

		FOR OHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0019091</u></p> <p>Facility Name: <u>NORTHWEST HOME FOR THE AGED</u></p> <p>Address: <u>6300 N. CALIFORNIA</u> <u>CHICAGO</u> <u>60659</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 973-1900</u> Fax # <u>(773) 973-1904</u></p> <p>IDPA ID Number: <u>36-2216170</u></p> <p>Date of Initial License for Current Owners: <u>02/01/73</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:15%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>FRED OSKIN</u> (Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>FRED OSKIN</u> (Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input type="checkbox"/> "Sub-S" Corp.																												
	<input type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>FRED OSKIN</u> (Title) <u>ADMINISTRATOR</u>																												
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																												

Facility Name & ID Number NORTHWEST HOME FOR THE AGED

0019091 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	164	Skilled (SNF)	164	59,860	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	164	TOTALS	164	59,860	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	5,790	369	2,034	8,193	8
9	SNF/PED					9
10	ICF	29,794	8,321		38,115	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,584	8,690	2,034	46,308	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.36%

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 2/1/73

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 164 and days of care provided 2,034

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

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
	A. General Services										
1	Dietary	348,970	74,202	4,490	427,662		427,662	0	427,662		1
2	Food Purchase		368,717		368,717	(76,650)	292,067	0	292,067		2
3	Housekeeping	330,904	79,711	0	410,615		410,615	0	410,615		3
4	Laundry	223,869	39,894	0	263,763		263,763	0	263,763		4
5	Heat and Other Utilities			166,363	166,363		166,363	0	166,363		5
6	Maintenance	111,575	63,673	55,162	230,410		230,410	3,315	233,725		6
7	Other (specify):*			52,054	52,054		52,054	0	52,054		7
8	TOTAL General Services	1,015,318	626,197	278,069	1,919,584	(76,650)	1,842,934	3,315	1,846,249		8
	B. Health Care and Programs										
9	Medical Director	0		3,520	3,520		3,520	0	3,520		9
10	Nursing and Medical Records	2,750,401	276,788	89,172	3,116,361		3,116,361	0	3,116,361		10
10a	Therapy	200,303		9,602	209,905		209,905	0	209,905		10a
11	Activities	170,807	45,706	380	216,893		216,893	0	216,893		11
12	Social Services	109,439		0	109,439		109,439	0	109,439		12
13	Nurse Aide Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	3,230,950	322,494	102,674	3,656,118	0	3,656,118	0	3,656,118		16
	C. General Administration										
17	Administrative	93,627		0	93,627		93,627	0	93,627		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			82,157	82,157		82,157	(1,012)	81,145		19
20	Dues, Fees, Subscriptions & Promotions			81,418	81,418		81,418	(45,478)	35,940		20
21	Clerical & General Office Expenses	177,788	45,937	59,649	283,374		283,374	0	283,374		21
22	Employee Benefits & Payroll Taxes			832,714	832,714	76,650	909,364	0	909,364		22
23	Inservice Training & Education			9,620	9,620		9,620	0	9,620		23
24	Travel and Seminar			0	0		0	0	0		24
25	Other Admin. Staff Transportation			7,818	7,818		7,818	0	7,818		25
26	Insurance-Prop.Liab.Malpractice			163,436	163,436		163,436	0	163,436		26
27	Other (specify):*			106,685	106,685		106,685	(106,685)	0		27
28	TOTAL General Administration	271,415	45,937	1,343,497	1,660,849	76,650	1,737,499	(153,175)	1,584,324		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,517,683	994,628	1,724,240	7,236,551	0	7,236,551	(149,860)	7,086,691		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			223,430	223,430		223,430	4,324	227,754			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			0	0		0	0	0			32
33	Real Estate Taxes			0	0		0	0	0			33
34	Rent-Facility & Grounds			0	0		0	0	0			34
35	Rent-Equipment & Vehicles			0	0		0	0	0			35
36	Other (specify):* amort comp soft			8,166	8,166		8,166	0	8,166			36
37	TOTAL Ownership			231,596	231,596	0	231,596	4,324	235,920			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			0	0		0	0	0			38
39	Ancillary Service Centers		31,819	49,993	81,812		81,812	0	81,812			39
40	Barber and Beauty Shops			0	0		0	0	0			40
41	Coffee and Gift Shops			0	0		0	0	0			41
42	Provider Participation Fee			89,790	89,790		89,790	0	89,790			42
43	Other (specify):*			0	0		0	0	0			43
44	TOTAL Special Cost Centers	0	31,819	139,783	171,602	0	171,602	0	171,602			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,517,683	1,026,447	2,095,619	7,639,749	0	7,639,749	(145,536)	7,494,213			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,324	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(1,012)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(106,685)	27		24
25	Fund Raising, Advertising and Promotional	(45,478)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	3,315			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,536)		\$ 0	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)	0		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 0		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (145,536)		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	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
 NORTHWEST HOME FOR THE AGED

ID# 0019091

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 3315	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	Total	3,315		48
49				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED**# **0019091**

Report Period Beginning:

01/01/2001

Ending:

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	3,315	0	0	0	0	0	0	0	0	0	0	3,315	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	3,315	0	3,315	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,012)	0	0	0	0	0	0	0	0	0	0	(1,012)	19
20	Fees, Subscriptions & Promotions	(45,478)	0	0	0	0	0	0	0	0	0	0	(45,478)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(106,685)	0	0	0	0	0	0	0	0	0	0	(106,685)	27
28	TOTAL General Administration	(153,175)	0	(153,175)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(149,860)	0	(149,860)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHWEST HOME FOR THE AGED

0019091

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	4,324	0	0	0	0	0	0	0	0	0	0	4,324	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,324	0	4,324	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(145,536)	0	(145,536)	45									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number NORTHWEST HOME FOR THE AGED

0019091 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$				\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related																		
	B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related																		
15	TOTALS (line 9+line14)																		
							\$	0	\$	0	\$	0							
							\$	0	\$	0	\$	0							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number NORTHWEST HOME FOR THE AGED# 0019091 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	0 2
3. Under or (over) accrual (line 2 minus line 1).			\$	0 3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	0 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	0 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	0	8	
	1997	0	9	
	1998	0	10	
	1999	0	11	
	2000	0	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.				
		FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTHWEST HOME FOR THE AGED COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0019091

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>0.00</u>	\$ <u>0.00</u>

B. Real Estate Tax Cost Allocation:

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

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

C. Tax Bills

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

Facility Name & ID Number NORTHWEST HOME FOR THE AGED

0019091 Report Period Beginning:

01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,536 B. General Construction Type: Exterior BRICK Frame WOOD 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: 0 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 0 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>PATIENT CARE</u>	<u>24,221</u>	<u>1993</u>	<u>\$ 162,933</u>	1
2					2
3	TOTALS	<u>24,221</u>		<u>\$ 162,933</u>	3

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED**# **0019091**

Report Period Beginning:

01/01/2001

Ending:

12/31/2001**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	1973	1973	\$ 797,821	\$ 19,945	40	\$ 19,945	\$	\$ 575,847	4
5	8	1986	1986	418,000	10,450	40	10,450		161,975	5
6	6	1994	1994	682,486	17,052	40	17,052		127,890	6
7										7
8										8
	Improvement Type**									
9	LAND IMPROVEMENT		1973	12,360		10			12,360	9
10	LAND IMPROVEMENT		1981	88,292		10			88,292	10
11	LAND IMPROVEMENT		1982	32,553		10			32,553	11
12	LAND IMPROVEMENT		1983	55,207		10			55,207	12
13	LAND IMPROVEMENT		1984	60,325		10			60,325	13
14	LAND IMPROVEMENT		1985	12,481		20			12,481	14
15	LAND IMPROVEMENT		1986	33,262		20			33,262	15
16	LAND IMPROVEMENT		1986	99,906		20			99,906	16
17	LAND IMPROVEMENT		1987	3,507		10			3,507	17
18	LAND IMPROVEMENT		1988	46,957		10			46,957	18
19	LAND IMPROVEMENT		1989	11,021		10			11,021	19
20	LAND IMPROVEMENT		1989	52,943		10			52,943	20
21	LAND IMPROVEMENT		1993	1,500	150	20	150		1,275	21
22	BUILDING IMPROVEMENT		1973	314,577		20			314,577	22
23	BUILDING IMPROVEMENT		1974	7,564		40			7,564	23
24	BUILDING IMPROVEMENT		1975	24,726		20			24,726	24
25	BUILDING IMPROVEMENT		1976	61,018		20			61,018	25
26	BUILDING IMPROVEMENT		1977	16,352		20			16,352	26
27	BUILDING IMPROVEMENT		1978	3,161		20			3,161	27
28	BUILDING IMPROVEMENT		1979	77,150		20			77,150	28
29	BUILDING IMPROVEMENT		1980	36,176		20			36,176	29
30	BUILDING IMPROVEMENT		1981	24,284	611	20	611		24,824	30
31	BUILDING IMPROVEMENT		1982	11,976	600	20	600		11,700	31
32	BUILDING IMPROVEMENT		1983	51,666	2,584	20	2,584		47,804	32
33	BUILDING IMPROVEMENT		1984	62,215	3,110	20	3,110		54,425	33
34	BUILDING IMPROVEMENT		1985	16,670	838	20	838		13,827	34
35										35
36										36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

Facility Name & ID Number NORTHWEST HOME FOR THE AGED# 0019091

Report Period Beginning:

01/01/2001 Ending: 12/31/2001

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BUILDING IMPROVEMENT	1986	\$ 37,684	\$ 1,884	20	\$ 1,884	\$	\$ 29,202	37
38	BUILDING IMPROVEMENT	1987	82,905	4,145	20	4,145		60,103	38
39	BUILDING IMPROVEMENT	1988	47,481	2,374	20	2,374		32,049	39
40	BUILDING IMPROVEMENT	1990	74,109	0	10	0		74,109	40
41	BUILDING IMPROVEMENT	1991	1,043	56	10	56		1,043	41
42	BUILDING IMPROVEMENT	1991	5,901	295	20	295		3,098	42
43	BUILDING IMPROVEMENT	1992	1,755	88	20	88		836	43
44	BUILDING IMPROVEMENT	1993	86,526	4,326	10	8,650	4,324	86,526	44
45	BUILDING IMPROVEMENT	1994	64,428	3,222	20	3,222		24,165	45
46	AIR INTAKE	1995	3,899	194	20	194		1,261	46
47	WATER MIXING VALUE	1995	1,474	74	20	74		481	47
48	LAVATORY FAUCETS	1995	3,662	183	20	183		1,190	48
49	HOT WATER SYSTEM	1995	10,982	549	20	549		3,569	49
50	BATH TUB SLIPRESISTENT	1995	2,700	135	20	135		877	50
51	GENERATOR	1995	22,900	1,145	20	1,145		7,443	51
52	NEW WALL	1996	1,405	70	20	70		385	52
53	RETURN DUCK	1996	528	26	20	26		143	53
54	H2O WATER HEATER	1996	10,711	536	20	536		2,948	54
55	H2O BOOSTER	1996	14,484	724	20	724		3,982	55
56	NEW WINDOWS	1996	763	38	20	38		209	56
57	ROOF	1996	6,000	300	20	300		1,650	57
58	SEWER SYSTEM	1996	2,350	118	20	118		649	58
59	NEW DECK	1996	6,100	305	20	305		1,678	59
60	SERVICE SWITCH	1996	820	41	20	41		225	60
61	ELECTRICAL	1996	2,905	145	20	145		798	61
62	GUTTER BOX	1996	625	31	20	31		171	62
63	ELECTRICAL WORK	1996	3,300	165	20	165		907	63
64	ELECTRICAL SERVICE	1996	590	30	20	30		165	64
65	ELECTRONIC MAGNETIC DOOR	1996	624	31	20	31		171	65
66	FIRE DOORS	1996	10,100	505	20	505		2,777	66
67	BOILER FLUE PIPE	1996	2,296	115	20	115		632	67
68	HORIZONTAL WATER COOLED A/C	1996	9,000	450	20	450		2,475	68
69	NEWS PUMPS	1996	9,875	494	20	494		2,717	69
70	TOTAL (lines 4 thru 69)		\$ 3,646,081	\$ 78,134		\$ 82,458	\$ 4,324	\$ 2,417,739	70

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

Facility Name & ID Number NORTHWEST HOME FOR THE AGED# 0019091

Report Period Beginning:

01/01/2001 Ending: 12/31/2001

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,646,081	\$ 78,134		\$ 82,458	\$ 4,324	\$ 2,417,739	1
2	<u>NEW VALVES</u>	1996	2,368	118	20	118		649	2
3	<u>ROOF</u>	1997	35,350	1,767	20	1,767		7,952	3
4	<u>NEW BATHROOM FLOORS</u>	1997	3,198	160	20	160		20	4
5	<u>MANHOLE REPAIR</u>	1998	2,350	117	20	117		410	5
6	<u>TILING</u>	1998	23,105	1,155	20	1,155		4,043	6
7	<u>ROOF TOP UNIT</u>	1998	6,370	319	20	319		1,116	7
8	<u>CUSOM CABINTRY</u>	1999	3,300	165	20	165		413	8
9	<u>CONCRETE RAMPS</u>	1999	2,000	100	20	100		250	9
10	<u>SLIDING DOOR</u>	1999	9,046	452	20	452		1,130	10
11	<u>TILING</u>	1999	6,679	334	20	334		835	11
12	<u>PERIMETER PLASTIC</u>	1999	2,250	112	20	112		280	12
13	<u>WINDOWS</u>	1999	4,760	238	20	238		595	13
14	<u>NEW MANHOLE</u>	1999	3,180	159	20	159		398	14
15	<u>DRAIN PIPES</u>	1999	2,800	140	20	140		350	15
16	<u>KICK PLATES</u>	1999	4,070	204	20	204		510	16
17	<u>COOLING EQUIPMENT</u>	1999	8,142	407	20	407		1,017	17
18	<u>ELECTRIC EYE</u>	1999	3,141	157	20	157		393	18
19	<u>WINDOWS</u>	2000	1,076	54	20	54		81	19
20	<u>SIGN</u>	2000	6,150	307	20	307		461	20
21	<u>FLOORING</u>	2000	7,312	366	20	366		549	21
22	<u>CUBICLE CURTAINS</u>	2001	10,147	254	20	254		254	22
23	<u>WINDOWS</u>	2001	2,060	51	20	51		51	23
24	<u>ELEVATOR REHAB</u>	2001	20,485	512	20	512		512	24
25	<u>DRAINS AND GREASE TRAPS</u>	2001	3,500	87	20	87		87	25
26	<u>CONDENSING UNITS AND WIRING</u>	2001	9,965	249	20	249		249	26
27	<u>TILING</u>	2001	82,110	2,053	20	2,053		2,053	27
28	<u>OVERBED LIGHTS AND SCONCES</u>	2001	28,520	713	20	713		713	28
29	<u>STEEL DOORS</u>	2001	2,640	66	20	66		66	29
30	<u>WALLCOVERINGS</u>	2001	4,168	104	20	104		104	30
31	<u>CORNICES WITH BLACKOUT LINED DRAPERY</u>	2001	18,276	457	20	457		457	31
32	<u>FLOORING</u>	2001	31,589	790	20	790		790	32
33	<u>PAINTING</u>	2001	48,425	1,211	20	1,211		1,211	33
34	TOTAL (lines 1 thru 33)		\$ 4,044,613	\$ 91,512		\$ 95,836	\$ 4,324	\$ 2,445,738	34

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

Facility Name & ID Number **NORTHWEST HOME FOR THE AGED**

0019091

Report Period Beginning:

01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,044,613	\$ 91,512		\$ 95,836	\$ 4,324	\$ 2,445,738	1
2	CORNICES	2001	8,833	221	20	221		221	2
3	CRASHBARS, WALL BORDERS & CORNERGUARDS	2001	29,120	728	20	728		728	3
4	CORNICES, CORNER GUARDS & CUBICLE TRACKS	2001	15,202	380	20	380		380	4
5	BUILT-IN WARDROBES	2001	54,924	1,373	20	1,373		1,373	5
6	TILING, WALLPAPER & PAINTING 4 BATHROOMS	2001	11,741	294	20	294		294	6
7	SCONCES	2001	1,179	30	20	30		30	7
8	CORNER GUARDS	2001	345	9	20	9		9	8
9	AMBULANCE DOOR	2001	420	10	20	10		10	9
10	WALLCOVERING	2001	2,288	57	20	57		57	10
11	CUSTOM ORDER SCREEN SPRINT	2001	9,825	245	20	245		245	11
12	CARPETING	2001	8,810	220	20	220		220	12
13	VINYL FLOORING IN ACTIVITY ROOM	2001	5,287	132	20	132		132	13
14	CROWN MOLDING & HANDRAILS	2001	7,266	182	20	182		182	14
15	CRASH RAILS & BED LOCATORS	2001	9,322	233	20	233		233	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,209,175	\$ 95,626		\$ 99,950	\$ 4,324	\$ 2,449,852	34

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

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,110,803	\$ 115,971	\$ 115,971	\$ 0	10 YRS	\$ 755,230	71
72	Current Year Purchases	130,800	6,540	6,540	0	10 YRS	6,540	72
73	Fully Depreciated Assets	350,131			0		350,131	73
74					0			74
75	TOTALS	\$ 1,591,734	\$ 122,511	\$ 122,511	\$ 0		\$ 1,111,901	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		1998 CHRYSLER T & C	1997	\$ 26,467	\$ 5,293	\$ 5,293	\$ 0	5	\$ 23,908	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 26,467	\$ 5,293	\$ 5,293	\$ 0		\$ 23,908	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)	\$ 5,990,309	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 223,430	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 227,754	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,324	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,585,661	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	TOTAL				\$ _____			7

**

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

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

9. Option to Buy: YES NO Terms: _____*

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

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

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

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

* 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.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input 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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 3,321	\$		\$ 3,321	1
2	Licensed Speech and Language Development Therapist		hrs			5,520			5,520	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			6,415			6,415	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				31,819		31,819	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					34,737			34,737	13
14	TOTAL			\$		\$ 49,993	\$ 31,819		\$ 81,812	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 NORTHWEST HOME FOR THE AGED

0019091

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 64,482	\$	1
2	Cash-Patient Deposits	400,122		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,052,018		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	169,111		6
7	Other Prepaid Expenses	13,591		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,699,324	\$ 0	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	673,247		13
14	Buildings, at Historical Cost	1,898,307		14
15	Leasehold Improvements, at Historical Cost	1,838,690		15
16	Equipment, at Historical Cost	1,618,201		16
17	Accumulated Depreciation (book methods)	(3,535,538)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>COMPUTER SOFTWARE</u>	7,346		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,500,253	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,199,577	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 164,592	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	407,745		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	82,726		34
35	Federal and State Income Taxes			35
36	Other Current Liabilities(specify):			
36	<u>INTERFUND TRANSFER</u>	3,116,865		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,771,928	\$ 0	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,771,928	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 427,649	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,199,577	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,241,406	1
2	Restatements (describe):		2
3	POST CLOSING AUDIT ADJUSTMENT	691,117	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,932,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,504,874)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,504,874)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 427,649	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,937,870	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,937,870	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(435)	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ (435)	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(307)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ (307)	23
D. Non-Operating Revenue			
24	Contributions	172,971	24
25	Interest and Other Investment Income***	1,744	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 174,715	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	501	28
28a		22,531	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,032	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,134,875	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,919,584	31
32	Health Care	3,656,118	32
33	General Administration	1,660,849	33
B. Capital Expense			
34	Ownership	231,596	34
C. Ancillary Expense			
35	Special Cost Centers	81,812	35
36	Provider Participation Fee	89,790	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,639,749	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,504,874)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,504,874)	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 **NORTHWEST HOME FOR THE AGED**

0019091

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,360	1,982	\$ 56,349	\$ 28.43	1
2	Assistant Director of Nursing	1,864	2,124	62,066	29.22	2
3	Registered Nurses	32,348	35,452	903,581	25.49	3
4	Licensed Practical Nurses	17,605	19,200	363,318	18.92	4
5	Nurse Aides & Orderlies	97,001	105,886	1,116,790	10.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,078	15,995	200,303	12.52	8
9	Activity Director	2,048	2,327	45,154	19.40	9
10	Activity Assistants	9,355	10,597	125,653	11.86	10
11	Social Service Workers	5,478	6,503	109,439	16.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,893	2,165	32,477	15.00	14
15	Cook Helpers/Assistants	31,610	34,316	316,493	9.22	15
16	Dishwashers					16
17	Maintenance Workers	6,002	6,617	111,575	16.86	17
18	Housekeepers	30,824	33,736	330,904	9.81	18
19	Laundry	22,521	24,888	223,869	9.00	19
20	Administrator	1,864	2,080	93,627	45.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,964	8,788	177,788	20.23	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	6,072	7,086	112,650	15.90	31
32	Other Health Care Nsg Clerical	5,822	6,733	135,647	20.15	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	295,709	326,475	\$ 4,517,683 *	\$ 13.84	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	monthly fees	\$ 4,490	1-3	35
36	Medical Director	monthly fees	3,520	9-3	36
37	Medical Records Consultant	monthly fees	720	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fees	5,140	10-3	39
40	Physical Therapy Consultant	monthly fees	1,979	10a-3	40
41	Occupational Therapy Consultant	monthly fees	7,623	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	monthly fees	380	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 23,852		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		61,138	10-3	52
53	TOTAL (lines 50 - 52)		\$ 61,138		53

Facility Name & ID Number NORTHWEST HOME FOR THE AGED

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY1998	6 FY1999	7 FY2000	8 FY2001	9 FY2002	10 FY2003	11 FY2004	12 FY2005	13 FY2006
					1	PAINT/DECORATING	6/98	\$ 3,899	3 YRS	\$ 650	\$ 1,299	\$ 1,299	\$ 651
2	PAINT/DECORATING	6/99	7,994	3 YRS		1,333	2,664	2,664	1,333				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 11,893		\$ 650	\$ 2,632	\$ 3,963	\$ 3,315	\$ 1,333	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 57,290 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 89,790
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. \$ 76,650 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 5%
- 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? NO
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? 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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	4,490
	REPAIRS & MAINTENANCE	0
		0
		4,490
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	69,490
	ELECTRICITY	96,873
	WATER	0
	CABLE TV - LOBBY	0
		0
		166,363
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,084
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	23,838
	ELEVATOR MAINTENANCE & REPAIR	21,500
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,740
	FIRE SERVICE	0
		0
		0
		0
		55,162
7	OTHER	
	SCAVENGER	52,054
	SECURITY SERVICE	0
		52,054
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	3,520
		3,520

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	61,138
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	720
	PHARMACY CONSULTANT XVIII B 39-2	5,140
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	22,174
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		89,172
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	1,979
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	7,623
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		9,602
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	380
		0
		380
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	14,055
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	68,102
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	82,157
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	45,478
	EMPLOYEE WANT ADS XIX F	26,196
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	6,975
	LICENSES & PERMITS XIX F	2,299
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	470
21	CLERICAL & GENERAL OFFICE EXPENSES	81,418
	BANK CHARGES	0
	EQUIPMENT REPAIR & MAINTENANCE	27,692
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	31,957
	MESSENGER SERVICE	0
		0
		59,649

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	342,840
	UNEMPLOYMENT COMPENSATION XIX D	13,279
	WORKERS COMPENSATION INSURANC XIX D	127,267
	HOSPITALIZATION INSURANCE XIX D	286,073
	EMPLOYEE BENEFITS - OTHER XIX D	21,409
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	41,846
	CHICAGO HEAD TAX XIX D	0
		832,714
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	9,620
		9,620
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,818
		7,818
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	163,436
		163,436
27	OTHER	
	BAD DEBTS VI 24	106,685
		0
		106,685

GRAND TOTAL COLUMN 3 OTHER

1,724,240

NORTHWEST HOME FOR THE AGED
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2001

TOTAL FOOD PURCHASE	368,717
LESS SALES TAX	0

NET FOOD	368,717
TOTAL PATIENT CENSUS	46,308
TIME 3 MEALS PER DAY	3

TOTAL PATIENT MEALS	138924
ADD # EMPLOYEE MEALS/DAY	100
TIME # DAYS	365

TOTAL EMPLOYEE MEALS	36500

PATIENT MEALS	138924
ADD EMPLOYEE MEALS	36500

TOTAL MEALS/YEAR	175424
NET FOOD	368717
DIVIDE TOTAL MEALS/YEAR	175424
COST PER MEAL	2.1
TIME EMPLOYEE MEALS	36500

EMPLOYEE MEAL RECLASSIFICATION	76650
	=====