100,000</u>	<u>100,000</u>	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	<b>Total</b>		\$ <b>200,000</b>			\$ <b>200,000</b>	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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)		
15	V	17 SALARY - J. FINN	\$	FINN CONSULTING, INC.	100.00%	\$ 32,400	\$	32,400	15
16	V	27 PAYROLL TAXES				2,535		2,535	16
17	V								17
18	V	17 MANAGEMENT FEES	100,000					(100,000)	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		\$ 100,000			\$ 34,935	\$ *	(65,065)	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name & ID Number LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

## 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	STANTON ARON	OWNER	ADMIN	12.95%	SEE ATTACHED	23	35.38%	Alloc. Pro He	\$ 101,922	17-7	1
2	JACK FINN	OWNER	ADMIN	17.26%	SEE ATTACHED	18	51.45%	Alloc. Finn C	32,400	17-7	2
3	NANJEAN PAINTER	OWNER	ADMIN	1.44%	SEE ATTACHED	10	20.00%	Dietary	7,008	01-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 141,330		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 LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

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

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

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

Facility Name & ID Number LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

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 PRO HEALTH CARE, INC. C/O FR&R  
 Street Address 111 PFINGSTEN ROAD  
 City / State / Zip Code DEERFIELD, IL 60115  
 Phone Number ( 847)236-1111  
 Fax Number ( 847)236-1155

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HOURS WORKED 51	4	\$ 226,000	\$ 226,000	23	\$ 101,922	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED 51	4	8,372		23	3,776	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 234,372	\$ 226,000		\$ 105,698	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

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

Name of Related Organization GAF, LTD. C/O FR&R  
 Street Address 111 PFINGSTEN ROAD  
 City / State / Zip Code DEERFIELD, IL 60115  
 Phone Number (847)236-1111  
 Fax Number (847)236-1155

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3	17	MNGMNT. FEES - FINN CONS.	DIRECT ALLOCATION	1	100,000			100,000	3
4	17	MNGMNT. FEES - PRO HEALT	DIRECT ALLOCATION	1	100,000			100,000	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 200,000	\$		\$ 200,000	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

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 FINN CONSULTING INC.  
 Street Address 2901 W. COYLE  
 City / State / Zip Code CHICAGO, IL 60645  
 Phone Number (773)764-3466  
 Fax Number

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	SALARY - J. FINN	AVG. HOURS WORKED 35	2	\$ 63,000	\$ 63,000	18	32,400	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED 35	2	4,930		18	2,535	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 67,930	\$ 63,000		\$ 34,935	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

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

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

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

Facility Name & ID Number LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

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

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

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

Facility Name & ID Number LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

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

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

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

Facility Name & ID Number LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

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

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

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

Facility Name & ID Number LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

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

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

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

Facility Name & ID Number LAKE COOK TERRACE NURSING CE # 0039669 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

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

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

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

Facility Name &amp; ID Number

LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning:

01/01/01

Ending:

12/31/01

## 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	2	3	4	5	6	7	8	9	10											
										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				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	MANUFACTURERS BANK		X	LINE OF CREDIT	VARIES	7/10/00	1,300,000	395,000			21,934	6								
7											7									
8											8									
9	TOTAL Facility Related						\$ 1,300,000	\$ 395,000			\$ 21,934	9								
<b>B. Non-Facility Related*</b>																				
10	See Supplemental Schedule						2,265,836	1,550,512			118,507	10								
11	INTEREST INCOME										(66)	11								
12											12									
13											13									
14	TOTAL Non-Facility Related						\$ 2,265,836	\$ 1,550,512			\$ 118,441	14								
15	TOTALS (line 9+line14)						\$ 3,565,836	\$ 1,945,512			\$ 140,375	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

LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning:

01/01/01

Ending:

12/31/01

**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	2	3	4	5	6	7	8	9	10											
										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				Original	Balance			
1	DUE TO SHERIDAN						\$	\$ 140,000			\$	1								
2	ALLOCATED- GAF PARTNE	X		MORTGAGE	40,401	9/93		2,265,836	1,410,512		10.75%	129,861	2							
3	ALLOCATED- GAF PARTNE	X		INTEREST INCOME								(11,354)	3							
4													4							
5													5							
6													6							
7													7							
8													8							
9													9							
10													10							
11													11							
12													12							
13													13							
14													14							
15													15							
16													16							
17													17							
18													18							
19													19							
20													20							
21							\$	2,265,836	\$ 1,550,512			\$ 118,507	21							

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

**B. Real Estate Taxes**

**Important**, 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.	\$	<b>150,200</b>	<b>1</b>
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.)	\$	<b>147,867</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(2,333)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>155,300</b>	<b>4</b>
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>	\$	<b>3,500</b>	<b>5</b>
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 \$ 1,797 For 19 94 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>156,467</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1996	<b>135,555</b>	<b>8</b>
	1997	<b>136,449</b>	<b>9</b>
	1998	<b>139,820</b>	<b>10</b>
	1999	<b>143,084</b>	<b>11</b>
	2000	<b>147,867</b>	<b>12</b>

<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

**Accrual = 151169 x 1.03 = 155300 (rounded)**

**The 1994 Real Estate Tax Refund has not been adjusted out since the 1994 Real Estate Taxes were not used in rate setting.**

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**



Facility Name & ID Number LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning:

01/01/01

Ending:

12/31/01

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior BRICK Frame BRICK 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 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILTY</u>			\$ <u>200,000</u>	1
2					2
3	<b>TOTALS</b>			\$ <b>200,000</b>	3

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	140	1993	1993	\$ 2,132,500	\$ 54,679	35	\$ 106,625	\$ 51,946	\$ 613,775	4
5			1993	25,000		35	1,250	1,250	7,500	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1994	61,594		20	3,079	3,079	22,307	9
10	Various		1995	220,229		20	11,014	11,014	71,961	10
11	Various		1996	141,678		20	7,085	7,085	39,951	11
12	Various		1997	117,480		20	5,875	(5,875)	27,566	12
13							-		-	13
14							-		-	14
15							-		-	15
16							-		-	16
17							-		-	17
18							-		-	18
19							-		-	19
20							-		-	20
21							-		-	21
22							-		-	22
23							-		-	23
24							-		-	24
25							-		-	25
26							-		-	26
27							-		-	27
28							-		-	28
29							-		-	29
30							-		-	30
31							-		-	31
32							-		-	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	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		584,042	12,385		26,326	13,941	284,138	68
69			62,871			(62,871)		69
70		\$ 3,282,523	\$ 129,935		\$ 161,254	\$ 19,569	\$ 1,067,198	70

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

Facility Name &amp; ID Number LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning:

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## 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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,282,523	\$ 129,935		\$ 161,254	\$ 31,319	\$ 1,067,198	1
2	GREASE TRAP-PLUMBING	1998	1,190		20	60	60	235	2
3	ROOFING & INSULATION	1998	19,800		20	990	990	3,713	3
4	HOT WATER HEATER	1998	4,246		20	212	212	795	4
5	SECURITY DEVICE	1998	669		20	33	33	124	5
6	WALK IN COOLER	1998	1,285		20	64	64	240	6
7	CARPETING	1998	816		20	41	41	150	7
8	EXHAUST PIPING	1998	5,400		20	270	270	968	8
9	PUMP MOTOR	1998	518		20	26	26	93	9
10	DUCT WORK	1998	1,170		20	59	59	216	10
11	CIRCUITRY	1998	635		20	32	32	125	11
12	PATIO	1998	1,230		20	62	62	222	12
13	PLUMBING	1998	1,663		20	83	83	277	13
14	DRYWALL & ALUM RETAI	1998	1,528		20	76	76	247	14
15	PLUMBING & TOILETS	1998	3,408		20	170	170	553	15
16	CARPETING	1998	889		20	44	44	143	16
17	FLOOR & WALL TILES	1998	2,325		20	116	116	367	17
18	WALLPAPER & TILING	1998	5,633		20	282	282	870	18
19	TILES	1998	2,038		20	102	102	323	19
20	EJECTOR PUMPS	1998	1,675		20	84	84	259	20
21	DRAPERIE	1998	5,309		20	265	265	950	21
22	BATH WALLS & FLOORS	1999	12,886		20	644	644	1,771	22
23	WOOD DOORS	1999	3,891		20	195	195	553	23
24	SINK	1999	1,618		20	81	81	230	24
25	DOORS	1999	718		20	36	36	99	25
26	BOILER	1999	2,985		20	149	149	435	26
27	FAUCET	1999	986		20	49	49	139	27
28	TOILETS	1999	3,156		20	158	158	448	28
29	ROOM REMODELING	1999	2,250		20	113	113	301	29
30	ROOM REMODELING	1999	4,354		20	218	218	563	30
31	ROOM REMODELING	1999	3,480		20	174	174	493	31
32	ROOM REMODELING	1999	2,207		20	110	110	266	32
33	DOORS	1999	446		20	22	22	59	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,382,927	\$ 129,935		\$ 166,274	\$ 36,339	\$ 1,083,425	34

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

Facility Name &amp; ID Number LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning:

01/01/01

Ending:

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## 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	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,382,927	\$ 129,935		\$ 166,274	\$ 36,339	\$ 1,083,425	1
2	WALLPAPER & TILING	1999	8,242		20	412	412	1,099	2
3	ELECTRICAL	1999	965		20	48	48	128	3
4	LIGHT FIXTURES	1999	2,476		20	124	124	310	4
5	WALLPAPER	1999	1,126		20	56	56	140	5
6	VANITY	1999	1,466		20	73	73	170	6
7	CORNICES	1999	6,954		20	348	348	812	7
8	WALL BATH BARS	1999	519		20	26	26	74	8
9	PANELING	1999	785		20	39	39	91	9
10	BATHROOM HARDWARE	1999	460		20	23	23	52	10
11	WALL TILE	1999	930		20	47	47	141	11
12	CORNICES & PANELING	1999	3,882		20	194	194	582	12
13	ROOM REMODELING	1999	5,137		20	257	257	535	13
14	LANDSCAPING	1999	1,327		20	119	119	252	14
15	OFFICE EXPANSON	2000	129,746		20	3,327	3,327	5,129	15
16	ARCHITECT	2000	8,000		20	205	205	401	16
17	WALLPAPER & CARPETIN	2000	12,296		20	315	315	617	17
18	REDECORATING	2000	26,956		20	691	691	1,065	18
19	ARCHITECT	2000	4,060		20	104	104	204	19
20	PUMP	2000	1,409		20	64	64	64	20
21	W. GLASS	2000	650		20	30	30	30	21
22	WINDOW	2000	772		20	20	20	31	22
23	THERMOPANE WINDOWS	2000	6,244		20	160	160	247	23
24	EXTERIOR LIGHTING	2000	2,569		20	66	66	107	24
25	DOOR RELEASE BUTTON	2000	728		20	19	19	29	25
26	BOILER	2000	660		20	17	17	26	26
27	PAINTING	2000	1,500		20	38	38	59	27
28	GLASS	2000	4,000		20	103	103	150	28
29	WALLPAPER	2000	846		20	22	22	34	29
30	WALLPAPER	2000	6,640		20	170	170	305	30
31	SOUND SYSTEM	2000	783		20	20	20	34	31
32	CURIO CABINET	2000	2,725		20	70	70	90	32
33	WASH SINK	2000	516		20	13	13	19	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,628,296	\$ 129,935		\$ 173,494	\$ 43,559	\$ 1,096,452	34

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

Facility Name &amp; ID Number LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning:

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Ending:

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## 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	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,628,296	\$ 129,935		\$ 173,494	\$ 43,559	\$ 1,096,452	1
2	TOILET	2000	2,130		20	55	55	71	2
3	WASHROOM REMODELING	2000	7,800		20	200	200	275	3
4	TILES	2000	5,447		20	140	140	193	4
5	ROOFING	2000	1,190		20	31	31	40	5
6	ELECTRIC	2000	800		20	21	21	25	6
7	WA MONITORS	2000	1,030		20	26	26	40	7
8	LANDSCAPING	2000	1,065		20	101	101	155	8
9	WINDOWS AND DOORS	2000	4,599		20	118	118	182	9
10	REFRIGERATOR	2000	2,288		20	59	59	91	10
11	WA MONITOR	2000	2,117		20	54	54	83	11
12	DECORATING	2000	855		20	22	22	32	12
13	WINDOW TREATMENT	2000	5,068		20	130	130	146	13
14	FIRE ALARM	2000	8,781		20	225	225	253	14
15	HEAT EXCHANGER	2000	1,745		20	45	45	54	15
16	VENTING	2000	1,940		20	50	50	56	16
17	CURB/ROOF	2001	685		20	23	23	23	17
18	WALLPAPER	2001	2,000		20	92	92	92	18
19	HOT WATER HEATER	2001	2,123		20	97	97	97	19
20	WINDOW TREATMENT	2001	151		20	8	8	9	20
21	WALLPAPER	2001	333		20	17	17	24	21
22	PVC PIPING	2001	4,769		20	119	119	119	22
23	EXHAUST FAN	2001	2,426		20	61	61	61	23
24	GLASS	2001	500		20	10	10	10	24
25	WALLPAPER	2001	1,235		20	26	26	26	25
26	BORDER/WALLPAPER	2001	7,263		20	151	151	151	26
27	CURTAINS	2001	7,518		20	157	157	157	27
28	CABINET/BOARD	2001	6,611		20	110	110	110	28
29	WALLPAPER	2001	3,950		20	50	50	50	29
30	WG MONITOR	2001	1,020		20	17	17	17	30
31	PVC PIPING	2001	3,541		20	30	30	30	31
32	CORNICE W/LINED DRAP	2001	8,401		20	70	70	70	32
33	WALLPAPER	2001	4,000		20	33	33	33	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,731,677	\$ 129,935		\$ 175,842	\$ 45,907	\$ 1,099,227	34

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

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	
1	Totals from Page 12D, Carried Forward		\$ 3,731,677	\$ 129,935		\$ 175,842	\$ 45,907	\$ 1,099,227	1
2	ROOF/WALL REPAIR	2001	8,300		20	69	69	69	2
3	SURVEILANCE CAMERAS	2001	5,825		20	97	97	97	3
4	ALARM/AUTOMATIC DOOR	2001	812		20	7	7	7	4
5	DRYWALL	2001	9,850		20	41	41	41	5
6	WALLPAPER	2001	3,600		20	15	15	15	6
7	WATER SALENOID	2001	630		20	32	32	32	7
8	HEAT INDUCER	2001	1,696		20	85	85	85	8
9	PLUMBING WORK	2001	1,650		20	83	83	83	9
10	PLUMBING WORK	2001	3,925		20	196	196	196	10
11	PIPE REPAIRS	2001	915		20	46	46	46	11
12	PLUMBING WORK	2001	625		20	31	31	31	12
13	WIRING	2001	1,200		20	60	60	60	13
14	FOUNDATION WORK	2001	2,615		20	131	131	131	14
15	WATER HEATER REPAIRS	2001	849		20	85	85	85	15
16	WALL REPAIRS	2001	1,390		20	70	70	70	16
17	AC REPAIR	2001	2,323		20	116	116	116	17
18	DOORS	2001	900		20	90	90	90	18
19	PUMP REPAIRS	2001	560		20	56	56	56	19
20	EVACUATION SIGNS	2001	583		20	58	58	58	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,779,925	\$ 129,935		\$ 177,208	\$ 47,273	\$ 1,100,593	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,779,925	\$ 129,935		\$ 177,208	\$ 47,273	\$ 1,100,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,779,925	\$ 129,935		\$ 177,208	\$ 47,273	\$ 1,100,593	34

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

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	
1	Totals from Page 12F, Carried Forward		\$ 3,779,925	\$ 129,935		\$ 177,208	\$ 47,273	\$ 1,100,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,779,925	\$ 129,935		\$ 177,208	\$ 47,273	\$ 1,100,593	34

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

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	
1	Totals from Page 12G, Carried Forward		\$ 3,779,925	\$ 129,935		\$ 177,208	\$ 47,273	\$ 1,100,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,779,925	\$ 129,935		\$ 177,208	\$ 47,273	\$ 1,100,593	34

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

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	
1	Totals from Page 12H, Carried Forward		\$ 3,779,925	\$ 129,935		\$ 177,208	\$ 47,273	\$ 1,100,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,779,925	\$ 129,935		\$ 177,208	\$ 47,273	\$ 1,100,593	34

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

Facility Name & ID Number LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning:

01/01/01

Ending:

12/31/01

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		
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
	Improvement Type**									
9	GAF PARTNERSHIP		1981	5,694		20			5,694	9
10			1982	17,924		20			17,924	10
11			1983	5,201		20			5,201	11
12			1984	27,884		20			27,884	12
13			1985	77,350	2,232	20	3,870	1,638	61,555	13
14			1986	37,603	1,579	20	1,880	301	32,526	14
15			1987	38,247	1,213	20	1,913	700	5,812	15
16			1988	13,918	441	20	650	209	7,226	16
17			1989	53,326	1,559	20	2,667	1,108	23,992	17
18			1990	39,155	1,244	20	1,958	714	16,672	18
19			1991	101,697	1,552	20	5,085	3,533	35,395	19
20			1992	16,406	307	20	821	514	4,516	20
21			1993	149,637	2,258	20	7,482	5,224	39,741	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										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-REP, Line 70 for total

Facility Name & ID Number LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	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)	\$ 584,042	\$ 12,385		\$ 26,326	\$ 13,941	\$ 284,138	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	\$ 556,456	\$ 1,011	\$ 35,861	\$ 34,850	10	\$ 411,010	71
72	Current Year Purchases	63,751		4,793	4,793	10	4,793	72
73	Fully Depreciated Assets	122,795				10	122,795	73
74								74
75	TOTALS	\$ 743,002	\$ 1,011	\$ 40,654	\$ 39,643		\$ 538,598	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	FACILITY	VAN	1997	\$ 6,999	\$	\$ 700	\$ 700	5	\$ 3,033	76
77										77
78										78
79										79
80	TOTALS			\$ 6,999	\$	\$ 700	\$ 700		\$ 3,033	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)	\$ 4,729,926	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 130,946	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,562	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 87,616	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,642,224	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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 13,907 Description: SEE ATTACHED

(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	ADMINISTRATIVE		\$ 525	\$ 6,825	17
18					18
19					19
20					20
21	TOTAL		\$ 525	\$ 6,825	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. /2002 \$ \_\_\_\_\_

13. /2003 \$ \_\_\_\_\_

14. /2004 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		360		360
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		4,400		4,400
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 4,760	\$	\$ 4,760
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,760		

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	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>11</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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,328				1,328	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs			108,093				108,093	4
5	Physician Care	39 - 03	visits			36,263				36,263	5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescripts				53,941			53,941	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):						19,606			19,606	13
14	<b>TOTAL</b>			\$		\$ 145,684	\$ 73,547		\$	219,231	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 LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning: 01/01/01

Ending:

12/31/01

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(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	\$ 54,123	\$ 217,116	1
2	Cash-Patient Deposits	21,909	21,909	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,009,463	1,009,463	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	2,000	2,000	5
6	Prepaid Insurance	32,013	32,013	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See supplemental schedule</a>	42,685	42,685	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,162,193	\$ 1,325,186	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		200,000	13
14	Buildings, at Historical Cost		2,132,500	14
15	Leasehold Improvements, at Historical Cost	963,146	1,370,722	15
16	Equipment, at Historical Cost	352,034	763,547	16
17	Accumulated Depreciation (book methods)	(372,540)	(1,463,509)	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): <a href="#">See supplemental schedule</a>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 942,640	\$ 3,003,260	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,104,833	\$ 4,328,446	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 234,934	\$ 234,934	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,164	33,164	28
29	Short-Term Notes Payable	330,000	330,000	29
30	Accrued Salaries Payable	107,997	107,997	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,252	8,252	31
32	Accrued Real Estate Taxes(Sch.IX-B)	155,300	155,300	32
33	Accrued Interest Payable		9,984	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		2,330	35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See supplemental schedule</a>	1,712	1,712	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 871,359	\$ 883,673	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	766,915	205,000	39
40	Mortgage Payable		1,410,512	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See supplemental schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 766,915	\$ 1,615,512	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,638,274	\$ 2,499,185	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 466,559	\$ 1,829,261	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,104,833	\$ 4,328,446	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 573,749	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 573,749	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(107,190)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (107,190)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 466,559	24 *

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

Facility Name &amp; ID Number LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning: 01/01/01

Ending:

12/31/01

**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	\$ 4,913,174	1
2	Discounts and Allowances for all Levels	(74,495)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,838,679	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	368,510	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 368,510	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	83,133	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,935	19
20	Radiology and X-Ray		20
21	Other Medical Services	22,832	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 115,900	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	66	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 66	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See supplemental schedule</u>	1,913	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,913	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,325,068	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	957,592	31
32	Health Care	1,917,979	32
33	General Administration	1,639,897	33
<b>B. Capital Expense</b>			
34	Ownership	620,606	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	219,534	35
36	Provider Participation Fee	76,650	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,432,258	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(107,190)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (107,190)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning: 01/01/01

Ending:

12/31/01

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	2,080	2,080	\$ 63,670	\$ 30.61	1
2	Assistant Director of Nursing	693	701	21,181	30.22	2
3	Registered Nurses	11,483	11,911	257,766	21.64	3
4	Licensed Practical Nurses	17,227	18,719	402,821	21.52	4
5	Nurse Aides & Orderlies	76,990	79,994	665,688	8.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,886	8,694	106,457	12.24	8
9	Activity Director					9
10	Activity Assistants	7,803	8,177	86,856	10.62	10
11	Social Service Workers	13,574	14,280	176,793	12.38	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	37,657	18.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,226	17,118	127,209	7.43	15
16	Dishwashers					16
17	Maintenance Workers	7,211	7,587	85,057	11.21	17
18	Housekeepers	21,223	22,330	185,335	8.30	18
19	Laundry	10,312	10,772	80,975	7.52	19
20	Administrator	2,080	2,080	83,899	40.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,480	3,672	62,734	17.08	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	1,517	1,653	16,035	9.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	201,865	211,848	\$ 2,460,133 *	\$ 11.61	34

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	155	\$ 13,115	01-03	35
36	Medical Director	110	3,300	09-03	36
37	Medical Records Consultant	MONTHLY	4,375	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	3,500	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,708	11-03	44
45	Social Service Consultant	93	3,728	12-03	45
46	Other(specify)				46
47	Psycho-Social Rehab Consultant	125	3,760	12-03	47
48					48
49	TOTAL (lines 35 - 48)	525	\$ 34,486		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	349	\$ 16,039	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	349	\$ 16,039		53

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

\*\* See instructions.

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Shelley Martinez	Administrator	0	\$ 83,899	Workers' Compensation Insurance	\$ 77,002	IDPH License Fee	\$ 400	
				Unemployment Compensation Insurance	17,871	Advertising: Employee Recruitment	3,326	
				FICA Taxes	188,036	Health Care Worker Background Check	1,000	
				Employee Health Insurance	66,504	(Indicate # of checks performed 142 )		
				Employee Meals	19,385	Licenses	6,842	
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Page Advertising	1,799	
				Employee Benefits	16,830	Promotional Advertising	10,148	
				Union Health and Welfare	70,553	Dues - ICLTC	3,082	
				Christmas Expense	3,457			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,899					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
GAF, LTD - Management Fees			\$ 200,000				Out-of-State Travel	\$
PRO HEALTH - Administrative Fees			47,246					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 247,246				Seminar Expense	2,746
C. Professional Services				TOTAL			(agree to Sch. V, line 20, col. 8)	
Vendor/Payee	Type		Amount	\$ 459,638			TOTAL (agree to Sch. V, line 24, col. 8)	
Frank Ruffner Montgomery	Collections-Adj out Page 5		\$ 4,135					\$ 3,354
Frost, Ruttenberg & Rothblatt	Accounting		40,349					
Property Valuation Services	Property Valuation		3,500					
Personnel Planners	Unemployment Consultant		900					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 48,884					

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

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

Facility Name &amp; ID Number LAKE COOK TERRACE NURSING CE

# 0039669

Report Period Beginning:

01/01/01

Ending:

12/31/01

**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. ICLTC - \$3,802
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,187 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. \$ 76,650  
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. \$ 19,385 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? 100% of In  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? 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? \_\_\_\_\_  
Firm Name: NO 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