

		FOR OHF USE				

LL 1

**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>0042374</u></p> <p><b>Facility Name:</b> <u>MARINER HEALTH OF WESTCHESTER</u></p> <p><b>Address:</b> <u>2901S. WOLF ROAD</u> <u>WESTCHESTER</u> <u>60154</u> Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>(708) 531-1441</u> Fax # <u>(708) 409-1271</u></p> <p><b>IDPA ID Number:</b> <u>58-1398665001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>10/01/89</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 style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>LINDA HOLTZSCHEITER</u></td> </tr> <tr> <td></td> <td>(Title) <u>REIMBURSEMENT MANAGER</u></td> </tr> <tr> <td></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Print Name and Title) <u>Cathy Simeoni</u> <u>Manager - Healthcare Consulting</u></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Kellogg &amp; Andelson, Accountancy Corporation</u> <u>16162 Beach Blvd, #308, Huntington Beach, CA 92647</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(714) 596-7713</u> Fax # <u>(714) 596-7721</u></td> </tr> </table> <p align="right"><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>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>LINDA HOLTZSCHEITER</u>		(Title) <u>REIMBURSEMENT MANAGER</u>		(Signed) _____ (Date) _____	<b>Paid Preparer</b>	(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>
<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 _____																																						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____																																						
	(Type or Print Name) <u>LINDA HOLTZSCHEITER</u>																																						
	(Title) <u>REIMBURSEMENT MANAGER</u>																																						
	(Signed) _____ (Date) _____																																						
<b>Paid Preparer</b>	(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>																																						

Facility Name & ID Number MARINER HEALTH OF WESTCHESTER

# 0042374 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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</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>12,185</u>	<u>18,454</u>	<u>5,937</u>	<u>36,576</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,185</u>	<u>18,454</u>	<u>5,937</u>	<u>36,576</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.51%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 10/01/89

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/01/89 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 60 and days of care provided 5,214

Medicare Intermediary Empire Medicare Services

**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.

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number MARINER HEALTH OF WESTCHESTER # 0042374 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	226,783	25,561	27,133	279,477		279,477		279,477		1
2	Food Purchase		179,108		179,108		179,108		179,108		2
3	Housekeeping		8,494	147,900	156,394		156,394		156,394		3
4	Laundry		17,765	116,303	134,068		134,068		134,068		4
5	Heat and Other Utilities			112,211	112,211		112,211	680	112,891		5
6	Maintenance	29,381	68,876	65,512	163,769		163,769	312	164,081		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	256,164	299,804	469,059	1,025,027		1,025,027	992	1,026,019		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	(2,822)		57,488	54,666		54,666		54,666		9
10	Nursing and Medical Records	1,931,744	210,592	243,248	2,385,584		2,385,584	17,189	2,402,773		10
10a	Therapy	136,648	3,201	87,745	227,594		227,594		227,594		10a
11	Activities	59,573	4,995	1,218	65,786		65,786		65,786		11
12	Social Services	33,864		1,173	35,037		35,037		35,037		12
13	Nurse Aide Training										13
14	Program Transportation			14,118	14,118		14,118		14,118		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,159,007	218,788	404,990	2,782,785		2,782,785	17,189	2,799,974		16
	<b>C. General Administration</b>										
17	Administrative	92,466			92,466		92,466		92,466		17
18	Directors Fees										18
19	Professional Services			6,467	6,467		6,467	7,088	13,555		19
20	Dues, Fees, Subscriptions & Promotions			17,381	17,381		17,381	199	17,580		20
21	Clerical & General Office Expenses	252,474	16,469	115,715	384,658		384,658	63,310	447,968		21
22	Employee Benefits & Payroll Taxes			422,964	422,964		422,964		422,964		22
23	Inservice Training & Education			458	458		458		458		23
24	Travel and Seminar			9,598	9,598		9,598	9,104	18,702		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			119,129	119,129		119,129	(79,435)	39,694		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	344,940	16,469	691,712	1,053,121		1,053,121	266	1,053,387		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,760,111	535,061	1,565,761	4,860,933		4,860,933	18,447	4,879,380		29

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

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

Facility Name & ID Number MARINER HEALTH OF WESTCHESTER #0042374 Report Period Beginning: 1/1/01 Ending: 12/31/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			144,189	144,189		144,189	153,184	297,373		30
31	Amortization of Pre-Op. & Org.			487,031	487,031		487,031		487,031		31
32	Interest										32
33	Real Estate Taxes			255,510	255,510		255,510		255,510		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* <b>h/o prop tax/ins</b>							32,056	32,056		36
37	<b>TOTAL Ownership</b>			886,730	886,730		886,730	185,240	1,071,970		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		154,047	8,590	162,637		162,637		162,637		39
40	Barber and Beauty Shops			25,688	25,688		25,688	(25,688)	(0)		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			65,880	65,880		65,880		65,880		42
43	Other (specify):* <b>See attached</b>			6,499	6,499		6,499		6,499		43
44	<b>TOTAL Special Cost Centers</b>		154,047	106,657	260,704		260,704	(25,688)	235,016		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,760,111	689,108	2,559,148	6,008,367		6,008,367	177,999	6,186,366		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 **MARINER HEALTH OF WESTCHESTER**

# **0042374**

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				4
5	Telephone, TV & Radio in Resident Rooms	(10,774)	21		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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	36,981	21		24
25	Fund Raising, Advertising and Promotional	(1,642)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(43,070)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (18,505)		\$	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)	196,504		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 196,504		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 177,999		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

STATE OF ILLINOIS  
MARINER HEALTH OF WESTCHESTER

Page 5A

ID# 0042374  
Report Period Beginning: 1/1/01  
Ending: 12/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sales Tax	\$ (2,062)	21	1
2	Open House Expense	(325)	21	2
3	FAS 121*	89,336	30	3
4	Barber & Beauty	(25,688)	40	4
5	Miscellaneous Revenue	(1,355)	21	5
6	Personal Purchases Revenue	(6,069)	21	6
7	Misc Receipts	(607)	21	7
8	Professional Liability Insurance	(73,678)	26	8
9	Depreciation Reconciliation	63,848	30	9
10	Marketing Wages	(86,470)	21	10
11				11
12				12
13	**The facility re-valued their assets in 1999. We			13
14	have reported the historical costs of the assets			14
15	consistent with the prior years, and have ensured			15
16	that depreciation expense is reported on straight			16
17	line. This adjustment is necessary to reverse the			17
18	re-valuation of historical cost.			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>	(43,070)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number MARINER HEALTH OF WESTCHESTER# 0042374 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	680	0	0	0	0	0	0	0	0	0	680	5
6	Maintenance	0	312	0	0	0	0	0	0	0	0	0	312	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	992	0	0	0	0	0	0	0	0	0	992	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	17,189	0	0	0	0	0	0	0	0	0	17,189	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	17,189	0	0	0	0	0	0	0	0	0	17,189	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	7,088	0	0	0	0	0	0	0	0	0	7,088	19
20	Fees, Subscriptions & Promotions	0	199	0	0	0	0	0	0	0	0	0	199	20
21	Clerical & General Office Expenses	(72,323)	135,633	0	0	0	0	0	0	0	0	0	63,310	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	9,104	0	0	0	0	0	0	0	0	0	9,104	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(73,678)	(5,757)	0	0	0	0	0	0	0	0	0	(79,435)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(146,001)	146,267	0	0	0	0	0	0	0	0	0	266	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(146,001)	164,448	0	0	0	0	0	0	0	0	0	18,447	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
				American Pharmac. Services	Glenview, Ill	Pharmacy

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%	\$ 680	\$ 680 1
2	V	6 Repairs and Maintenance		Mariner Post Acute Network	100.00%	312	312 2
3	V	19 Professional Services		Mariner Post Acute Network	100.00%	7,088	7,088 3
4	V	20 Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	199	199 4
5	V	10 Nursing and Medical Records		Mariner Post Acute Network	100.00%	17,189	17,189 5
6	V	21 Clerical and General Office Exp		Mariner Post Acute Network	100.00%	135,633	135,633 6
7	V	24 Travel and Seminar		Mariner Post Acute Network	100.00%	9,104	9,104 7
8	V	26 Insurance Premium		Mariner Post Acute Network	100.00%	(5,757)	(5,757) 8
9	V	36 Depreciation		Mariner Post Acute Network	100.00%	23,192	23,192 9
10	V	36 Taxes-Property		Mariner Post Acute Network	100.00%	363	363 10
11	V	36 Rental & Leasing		Mariner Post Acute Network	100.00%	6,190	6,190 11
12	V	36 Lease Expense		Mariner Post Acute Network	100.00%	2,308	2,308 12
13	V	36 Property Insurance		Mariner Post Acute Network	100.00%	3	3 13
14	Total		\$			\$ 196,504	\$ * 196,504 14

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

Facility Name & ID Number **MARINER HEALTH OF WESTCHESTER** # **0042374** 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 MARINER HEALTH OF WESTCHESTER # 0042374 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	\$		\$ 680	1
2	6	Repairs and Maintenance	Facility Costs		9,731			312	2
3	19	Professional Services	Facility Costs		205,127			7,088	3
4	20	Fees, Subscriptions, Promotions	Facility Costs		6,427			199	4
5	10	Nursing and Medical Records	Facility Costs		67,554			17,189	5
6	21	Clerical and General Office Exp	Facility Costs		6,582,242			135,633	6
7	24	Travel and Seminar	Facility Costs		638,416			9,104	7
8	26	Insurance Premium	Facility Costs		(129,286)			(5,757)	8
9	36	Depreciation	Facility Costs		735,846			23,192	9
10	36	Taxes-Property	Facility Costs		30,882			363	10
11	36	Rental & Leasing	Facility Costs		185,889			6,190	11
12	36	Lease Expense	Facility Costs		98,311			2,308	12
13	36	Property Insurance	Facility Costs		76			3	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	\$		\$ 196,504	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		3	4	5	6		7	8	9	10						
			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		Third National Bank		X	Mortgage			\$	\$ 5,277,648			\$	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>					\$	\$ 5,277,648			\$		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>					\$	\$ 5,277,648			\$		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.		\$	<b>234,302</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>249,889</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>15,587</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>239,923</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>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 \$ _____ For 19 _____ 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>255,510</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1996	<b>282,278</b>	<b>8</b>	<b>FOR OHF USE ONLY</b>	
	1997	<b>242,542</b>	<b>9</b>		
	1998	<b>243,979</b>	<b>10</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2000 \$ <b>13</b>
	1999	<b>242,963</b>	<b>11</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
	2000	<b>245,247</b>	<b>12</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
<b>2001 Real Estate Tax Accrual = \$239,923</b>				<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</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 MARINER HEALTH OF WESTCHESTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042374

CONTACT PERSON REGARDING THIS REPORT Cathy Simeoni

TELEPHONE (714) 596-7713, Ext 12 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>15-29-300-018-0000</u>	<u>2901 S WOLF RD, WESTCHESTER,</u>	\$ <u>245,247.30</u>	\$ <u>245,247.30</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>245,247.30</u>	\$ <u>245,247.30</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: 37,531 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories           

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

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

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

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

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

---



---



---



---



---

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: Goodwill=\$674,800 Deferred Finance=\$113,963 2. Number of Years Over Which it is Being Amortized: Goodwill=40, Defer Fin=9  
3. Current Period Amortization: 487,031 4. Dates Incurred: Goodwill=1996, Deferred finance costs=1994

Nature of Costs: Goodwill=\$487,031  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1989	\$ 795,000	1
2					2
3	TOTALS			\$ 795,000	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	120	1989	1989	\$ 4,412,330	\$	40	\$ 110,308	\$ 110,308	\$ 661,849	4
5		1991	1991	217,404	5,435	40	5,435		32,610	5
6		1993	1993	15,459	386	40	386		2,317	6
7		1994	1994	14,498	1,216	40	1,216		7,295	7
8		1995	1995	2,902	73	40	73		437	8
<b>Improvement Type**</b>										
9	TILES		1996	2,092	53	40	53		280	9
10	CARPETING		1996	2,118	303	7	303		1,640	10
11	DRYWALL		1996	1,200	30	40	30		174	11
12	BUILDING IMP / APCO		1996	4,439	111	40	111		629	12
13	BOOSTER HEATER UPGRADE		1996	2,810	401	7	401		2,240	13
14	REPAIR OF WASHER		1996	1,671	239	7	239		1,294	14
15	PLUMBING REPAIRS		1996	5,328	761	7	761		3,956	15
16	HEALTHCARE DESIGNS		1997	6,896	172	40	172		732	16
17	WALLCOVERINGS		1997	55,860	1,395	40	1,395		5,797	17
18	DRAPERIES		1997	66,932	9,562	7	9,562		40,805	18
19	PAINTING AND DECORATING		1997	14,813	372	40	372		1,548	19
20	CARPETING		1997	38,524	5,505	7	5,505		23,376	20
21	BUILDING INTERIOR DESIGNING - NRSNG & THERAPY ROOMS		1997	50,274	1,257	40	1,257		5,343	21
22	PHONE SYSTEMS		1998	33,091	4,964	5	4,964		19,856	22
23	BUILDING INTERIOR DESIGNING - NRSNG & THERAPY ROOMS		1998	52,903	919	40	919		3,676	23
24	CONSTRUCTION AND RENOVATION-NRSNG & THRPY ROOMS		1998	139,140	3,276	40	3,276		13,590	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

## STATE OF ILLINOIS

Page 12A

Facility Name & ID Number MARINER HEALTH OF WESTCHESTER# 0042374

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Heat Air Units	1998	\$ 2,239	\$ 293	7	\$ 293	\$	\$ 1,172		37
38	Heat Air Units	1998	1,120	147	7	147		588		38
39	Window Treatments	1998	1,518	145	7	145		580		39
40	Cubicle Curtains	1998	1,180	42	7	42		168		40
41										41
42	Mariner Health Allocation	1990	27		7			54		42
43	Mariner Health Allocation	1991	18	1	7	1		18		43
44	Mariner Health Allocation	1992	45	6	7 - 15	6		100		44
45	Mariner Health Allocation	1993	111	7	15	7		96		45
46	Mariner Health Allocation	1994	1,573	232	15	232		2,368		46
47	Mariner Health Allocation	1995	21,658	637	40	637		5,204		47
48	Mariner Health Allocation	1996	3,321	213	7 - 40	213		1,404		48
49	Mariner Health Allocation	1997	1,118	29	7 - 40	29		146		49
50	Mariner Health Allocation	1998	2,905	55	7 - 40	55		220		50
51										51
52	Heat Exchange Install	1999	747	19	40	19		57		52
53	Heat Exchange Install	1999	6,222	156	40	156		468		53
54	Interior Design Serv	1999	150	4	40	4		12		54
55										55
56	Flooring-Dining Room	2000	1,065	107	10	107		178		56
57	Flooring-Resident Rooms	2000	2,127	213	10	213		355		57
58	Vinyl Tile Resident	2000	4,004	400	10	400		667		58
59	Vinyl Tile Dining Room	2000	2,064	206	10	206		344		59
60	Vinyl Flooring	2000	1,136	227	5	227		284		60
61	VCT w/ Wallbase	2000	2,650	265	10	265		331		61
62										62
63	ZoneAirHVAC Unit, Pt Rm 225	2001	1,850	134	15	134		134		63
64	3:Zoneline HVAC Units	2001	5,700	348	15	348		348		64
65	3:A/C Compressor, Rm 16A, B&17A	2001	5,700	222	15	222		222		65
66	Rooftop Condenser Coil-Kitchen	2001	3,880	108	15	108		108		66
67	Rpr Compressor, Leaks-F/A Syst	2001	3,800	127	10	127		127		67
68	Roof Repair-Kitchen & Rm 226	2001	833	28	10	28		28		68
69										69
70	TOTAL (lines 4 thru 69)		\$ 5,219,445	\$ 40,800		\$ 151,108	\$ 110,308	\$ 845,224		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	\$ 1,039,272	\$ 146,122	\$ 146,122	\$	7	\$ 804,545	71
72	Current Year Purchases	1,911	143	143	(0)		143	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,041,183	\$ 146,266	\$ 146,265	\$ (0)		\$ 804,688	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)	\$ 7,055,628	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 187,066	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 297,373	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 110,308	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,649,913	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: \_\_\_\_\_  
 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	<b>TOTAL</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: \$ 0 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><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><b>"We do not have a CNA Training Program"</b></p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

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

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

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

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

	Service	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		440 hrs	\$ 19,038		\$ 16,332	\$	440	\$ 35,370	1
2	Licensed Speech and Language Development Therapist		hrs			15,195			15,195	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		1783 hrs	42,609			1,900	1,783	44,509	4
5	Physician Care		visits							5
6	Dental Care		visits			65			65	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts		161	8,525	154,047	161	162,572	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 61,647	161	\$ 40,117	\$ 155,947	2,384	\$ 257,711	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 & ID Number **MARINER HEALTH OF WESTCHESTER** # **0042374** 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	\$ 600	1
2	Cash-Patient Deposits	138,935	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	524,582	3
4	Supply Inventory (priced at )		4
5	Short-Term Investments		5
6	Prepaid Insurance	843	6
7	Other Prepaid Expenses	385,694	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,050,654	10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	284,106	13
14	Buildings, at Historical Cost	3,396,431	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	259,728	16
17	Accumulated Depreciation (book methods)	(484,892)	17
18	Deferred Charges	157,129	18
19	Organization & Pre-Operating Costs	9,740,591	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,265,164)	20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify): <b>SEE ATTACHED SCHD 17.1</b>	153,309	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 12,241,238	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 13,291,892	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 329,350	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	225,372	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,123	31
32	Accrued Real Estate Taxes(Sch.IX-B)	239,923	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36	<b>SEE ATTACHED SCHEDULE 17.1</b>	137,279	36
37			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 935,047	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	<b>SEE ATTACHED SCHEDULE 17.1</b>	6,193,550	43
44			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 6,193,550	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,128,597	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 6,163,293	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 13,291,890	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>5,820,646</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>5,820,646</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>455,098</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>455,098</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Intercompany Transfers</b>	<b>(112,451)</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>(112,451)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>6,163,293</b>	<b>24</b> *

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

Facility Name & ID Number MARINER HEALTH OF WESTCHESTER

# 0042374

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	\$ 6,558,989	1
2	Discounts and Allowances for all Levels	(1,626,072)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,932,917	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	768,498	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 768,498	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	35,091	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	10,774	15
16	Rental of Facility Space		16
17	Sale of Drugs	460,024	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	103,285	19
20	Radiology and X-Ray		20
21	Other Medical Services	145,680	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 754,854	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	7,196	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 7,196	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,463,465	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,025,027	31
32	Health Care	2,782,785	32
33	General Administration	1,053,121	33
<b>B. Capital Expense</b>			
34	Ownership	886,730	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	194,824	35
36	Provider Participation Fee	65,880	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,008,367	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	455,098	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 455,098	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 **MARINER HEALTH OF WESTCHESTER**

# **0042374**

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	1,824	1,967	\$ 66,052	\$ 33.58	1
2	Assistant Director of Nursing	1,899	2,048	53,948	26.34	2
3	Registered Nurses	18,294	19,731	470,445	23.84	3
4	Licensed Practical Nurses	23,916	25,794	518,257	20.09	4
5	Nurse Aides & Orderlies	60,321	65,059	789,340	12.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,960	3,193	84,158	26.36	7
8	Rehab/Therapy Aides	3,100	3,344	52,354	15.66	8
9	Activity Director	2,018	2,176	25,376	11.66	9
10	Activity Assistants	3,573	3,854	33,976	8.82	10
11	Social Service Workers	1,984	2,140	33,277	15.55	11
12	Dietician					12
13	Food Service Supervisor	1,908	2,058	37,290	18.12	13
14	Head Cook	7,140	7,700	80,043	10.40	14
15	Cook Helpers/Assistants	12,991	14,012	107,943	7.70	15
16	Dishwashers					16
17	Maintenance Workers	1,679	1,811	29,218	16.13	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,984	2,140	80,821	37.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,667	12,583	168,412	13.38	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	3,708	3,999	42,731	10.69	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	4,262	4,597	86,470	18.81	33
34	TOTAL (lines 1 - 33)	165,228	178,206	\$ 2,760,111 *	\$ 15.49	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	659	\$ 26,360	1-3	35
36	Medical Director	260	57,488	9-3	36
37	Medical Records Consultant	98	4,368	10-3	37
38	Nurse Consultant	354	17,189	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	22	1,218	11-3	44
45	Social Service Consultant	24	1,173	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,416	\$ 107,796		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,442	\$ 77,482	10-3	50
51	Licensed Practical Nurses	2,190	69,463	10-3	51
52	Nurse Aides	3,937	80,555	10-3	52
53	TOTAL (lines 50 - 52)	7,569	\$ 227,500		53

**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	
BOLAND, SANDRA	Administrator	0	\$ 92,466	Workers' Compensation Insurance	\$ 87,597	IDPH License Fee	\$ 200	
				Unemployment Compensation Insurance	54,262	Advertising: Employee Recruitment		
				FICA Taxes	204,305	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	69,838	Other Licenses Fees	838	
				Employee Meals		DUES	16,343	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	199	
				Other Employee Benefits	6,962			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 92,466			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 422,964	TOTAL (agree to Sch. V, line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$		G. Schedule of Travel and Seminar**		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Legal Fees	Legal Fees		\$ 6,467			\$	Out-of-State Travel	\$ 5,212
							In-State Travel	4,386
							Home Office Allocation	9,104
							Seminar Expense	
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 6,467	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 18,702

\* Attach copy of IMRF notifications

\*\*See instructions.



**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 Association
- (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? 10
- (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. \$ 65,880  
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? n/a 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. \$ n/a  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? n/a  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**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.** \$ 0
- (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? yes  
Attach invoices and a summary of services for all architect and appraisal fees.