

		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>0037671</u></p> <p><b>Facility Name:</b> <u>LASALLE HEALTHCARE CENTER</u></p> <p><b>Address:</b> <u>1445 Chartres Street</u> <u>LaSalle</u> <u>61301</u> Number City Zip Code</p> <p><b>County:</b> <u>LaSalle</u></p> <p><b>Telephone Number:</b> <u>(815) 223-4700</u> Fax # <u>(815) 223-6630</u></p> <p><b>IDPA ID Number:</b> <u>36-2795206</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>2/19/1992</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input 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> Name: <u>Cathy Simeoni</u> Telephone Number: <u>(714) 596-7713, Ext 12</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 checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input 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>1/1/01</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"> <tr> <td data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>LINDA HOLTZSCHEITER</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Title) <u>REIMBURSEMENT MANAGER</u> (Signed) _____ (Date) _____ (Print Name and Title) <u>Cathy Simeoni</u> <u>Manager - Healthcare Consulting</u> (Firm Name &amp; Address) <u>Kellogg &amp; Andelson, Accountancy Corporation</u> <u>16162 Beach Blvd, #308, Huntington Beach, CA 92647</u> (Telephone) <u>(714) 596-7713</u> Fax # <u>(714) 596-7721</u></td> </tr> </table> <p><b>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>LINDA HOLTZSCHEITER</u>	Paid Preparer	(Title) <u>REIMBURSEMENT MANAGER</u> (Signed) _____ (Date) _____ (Print Name and Title) <u>Cathy Simeoni</u> <u>Manager - Healthcare Consulting</u> (Firm Name & Address) <u>Kellogg &amp; Andelson, Accountancy Corporation</u> <u>16162 Beach Blvd, #308, Huntington Beach, CA 92647</u> (Telephone) <u>(714) 596-7713</u> Fax # <u>(714) 596-7721</u>
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Facility Name & ID Number LASALLE HEALTHCARE CENTER# 0037671 Report Period Beginning: 1/1/01 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	<u>50</u>	Skilled (SNF)	<u>50</u>	<u>18,250</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>51</u>	Intermediate (ICF)	<u>51</u>	<u>18,615</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>10,814</u>	<u>3,112</u>	<u>3,671</u>	<u>17,597</u>	8
9	SNF/PED					9
10	ICF	<u>13,159</u>	<u>4,959</u>	<u>12</u>	<u>18,130</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,973</u>	<u>8,071</u>	<u>3,683</u>	<u>35,727</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 96.91%D. How many bed-hold days during this year were paid by Public Aid?  
238 (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)NONEF. Does the facility maintain a daily midnight census? YESG. 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 01/01/92J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 01/01/92 NO K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number  
of beds certified 26 and days of care provided 3,647Medicare Intermediary AdminaStar Kentucky

## 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 LASALLE HEALTHCARE CENTER # 0037671 Report Period Beginning: 1/1/01 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	134,230	8,419	7,683	150,332		150,332		150,332		1
2	Food Purchase		125,389		125,389		125,389		125,389		2
3	Housekeeping	100,372	9,792	1,365	111,529		111,529		111,529		3
4	Laundry	40,881	10,249		51,130		51,130		51,130		4
5	Heat and Other Utilities			88,689	88,689		88,689	409	89,098		5
6	Maintenance	42,136	29,899	28,904	100,939		100,939	192	101,131		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	317,619	183,748	126,641	628,008		628,008	601	628,609		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,236,515	78,152	14,535	1,329,202		1,329,202	11,016	1,340,218		10
10a	Therapy	112,380	533	2,788	115,701		115,701		115,701		10a
11	Activities	53,853	7,109	2,386	63,348		63,348	(222)	63,126		11
12	Social Services	29,736		2,387	32,123		32,123		32,123		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,432,484	85,794	31,096	1,549,374		1,549,374	10,794	1,560,168		16
	<b>C. General Administration</b>										
17	Administrative	63,805			63,805		63,805		63,805		17
18	Directors Fees										18
19	Professional Services			336	336		336	4,037	4,373		19
20	Dues, Fees, Subscriptions & Promotions			6,196	6,196		6,196	126	6,322		20
21	Clerical & General Office Expenses	77,052	8,263	(28,026)	57,289		57,289	188,605	245,894		21
22	Employee Benefits & Payroll Taxes			328,265	328,265		328,265		328,265		22
23	Inservice Training & Education			435	435		435		435		23
24	Travel and Seminar			5,281	5,281		5,281	12,565	17,846		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			73,473	73,473		73,473	(38,723)	34,750		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	140,857	8,263	385,960	535,080		535,080	166,610	701,690		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,890,960	277,805	543,697	2,712,462		2,712,462	178,005	2,890,467		29

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

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			37,829	37,829		37,829	62,381	100,210			30
31	Amortization of Pre-Op. & Org.			160,932	160,932		160,932		160,932			31
32	Interest											32
33	Real Estate Taxes			26,164	26,164		26,164		26,164			33
34	Rent-Facility & Grounds			408,836	408,836		408,836		408,836			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* SEE 4.2 ATTCHD							20,684	20,684			36
37	<b>TOTAL Ownership</b>			633,761	633,761		633,761	83,065	716,826			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,491	10,476	15,967		15,967		15,967			39
40	Barber and Beauty Shops			12,955	12,955		12,955	(12,955)	(0)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*			193	193		193		193			43
44	<b>TOTAL Special Cost Centers</b>		5,491	78,921	84,412		84,412	(12,955)	71,457			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,890,960	283,296	1,256,379	3,430,635		3,430,635	248,115	3,678,750			45

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

Facility Name & ID Number **LASALLE HEALTHCARE CENTER**

# **0037671**

Report Period Beginning: **1/1/01**

Ending: **12/31/01**

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(177)	21		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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(575)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	77,982	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(579)	21		28
29	Other-Attach Schedule	5,121			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 81,772		\$	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)	166,343		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 166,343		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 248,115		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

LASALLE HEALTHCARE CENTER

ID# 0037671

Report Period Beginning: 1/1/01

Ending: 12/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sales Taxes	\$ (1,556)	21	1
2	Open House Expense	(325)	21	2
3	Small Balance Adjustment	(1)	21	3
4	Memorium/Benevolence	(1,141)	21	4
5	FAS 121 **	3,722	30	5
6	Barber & Beauty	(12,955)	40	6
7	Activity Program Receipts	(222)	11	7
8	Depreciation Reconciliation	58,659	30	8
9	Professional Liability Insurance	(36,179)	26	9
10	Marketing Expense	(4,881)	21	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	5,121		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **LASALLE HEALTHCARE CENTER**# **0037671** Report Period Beginning:

1/1/01

Ending:

12/31/01

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	409	0	0	0	0	0	0	0	0	0	409	5
6	Maintenance	0	192	0	0	0	0	0	0	0	0	0	192	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	601	0	0	0	0	0	0	0	0	0	601	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	11,016	0	0	0	0	0	0	0	0	0	11,016	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(222)	0	0	0	0	0	0	0	0	0	0	(222)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	(222)	11,016	0	0	0	0	0	0	0	0	0	10,794	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,037	0	0	0	0	0	0	0	0	0	4,037	19
20	Fees, Subscriptions & Promotions	0	126	0	0	0	0	0	0	0	0	0	126	20
21	Clerical & General Office Expenses	68,747	119,858	0	0	0	0	0	0	0	0	0	188,605	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,565	0	0	0	0	0	0	0	0	0	12,565	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(36,179)	(2,544)	0	0	0	0	0	0	0	0	0	(38,723)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	32,568	134,042	0	0	0	0	0	0	0	0	0	166,610	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	32,346	145,659	0	0	0	0	0	0	0	0	0	178,005	29



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
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute Network	Atlanta, GA	Bookkeeping & Management

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	5 Utilities	\$	Mariner Post Acute Network	100.00%	\$ 409	\$	409	1
2	V	6 Repairs and Maintenance		Mariner Post Acute Network	100.00%	192		192	2
3	V	19 Professional Services		Mariner Post Acute Network	100.00%	4,037		4,037	3
4	V	20 Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	126		126	4
5	V	10 Nursing and Medical Records		Mariner Post Acute Network	100.00%	11,016		11,016	5
6	V	21 Clerical and General Office Exp		Mariner Post Acute Network	100.00%	119,858		119,858	6
7	V	24 Travel and Seminar		Mariner Post Acute Network	100.00%	12,565		12,565	7
8	V	26 Insurance Premium		Mariner Post Acute Network	100.00%	(2,544)		(2,544)	8
9	V	36 Depreciation		Mariner Post Acute Network	100.00%	14,482		14,482	9
10	V	36 Taxes-Property		Mariner Post Acute Network	100.00%	608		608	10
11	V	36 Rental & Leasing		Mariner Post Acute Network	100.00%	3,658		3,658	11
12	V	36 Lease Expense		Mariner Post Acute Network	100.00%	1,935		1,935	12
13	V	36 Property Insurance		Mariner Post Acute Network	100.00%	1		1	13
14	Total		\$			\$ 166,343	\$ *	166,343	14

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

Facility Name & ID Number LASALLE HEALTHCARE CENTER # 0037671 Report Period Beginning: 1/1/01 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									\$	1
2										2
3										3
4	NOT APPLICABLE									4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number LASALLE HEALTHCARE CENTER # 0037671 Report Period Beginning: 1/1/01 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 Mariner Post Acute Network  
 Street Address One Ravine Dr., Suite 1500  
 City / State / Zip Code Atlanta, GA 30346  
 Phone Number ( 770 ) 379-8203  
 Fax Number ( 770 ) 399-1971

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facility Costs		\$ 20,767	\$		\$ 409	1
2	6	Repairs and Maintenance	Facility Costs		9,731			192	2
3	19	Professional Services	Facility Costs		205,127			4,037	3
4	20	Fees, Subscriptions, Promotions	Facility Costs		6,427			126	4
5	10	Nursing and Medical Records	Facility Costs		67,554			11,016	5
6	21	Clerical and General Office Exp	Facility Costs		6,582,242			119,858	6
7	24	Travel and Seminar	Facility Costs		638,416			12,565	7
8	26	Insurance Premium	Facility Costs		(129,286)			(2,544)	8
9	36	Depreciation	Facility Costs		735,846			14,482	9
10	36	Taxes-Property	Facility Costs		30,882			608	10
11	36	Rental & Leasing	Facility Costs		185,889			3,658	11
12	36	Lease Expense	Facility Costs		98,311			1,935	12
13	36	Property Insurance	Facility Costs		76			1	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				\$ 8,451,982	\$		\$ 166,343	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<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												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	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.)

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

**B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2000 report.			\$	58,458	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	24,143	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(34,315)	3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	60,479	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	26,164	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1996	25,394	8	<b>FOR OHF USE ONLY</b>	
		1997	24,596	9	13	FROM R. E. TAX STATEMENT FOR 2000 \$
		1998	25,172	10	14	PLUS APPEAL COST FROM LINE 5 \$
		1999	31,824	11	15	LESS REFUND FROM LINE 6 \$
		2000	24,143	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
<b>2001 REAL ESTATE TAX ACCRUAL: \$60,479</b>						

**NOTES:**

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

**IMPORTANT NOTICE**

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

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

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

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

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

FACILITY NAME LASALLE HEALTHCARE CENTER COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0037671

CONTACT PERSON REGARDING THIS REPORT CATHY SIMEONI

TELEPHONE (714)596-7713 FAX #: (714)596-7721

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

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-09-451-000</u>	<u>PT E1/2 SE-BEG891.02 NE COR,S4C</u>	\$ <u>22,776.92</u>	\$ <u>22,776.92</u>
2. <u>17-09-449-000</u>	<u>PT SE4-9-33-1 BEG 1291.02' S NEC</u>	\$ <u>1,176.54</u>	\$ <u>1,176.54</u>
3. <u>17-09-450-000</u>	<u>IRREG .19ACS NE SE</u>	\$ <u>189.96</u>	\$ <u>189.96</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>24,143.42</u>	\$ <u>24,143.42</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 31,694 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number LASALLE HEALTHCARE CENTER

# 0037671

Report Period Beginning:

1/1/01

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	
<b>Improvement Type**</b>										
9	See Attached Schedules	1977		11,239		20			11,239	9
10	See Attached Schedules	1979		474		20			474	10
11	See Attached Schedules	1981		11,327	372	20	372		11,034	11
12	See Attached Schedules	1982		1,272	64	20	64		1,259	12
13	See Attached Schedules	1983		4,927	247	20	247		4,483	13
14	See Attached Schedules	1984		24,032	1,203	20	1,203		20,855	14
15	See Attached Schedules	1985		50,750	2,537	20	2,537		42,097	15
16	See Attached Schedules	1986		327	16	20	16		259	16
17	See Attached Schedules	1987		5,631	282	20	282		4,036	17
18	See Attached Schedules	1988		4,260	213	20	213		2,846	18
19	See Attached Schedules	1989		8,947	447	20	447		5,537	19
20	See Attached Schedules	1990		19,986	1,000	20	1,000		11,008	20
21	See Attached Schedules	1991		158,584	8,126	20	8,126		83,515	21
22	See Attached Schedules	1992		28,134	1,406	20	1,406		13,577	22
23	See Attached Schedules	1993		95,566	4,778	20	4,778		41,634	23
24	See Attached Schedules	1994		25,902	1,295	20	1,295		9,613	24
25										25
26	See Attached Schedules	1978		514		20			514	26
27	See Attached Schedules	1974		700		20			700	27
28	See Attached Schedules	1992		7,158	359	20	359		4,171	28
29	See Attached Schedules	1993		23,691	1,185	20	1,185		9,721	29
30	See Attached Schedules	1995		14,934	747	20	747		4,021	30
31										31
32	Depreciation Adjustment				8,901		8,901			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

STATE OF ILLINOIS

Facility Name & ID Number LASALLE HEALTHCARE CENTER

# 0037671

Report Period Beginning:

1/1/01

Ending:

Page 12A  
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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	PARKING LOT REPAIRS	1996	\$ 2,400	\$ 120	20	\$ 120	\$	\$ 648	37
38	DOOR & FRAMES	1996	1,679	84	20	84		458	38
39	THERAPY ADDITIONS	1997	5,709	285	20	285		1,292	39
40	THERAPY ROOM	1997	7,232	362	20	362		1,531	40
41	A/C REPAIR	1996	1,120	56	20	56		324	41
42	FIRE ALARM SYSTEM	1996	14,927	746	20	746		4,031	42
43	PLUMBING REPAIR	1996	772	39	20	39		201	43
44									44
45	SECURITY SYSTEM	1998	806	18	20	18		72	45
46	EXTERIOR SIGNS/FLAGPOLE	1998	3,221	34	20	34		136	46
47	WATER HEATER	1998	5,634	106	20	106		424	47
48									48
49	ALLOCATION-MARINER POST ACUTE			38,347		38,347		115,041	49
50									50
51	1:90 GAL. WATER HEATER	1999	4,700	470	10	470		1,096	51
52									52
53	7.5 TON CARRIER ROOFTOP INSTL	2001	8,250	688	10	688		688	53
54	W/N/C RTU CONDENSER, EVAPCOIL	2001	4,842	215	15	215		215	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)		\$ 559,647	\$ 74,748		\$ 74,748	\$	\$ 408,750	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	\$ 246,017	\$ 24,288	\$ 24,288	\$	10	\$ 198,639	71
72	Current Year Purchases	10,387	1,174	1,174			1,174	72
73	Fully Depreciated Assets	203,187				10	203,187	73
74								74
75	TOTALS	\$ 459,591	\$ 25,462	\$ 25,462	\$		\$ 403,000	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,019,238	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 100,210	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 100,210	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 811,750	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	Overhead Allocation	\$ 772	\$ 3	\$ 106	86
87	Overhead Allocation	1,531	6	172	87
88	Overhead Allocation	464	2	37	88
89	Overhead Allocation	215	1	16	89
90					90
91	TOTALS	\$ 2,982	\$ 12	\$ 331	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: NATIONWIDE HEALTH PROPERTIES  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
 If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1973</u>	<u>101</u>	<u>7/1/89</u>	\$ <u>408,836</u>	<u>10</u>	<u>40</u>	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>101</b>		\$ <b>408,836</b>			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

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

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

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

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

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
 (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

**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 type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

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

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

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

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

	Service	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		1306 hrs	\$ 35,062		\$	\$ 60	1,306	\$ 35,122	1
2	Licensed Speech and Language Development Therapist		416 hrs	12,481				416	12,481	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		406 hrs	11,379				406	11,379	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts		243	10,454	5,491	243	15,945	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>AUDIOLOGIST</b>					22			22	13
14	<b>TOTAL</b>			\$ 58,922	243	\$ 10,476	\$ 5,551	2,371	\$ 74,949	14

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

## STATE OF ILLINOIS

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Facility Name &amp; ID Number LASALLE HEALTHCARE CENTER

# 0037671

Report Period Beginning: 1/1/01

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	\$ 750	\$	1
2 Cash-Patient Deposits	48,486		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	645,028		3
4 Supply Inventory (priced at )	27,739		4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 722,003	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost	4,533		14
15 Leasehold Improvements, at Historical Cost	193,732		15
16 Equipment, at Historical Cost	189,480		16
17 Accumulated Depreciation (book methods)	(202,869)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	3,249,930		19
20 Accumulated Amortization - Organization & Pre-Operating Costs	(593,916)		20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): SEE ATTACHED SCHD 17.1	208		23
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,841,098	\$	24
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,563,101	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 132,833	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	161,557		30
31 Accrued Taxes Payable (excluding real estate taxes)	(142)		31
32 Accrued Real Estate Taxes(Sch.IX-B)	60,479		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 SEE ATTACHED SCHEDULE 17.1	143,771		36
37			37
<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 498,498	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43 SEE ATTACHED SCHEDULE 17.1	(1,846,506)		43
44			44
<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ (1,846,506)	\$	45
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ (1,348,008)	\$	46
47 <b>TOTAL EQUITY</b> (page 18, line 24)	\$ 4,911,109	\$	47
<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,563,101	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,392,348</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>4,392,348</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>637,117</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>637,117</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Intercompany Transfers</b>	<b>(118,356)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(118,356)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>4,911,109</b>	<b>24</b> *

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

Facility Name &amp; ID Number LASALLE HEALTHCARE CENTER

# 0037671

Report Period Beginning: 1/1/01

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	\$ 5,396,557	1
2	Discounts and Allowances for all Levels	(1,975,741)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,420,816	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	414,269	6
7	Oxygen	29,446	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 443,715	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	17,196	13
14	Non-Patient Meals	177	14
15	Telephone, Television and Radio	5,982	15
16	Rental of Facility Space		16
17	Sale of Drugs	80,608	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	69,653	19
20	Radiology and X-Ray	208	20
21	Other Medical Services	30,141	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 203,965	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	Miscellaneous Receipts	(744)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (744)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,067,752	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	628,008	31
32	Health Care	1,549,373	32
33	General Administration	535,082	33
<b>B. Capital Expense</b>			
34	Ownership	633,761	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	29,114	35
36	Provider Participation Fee	55,297	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,430,635	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	637,117	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 637,117	43

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

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

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

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

Facility Name & ID Number **LASALLE HEALTHCARE CENTER**

# **0037671**

Report Period Beginning: **1/1/01**

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	2,043	46,546	20.93	1
2	Assistant Director of Nursing	1,695	33,393	18.10	2
3	Registered Nurses	13,787	274,415	18.29	3
4	Licensed Practical Nurses	14,114	243,200	15.83	4
5	Nurse Aides & Orderlies	60,921	624,141	9.41	5
6	Nurse Aide Trainees				6
7	Licensed Therapist	2,846	81,587	26.34	7
8	Rehab/Therapy Aides	1,631	30,983	17.46	8
9	Activity Director	1,983	22,210	10.29	9
10	Activity Assistants	4,310	32,268	6.88	10
11	Social Service Workers	3,138	29,812	8.73	11
12	Dietician				12
13	Food Service Supervisor	1,993	33,288	15.35	13
14	Head Cook	6,538	51,655	7.26	14
15	Cook Helpers/Assistants	7,463	53,074	6.53	15
16	Dishwashers				16
17	Maintenance Workers	4,605	42,694	8.52	17
18	Housekeepers	13,009	101,829	7.19	18
19	Laundry	5,222	40,919	7.20	19
20	Administrator	2,008	58,302	26.68	20
21	Assistant Administrator				21
22	Other Administrative	1,818	28,943	14.63	22
23	Office Manager				23
24	Clerical	3,515	41,349	10.81	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	2,393	20,352	7.81	31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	<b>TOTAL (lines 1 - 33)</b>	<b>155,032</b>	<b>1,890,960 *</b>	<b>11.21</b>	<b>34</b>

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	150	4,982	1-3	35
36	Medical Director	96	9,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	243	11,016	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	2,386	11-3	44
45	Social Service Consultant	36	2,387	12-3	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>561</b>	<b>29,771</b>		<b>49</b>

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	<b>TOTAL (lines 50 - 52)</b>			<b>53</b>

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kathleen Dilbeck	Administrator	0	\$ 63,805	Workers' Compensation Insurance	\$ 30,716	IDPH License Fee	\$ 400	
				Unemployment Compensation Insurance	22,330	Advertising: Employee Recruitment		
				FICA Taxes	140,620	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	121,240	Other License Fees	581	
				Employee Meals		Dues	5,215	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	126	
				Other Employee Benefits	13,359			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,805			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 6,322		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 328,265	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Legal Fees	Legal Fees		\$ 336				Out-of-State Travel	\$
							In-State Travel	4,692
							Home Office Allocation	12,565
							Seminar Expense	589
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 336	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							\$ 17,846	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number LASALLE HEALTHCARE CENTER

# 0037671

Report Period Beginning:

1/1/01

Ending:

12/31/01

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ILLINOIS HEALTHCARE ASSOC.
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line \_\_\_\_\_
- (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. \$ 55,297  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 177
- (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? 0
- d. Have vehicle usage logs been maintained? NO
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.