

		FOR OHF USE					

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

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

**I. IDPH Facility ID Number:** 0036848

**Facility Name:** SKYVIEW TERRACE

**Address:** 1021 NORTH CHURCH STREET JACKSONVILLE 62650  
Number City Zip Code

**County:** MORGAN

**Telephone Number:** (217) 245-4174 **Fax #** (217) 243-5901

**IDPA ID Number:** 37-1274300

**Date of Initial License for Current Owners:** 01/31/91

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** BOB KAGDA **Telephone Number:** ( 847 ) 675-3585

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>MELVIN SIEGEL</u>	
	(Title) <u>PRESIDENT</u>	
<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____
	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>	
	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>	
	(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u>	

**MAIL TO: OFFICE OF HEALTH FINANCE  
ILLINOIS DEPARTMENT OF PUBLIC AID  
201 S. Grand Avenue East  
Springfield, IL 62763-0001** **Phone # (217) 782-1630**

Facility Name & ID Number SKYVIEW TERRACE# 0036848 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	<u>113</u>	Skilled (SNF)	<u>113</u>	<u>41,245</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>113</u>	TOTALS	<u>113</u>	<u>41,245</u>	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			<u>3,065</u>	<u>3,065</u>	8
9	SNF/PED					9
10	ICF	<u>23,315</u>	<u>4,615</u>	<u>274</u>	<u>28,204</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,315</u>	<u>4,615</u>	<u>3,339</u>	<u>31,269</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.81%

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)

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

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 01/31/91

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

YES  Date 01/31/91 NO 

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

YES  NO  If YES, enter numberof beds certified 23 and days of care provided 3,065Medicare Intermediary ADMINASTAR

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number SKYVIEW TERRACE # 0036848 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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	99,447	7,897	10,567	117,911		117,911	0	117,911		1
2	Food Purchase		136,559		136,559	(7,942)	128,617	(584)	128,033		2
3	Housekeeping	66,321	20,427	0	86,748		86,748	0	86,748		3
4	Laundry	30,559	7,845	1,784	40,188		40,188	0	40,188		4
5	Heat and Other Utilities			68,730	68,730		68,730	1,038	69,768		5
6	Maintenance	45,423	12,916	31,690	90,029		90,029	(3,024)	87,005		6
7	Other (specify):*			3,560	3,560		3,560	89	3,649		7
8	<b>TOTAL General Services</b>	<b>241,750</b>	<b>185,644</b>	<b>116,331</b>	<b>543,725</b>	<b>(7,942)</b>	<b>535,783</b>	<b>(2,481)</b>	<b>533,302</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		6,000	6,000		6,000	0	6,000		9
10	Nursing and Medical Records	949,805	55,951	16,677	1,022,433		1,022,433	10,514	1,032,947		10
10a	Therapy	0		3,609	3,609		3,609	0	3,609		10a
11	Activities	33,806	1,785	3,300	38,891		38,891	(3,167)	35,724		11
12	Social Services	46,155		0	46,155		46,155	0	46,155		12
13	Nurse Aide Training			686	686		686	0	686		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,029,766</b>	<b>57,736</b>	<b>30,272</b>	<b>1,117,774</b>	<b>0</b>	<b>1,117,774</b>	<b>7,347</b>	<b>1,125,121</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	52,354		206,200	258,554		258,554	17,767	276,321		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			203,024	203,024		203,024	(159,985)	43,039		19
20	Dues, Fees, Subscriptions & Promotions			26,574	26,574		26,574	(19,121)	7,453		20
21	Clerical & General Office Expenses	54,094	14,694	18,656	87,444		87,444	46,660	134,104		21
22	Employee Benefits & Payroll Taxes			172,298	172,298	7,942	180,240	0	180,240		22
23	Inservice Training & Education			2,348	2,348		2,348	196	2,544		23
24	Travel and Seminar			1,908	1,908		1,908	18,084	19,992		24
25	Other Admin. Staff Transportation			6,242	6,242		6,242	0	6,242		25
26	Insurance-Prop.Liab.Malpractice			128,385	128,385		128,385	1,649	130,034		26
27	Other (specify):*			0	0		0	14,036	14,036		27
28	<b>TOTAL General Administration</b>	<b>106,448</b>	<b>14,694</b>	<b>765,635</b>	<b>886,777</b>	<b>7,942</b>	<b>894,719</b>	<b>(80,714)</b>	<b>814,005</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,377,964</b>	<b>258,074</b>	<b>912,238</b>	<b>2,548,276</b>	<b>0</b>	<b>2,548,276</b>	<b>(75,848)</b>	<b>2,472,428</b>		<b>29</b>

\*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 SKYVIEW TERRACE

#0036848

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

## 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			21,299	21,299		21,299	25,816	47,115			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			7,322	7,322		7,322	139,270	146,592			32
33	Real Estate Taxes			17,408	17,408		17,408	0	17,408			33
34	Rent-Facility & Grounds			193,088	193,088		193,088	(183,759)	9,329			34
35	Rent-Equipment & Vehicles			13,430	13,430		13,430	7,487	20,917			35
36	Other (specify):*			0	0		0	0	0			36
37	<b>TOTAL Ownership</b>			252,547	252,547	0	252,547	(11,186)	241,361			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			0	0		0	0	0			38
39	Ancillary Service Centers		61,160	25,976	87,136		87,136	0	87,136			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			61,867	61,867		61,867	0	61,867			42
43	Other (specify):*			0	0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	61,160	87,843	149,003	0	149,003	0	149,003			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,377,964	319,234	1,252,628	2,949,826	0	2,949,826	(87,034)	2,862,792			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 SKYVIEW TERRACE

# 0036848

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

**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	414	30		9
10	Interest and Other Investment Income	(1,462)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(584)	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	(771)	21		18
19	Entertainment	0	20		19
20	Contributions	(8,164)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(11,455)	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>	0			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (22,022)		\$ 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)	(65,012)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (65,012)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (87,034)		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

SKYVIEW TERRACE

ID# 0036848

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$	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				48
49	<b>Total</b>	0		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number SKYVIEW TERRACE

# 0036848

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 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	(584)	0	0	0	0	0	0	0	0	0	0	(584)	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	1,038	0	0	0	0	0	0	0	0	0	1,038	5
6	Maintenance	0	(3,024)	0	0	0	0	0	0	0	0	0	(3,024)	6
7	Other (specify):*	0	89	0	0	0	0	0	0	0	0	0	89	7
8	<b>TOTAL General Services</b>	<b>(584)</b>	<b>(1,897)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,481)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	10,514	0	0	0	0	0	0	0	0	0	10,514	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,167)	0	0	0	0	0	0	0	0	0	(3,167)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>7,347</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,347</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	14,881	2,886	0	0	0	0	0	0	0	0	17,767	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(159,985)	0	0	0	0	0	0	0	0	0	(159,985)	19
20	Fees, Subscriptions & Promotions	(19,619)	498	0	0	0	0	0	0	0	0	0	(19,121)	20
21	Clerical & General Office Expenses	(771)	0	47,431	0	0	0	0	0	0	0	0	46,660	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	196	0	0	0	0	0	0	0	0	196	23
24	Travel and Seminar	0	0	18,084	0	0	0	0	0	0	0	0	18,084	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	1,649	0	0	0	0	0	0	0	0	1,649	26
27	Other (specify):*	0	0	14,036	0	0	0	0	0	0	0	0	14,036	27
28	<b>TOTAL General Administration</b>	<b>(20,390)</b>	<b>(144,606)</b>	<b>84,282</b>	<b>0</b>	<b>(80,714)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(20,974)</b>	<b>(139,156)</b>	<b>84,282</b>	<b>0</b>	<b>(75,848)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SKYVIEW TERRACE

# 0036848

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	414	0	470	24,932	0	0	0	0	0	0	0	25,816	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,462)	0	0	140,732	0	0	0	0	0	0	0	139,270	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	9,329	(193,088)	0	0	0	0	0	0	0	(183,759)	34
35	Rent-Equipment & Vehicles	0	0	7,487	0	0	0	0	0	0	0	0	7,487	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,048)</b>	<b>0</b>	<b>17,286</b>	<b>(27,424)</b>	<b>0</b>	<b>(11,186)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(22,022)</b>	<b>(139,156)</b>	<b>101,568</b>	<b>(27,424)</b>	<b>0</b>	<b>(87,034)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	CHICAGO	CONSULTING,
		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES LTD		BOOKKEEPING
		PARK RIDGE TERRACE	LOVES PARK			
		PARKVIEW TERRACE	EAST MOLINE			
		SPRINGFIELD TERRACE	SPRINGFIELD			
		VANDALIA TERRACE	VANDALIA			

**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	6 MAINTENANCE CONSULT	\$ 13,200			\$	\$ (13,200) 1
2	V	10 PSYCHO-SOCIAL CONSULT	3,513				(3,513) 2
3	V	11 ACTIVITIES CONSULTANT	3,300				(3,300) 3
4	V	19 ADMIN./BKPP. FEES	101,760				(101,760) 4
5	V	19 ADMIN. CONSULT. FEES	61,051				(61,051) 5
6	V	5 ELECTRICITY				1,038	1,038 6
7	V	6 MAINTENANCE				10,176	10,176 7
8	V	7 SCAVENGER				89	89 8
9	V	10 PSYCHO-SOCIAL CONSULT				14,027	14,027 9
10	V	11 ACTIVITIES CONSULTANT				133	133 10
11	V	17 ADMIN.SALARIES/MGMT				14,881	14,881 11
12	V	19 PROFESSIONAL FEES				2,826	2,826 12
13	V	20 ADVERTISING				498	498 13
14	Total		\$ 182,824			\$ 43,668	\$ * (139,156) 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 TOTAL OFFICE	\$	MELVIN ENTERPRISES, LTD.		\$ 47,431	\$ 47,431	15
16	V	23 SEMINARS				196	196	16
17	V	24 TRAVEL				18,084	18,084	17
18	V	26 INSURANCE				1,649	1,649	18
19	V	27 EMPLOYEE BENEFITS				14,036	14,036	19
20	V	30 DEPRECIATION (SL)				470	470	20
21	V	34 OFFICE RENT				9,329	9,329	21
22	V	35 EQUIPMENT RENT				7,487	7,487	22
23	V	17 MGMT FEES - SWS				2,886	2,886	23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 101,568	\$ * 101,568	39

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

VII. RELATED PARTIES (continued)

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

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

1		2		3 Cost Per General Ledger		4		5 Cost to Related Organization		6		7		8 Difference:	
Schedule V		Line		Item		Amount		Name of Related Organization		Percent of Ownership		Operating Cost of Related Organization		Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$	193,088	SKYVIEW NURSING ASSOCIATES				\$		\$	(193,088)	15	
16	V	30	DEPRECIATION								24,932		24,932	16	
17	V	32	INTEREST								140,732		140,732	17	
18	V													18	
19	V													19	
20	V													20	
21	V													21	
22	V													22	
23	V													23	
24	V													24	
25	V													25	
26	V													26	
27	V													27	
28	V													28	
29	V													29	
30	V													30	
31	V													31	
32	V													32	
33	V													33	
34	V													34	
35	V													35	
36	V													36	
37	V													37	
38	V													38	
39	Total			\$	193,088					\$	165,664	\$ *	(27,424)	39	

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	\$	SWS CONSULTING		\$	\$	15
16	V	17	MELVIN SIEGEL						16
17	V	17	MARTIN WEISS						17
18	V	17	DANIEL WEISS						18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

Facility Name & ID Number SKYVIEW TERRACE # 0036848 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	SEE ATTACHED SCHEDULE										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 SKYVIEW TERRACE

# 0036848 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 MAVIN ENTERPRISES, LTD.  
 Street Address 3845 OAKTON  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847 ) 679-0100  
 Fax Number ( 847 ) 679-0647

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	5	ELECTRICITY	PATIENT DAYS	151,711	7	\$ 5,036	\$ 31,269	\$ 1,038	1
2	6	MAINTENANCE	PATIENT DAYS	151,711	7	49,373	31,269	10,176	2
3	7	SCAVENGER	PATIENT DAYS	151,711	7	432	31,269	89	3
4	10	PSYCHO-SOCIAL CONSULT	PATIENT DAYS	151,711	7	68,057	31,269	14,027	4
5	11	ACTIVITIES CONSULTANT	PATIENT DAYS	151,711	7	646	31,269	133	5
6	17	ADMIN.SALARIES/MGMT	PATIENT DAYS	151,711	7	72,200	72,200	14,881	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	151,711	7	13,709	31,269	2,826	7
8	20	ADVERTISING	PATIENT DAYS	151,711	7	2,417	31,269	498	8
9	21	TOTAL OFFICE	PATIENT DAYS	151,711	7	230,125	144,338	47,431	9
10	23	SEMINARS	PATIENT DAYS	151,711	7	950	31,269	196	10
11	24	TRAVEL	PATIENT DAYS	151,711	7	87,742	31,269	18,084	11
12	26	INSURANCE	PATIENT DAYS	151,711	7	8,000	31,269	1,649	12
13	27	EMPLOYEE BENEFITS	PATIENT DAYS	151,711	7	68,102	31,269	14,036	13
14	30	DEPRECIATION (SL)	PATIENT DAYS	151,711	7	2,285	31,269	470	14
15	34	OFFICE RENT	PATIENT DAYS	151,711	7	45,262	31,269	9,329	15
16	35	EQUIPMENT RENT	PATIENT DAYS	151,711	7	36,325	31,269	7,487	16
17	17	MGMT FEES - SWS	PATIENT DAYS	151,711	7	14,000	31,269	2,886	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 704,661	\$ 216,538	\$ 145,236	25

Facility Name & ID Number SKYVIEW TERRACE

# 0036848 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

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

Name of Related Organization SKYVIEW NURSING ASSOCIATES  
 Street Address 3845 OAKTON  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847 ) 679-0100  
 Fax Number ( 847 ) 679-0647

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	30	DEPRECIATION	DIRECT COST	1	1	\$ 24,932	\$	1	\$ 24,932	1
2	32	INTEREST	DIRECT COST	1	1	140,732		1	140,732	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					\$ 165,664	\$		\$ 165,664	25

Facility Name & ID Number SKYVIEW TERRACE

# 0036848 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

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

Name of Related Organization SWS CONSULTING  
 Street Address 3745 OAKTON  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847 ) 679-0100  
 Fax Number ( 847 ) 679-0647

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	OWNER COMP - M. SIEGEL	HOURS		\$	\$		\$	1
2	17	OWNER COMP - M. WEISS	HOURS						2
3	17	OWNER COMP - D. WEISS	HOURS						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				\$	\$		\$	0

Facility Name & ID Number

SKYVIEW TERRACE

# 0036848

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	RELATED PARTY						\$	\$			\$	1				
2	SKYVIEW NURSING ASSOCIATES											2				
3	SUCCESS NATIONAL BANK		X	MORTGAGE	\$95,000.00	2/97	1,090,000	1,052,598	2/02	9.5000	140,732	3				
4												4				
5												5				
<b>Working Capital</b>																
6	SUCCESS NATIONAL BANK		X	LINE OF CREDIT	DEMAND	6/29/99	150,000	201,255		5.7500	7,322	6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>				\$95,000.00		\$ 1,240,000	\$ 1,253,853			\$ 148,054	9				
<b>B. Non-Facility Related*</b>																
10	IRS, IDR, ETC		X	LATE FEES								10				
11												11				
12												12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$ 0	\$ 0			\$ 0	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 1,240,000	\$ 1,253,853			\$ 148,054	15				

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number SKYVIEW TERRACE# 0036848 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.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>35,926</b>	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.)			\$	<b>26,667</b>	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(9,259)</b>	3																			
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>26,667</b>	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>17,408</b>	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
1996	<u>29,895</u>	<u>8</u>	<table border="1"> <thead> <tr> <th colspan="3">FOR OHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2000</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </tbody> </table>			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
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																					
1997	<u>30,976</u>	<u>9</u>																						
1998	<u>30,393</u>	<u>10</u>																						
1999	<u>26,453</u>	<u>11</u>																						
2000	<u>26,667</u>	<u>12</u>																						
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL.</b>																								
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.</b>																								

## 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 SKYVIEW TERRACE COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0036848

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 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>09-17-204-013</u>	<u>NURSING HOME</u>	\$ <u>26,667.14</u>	\$ <u>26,667.14</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>26,667.14</u>	\$ <u>26,667.14</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 home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

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

Facility Name & ID Number SKYVIEW TERRACE

# 0036848 Report Period Beginning:

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,500 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	0	1991	\$ 43,632	1
2					2
3	TOTALS			\$ 43,632	3

Facility Name & ID Number SKYVIEW TERRACE

# 0036848

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 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	113		1991		\$ 785,372	\$ 24,932	31.5	\$ 24,932	\$	\$ 247,452	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		VARIOUS		1993	1,792	46	20	90	44	735	9
10		VARIOUS		1994	1,801	46	20	90	44	720	10
11		GENERATOR REPAIRS		1996	2,508	65	20	125	60	698	11
12		VENT REPAIRS		1996	1,200	30	20	60	30	305	12
13		ROOF REPAIRS		1997	50,700	1,300	20	2,535	1,235	11,619	13
14		PAINT & WALLPAPER		1997	21,655	555	20	1,082	527	4,779	14
15		REPLACEMENT SWITCH IN GENERATOR		1998	1,037	26	20	51	25	179	15
16		WALLPAPER, HARDWARE FOR WALLS		1998	5,613	143	20	280	137	980	16
17		HANDRAILS		1998	2,579	66	20	128	62	449	17
18		FLOOR & COVE BASE		1998	12,944	331	20	647	316	2,265	18
19		PAINTING /CARPETING		1998	9,995	256	20	499	243	1,747	19
20		ROOM SIGNS		1998	1,095	28	20	54	26	189	20
21		WALLPAPER		1999	5,374	138	20	268	130	804	21
22		HAND RAIL BUMPER, CAP		1999	5,034	129	20	251	122	753	22
23		SOFFIT INSULATION		1999	4,638	119	20	231	112	693	23
24		VCT INSTALLATION, FLOOR PATCH, TILE		1999	13,515	347	20	675	328	2,025	24
25		ROOM SIGNS, FRAMED ARTWORK		1999	3,685	94	20	184	90	552	25
26		HEATERS AND AIR CONDITIONING UNITS		2000	4,032	147	27.5	147	220	220	26
27		BUILT IN CABINETS FOR ADM. AND BOOKKEEPING OFFICE		2000	6,500	236	27.5	236	354	354	27
28		VCT INSTALLATION,COVE BASES, TILES,VINYL SHEET		2000	13,488	490	27.5	490	735	735	28
29				2001	788	14	27.5	14	14	14	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.

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 SKYVIEW TERRACE

# 0036848

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

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

Facility Name & ID Number SKYVIEW TERRACE # 0036848 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	\$ 112,123	\$ 15,987	\$ 12,458	\$ (3,529)	5-10	\$ 49,872	71
72	Current Year Purchases	3,531	706	176	(530)	10	176	72
73	Fully Depreciated Assets	36,339			0		36,339	73
74	<u>MAVIN ALLOCATION</u>		470	470	0			74
75	TOTALS	\$ 151,993	\$ 17,163	\$ 13,104	\$ (4,059)		\$ 86,387	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	<u>FACILITY</u>	<u>1988 CHEVROLET</u>	<u>1993</u>	\$ 9,422	\$	\$ 942	\$ 942	10	\$ 8,321	76
77	<u>FACILITY</u>	<u>1991 PLYMOUTH VOYAGER</u>	<u>1994</u>	8,520			0	5	8,520	77
78							0			78
79							0			79
80	TOTALS			\$ 17,942	\$ 0	\$ 942	\$ 942		\$ 16,841	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,168,912	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,701	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,115	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 414	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 381,495	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.

Facility Name & ID Number SKYVIEW TERRACE

# 0036848

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

**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

\*\*

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: \$ 6,252

Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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>	\$ _____

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		<u>1997 FORD WAGON</u>	\$ <u>550.00</u>	\$ <u>3,878</u>	17
18		<u>2000 CHEVROLET VAN</u>	<u>825.00</u>	<u>3,300</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>1,375.00</u>	\$ <u>7,178</u>	21

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox" value="2"/></p> <p>HOURS PER AIDE <u>88</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 500	\$	\$ 500
2	Books and Supplies		86		86
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		100		100
9	TOTALS	\$ 0	\$ 686	\$ 0	\$ 686
10	SUM OF line 9, col. 1 and 2 (e)	\$ 686			

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$			\$ 72	\$		\$ 72	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				460			460	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				25,444			25,444	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescripts					52,484		52,484	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	EQUIPMENT Other (specify): <b>MEDICAL SUPPLIES</b>	39-2 39-2						6,785 1,891		6,785 1,891	13
14	TOTAL			\$			\$ 25,976	\$ 61,160		\$ 87,136	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 SKYVIEW TERRACE# 0036848Report 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 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,192	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	732,702		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,364		6
7	Other Prepaid Expenses	638		7
8	Accounts Receivable (owners or related parties)	758,956		8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	17,282		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,552,134	\$ 0	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	181,604		15
16	Equipment, at Historical Cost	126,335		16
17	Accumulated Depreciation (book methods)	(105,328)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 202,611	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,754,745	\$ 0	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 228,164	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	976,192		29
30	Accrued Salaries Payable	50,363		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,331		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,667		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,295,717	\$ 0	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,295,717	\$ 0	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 459,028	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,754,745	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>533,486</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ILLINOIS REPLACEMENT TAX</b>	(5,496)	<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>527,990</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(68,774)	<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>TREASURY STOCK</b>	(188)	<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>(68,962)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>459,028</b>	<b>24</b> *

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

Facility Name & ID Number SKYVIEW TERRACE

# 0036848

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

**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	\$ 2,874,698	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,874,698	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,892	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,892	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,462	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,462	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,881,052	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	543,725	31
32	Health Care	1,117,774	32
33	General Administration	886,777	33
<b>B. Capital Expense</b>			
34	Ownership	252,547	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	87,136	35
36	Provider Participation Fee	61,867	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,949,826	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(68,774)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (68,774)	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 SKYVIEW TERRACE

# 0036848

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	1,216	1,243	\$ 27,257	\$ 21.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,099	7,589	119,598	15.76	3
4	Licensed Practical Nurses	15,703	16,858	240,740	14.28	4
5	Nurse Aides & Orderlies	46,176	57,816	497,215	8.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,046	4,247	33,806	7.96	10
11	Social Service Workers	3,897	4,121	46,155	11.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,417	15,686	99,447	6.34	15
16	Dishwashers					16
17	Maintenance Workers	3,718	4,126	45,423	11.01	17
18	Housekeepers	10,890	11,928	66,321	5.56	18
19	Laundry	3,763	4,921	30,559	6.21	19
20	Administrator	2,072	2,196	52,354	23.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,099	4,452	54,094	12.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>SEE ATTACHED</u>	4,362	4,837	64,995	13.44	33
34	TOTAL (lines 1 - 33)	121,458	140,020	\$ 1,377,964 *	\$ 9.84	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	M	\$ 10,567	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	326	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	720	10-3	39
40	Physical Therapy Consultant	L	3,609	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	3,300	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47	<u>PCYCHO-SOCIAL CONSULT</u>	S	8,793	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,315		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	9	\$ 369		50
51	Licensed Practical Nurses	162	5,067		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	171	\$ 5,436		53

Facility Name & ID Number **SKYVIEW TERRACE**

# **0036848**

Report Period Beginning: **01/01/2001**

Ending: **12/31/2001**

**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	
NANCY RETHERFORD	ADMIN	0	\$ 37,171	Workers' Compensation Insurance	\$ 30,728	IDPH License Fee	\$	
KELLY MATHIS	ADMIN	0	15,183	Unemployment Compensation Insurance	13,883	Advertising: Employee Recruitment	2,654	
				FICA Taxes	102,956	Health Care Worker Background Check	10	
				Employee Health Insurance	22,127	(Indicate # of checks performed <u>1</u> )		
				Employee Meals	7,942	MARKETING/ADV/PROMO	11,455	
				Illinois Municipal Retirement Fund (IMRF)*		MGMT CO ALLOCATION	498	
				EMPLOYEE BENEFITS - OTHER	2,604	CONTRIBUTIONS	8,164	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	4,148	
				PENSION/PROFIT SHARING PLANS	0	LICENSES & PERMITS	143	
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX	0	TRUST FEES/CONTRIBUTIONS	(8,164)	
(List each licensed administrator separately.)			\$ 52,354	INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( )	
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(11,455)	
Description			Amount			Yellow page advertising	( 0 )	
SWS CONSULTING MANAGEMENT FEES			\$ 152,572	TOTAL (agree to Schedule V, line 22, col.8)	\$ 180,240	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,453	
MELVIN SIEGEL MANAGEMENT FEES			40,128					
FAMILY PARTNERS MANAGEMENT			13,500					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 206,200	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount		
C. Professional Services							G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount				Description	Amount
			\$				Out-of-State Travel	\$
							In-State Travel	
								1,908
							MGMT CO ALLOCATION	18,084
							Seminar Expense	
								0
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
SEE ATTACHED SCHEDULE			203,024	TOTAL		\$	TOTAL	\$ 19,992
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 203,024					

\* 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. IL COUNCIL LONG TERM CARE \$4147
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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. \$ 61,867  
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. \$ 7,942 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. \$ \_\_\_\_\_  
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.** \$ N/A
- (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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	10,567
	REPAIRS & MAINTENANCE	0
		0
		10,567
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	1,784
		0
		1,784
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	12,157
	ELECTRICITY	37,364
	WATER	14,490
	CABLE TV - LOBBY	4,719
		0
		68,730
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	3,225
	PAINTING & DECORATING	906
	BUILDING REPAIRS	0
	MAINTENANCE CONSULTANT	13,200
	EQUIPMENT MAINTENANCE & REPAIR	12,014
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,902
	FIRE SERVICE	443
		0
		0
		0
		31,690
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	2,616
	SECURITY SERVICE	944
		0
		3,560
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	5,436
	LABORATORY & XRAY EXPENSE	1,402
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	8,793
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	326
	PHARMACY CONSULTANT XVIII B 39-2	720
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		16,677
<b>10a</b>	<b>THERAPY</b>	
	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	3,609
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,609
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,300
		0
		3,300
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	686
		686

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	206,200
18	<b>DIRECTORS FEES</b>	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	9,573
	ADMINISTRATIVE CONSULTANTS XIX C	61,051
	PROFESSIONAL FEES XIX C	30,640
	BOOKKEEPING/ADMINISTRATIVE SERVICES	101,760
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	203,024
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	11,455
	EMPLOYEE WANT ADS XIX F	2,654
	CONTRIBUTIONS VI 20 XIX F	235
	DUES & SUBSCRIPTIONS XIX F	4,148
	LICENSES & PERMITS XIX F	143
	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	7,929
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	10
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	26,574
	BANK CHARGES	522
	EQUIPMENT REPAIR & MAINTENANCE	922
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	771
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,441
	MESSENGER SERVICE	0
		18,656

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	102,956
	UNEMPLOYMENT COMPENSATION XIX D	13,883
	WORKERS COMPENSATION INSURANC XIX D	30,728
	HOSPITALIZATION INSURANCE XIX D	22,127
	EMPLOYEE BENEFITS - OTHER XIX D	2,604
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	172,298
	EDUCATION & SEMINARS	2,348
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	1,908
		0
		1,908
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	6,242
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	128,385
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

912,238

SKYVIEW TERRACE  
 EMPLOYEE MEAL RECLASSIFICATION  
 12/31/2001

TOTAL FOOD PURCHASE	136,559	PATIENT MEALS	93807
LESS SALES TAX	(584)	ADD EMPLOYEE MEALS	5840
	-----		-----
NET FOOD	135,975	TOTAL MEALS/YEAR	99647
TOTAL PATIENT CENSUS	31,269	NET FOOD	135975
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	99647
	-----		
TOTAL PATIENT MEALS	93807	COST PER MEAL	1.36
		TIME EMPLOYEE MEALS	5840
ADD # EMPLOYEE MEALS/DAY	16		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	7942
	-----		=====
TOTAL EMPLOYEE MEALS	5840		