

		FOR BHF USE				

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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:** 0043141

**Facility Name:** Dolton Healthcare Centre

**Address:** 14325 South Blackstone Avenue Dolton 60419  
 Number City Zip Code

**County:** Cook

**Telephone Number:** (708) 849-5000 **Fax #** (708) 849-5175

**HFS ID Number:** 36-4184122

**Date of Initial License for Current Owners:** 1-Oct-97

**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 type="checkbox"/> "Sub-S" Corp.	
	<input checked="" 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:** Christopher Vicere **Telephone Number:** (773) 604-4416

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-05 to 31-Dec-05 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.

**Officer or Administrator of Provider**

(Signed) \_\_\_\_\_ 31st March, 2006  
 (Date)

(Type or Print Name) Christopher Vicere

(Title) Vice President - Finance

**Paid Preparer**

(Signed) \_\_\_\_\_ (Date)

(Print Name and Title) \_\_\_\_\_

(Firm Name & Address) \_\_\_\_\_

(Telephone) ( ) \_\_\_\_\_ Fax # ( ) \_\_\_\_\_

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Dolton Healthcare Centre# 0043141 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

## 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	40	Skilled (SNF)	40	14,600	1
2		Skilled Pediatric (SNF/PED)			2
3	40	Intermediate (ICF)	40	14,600	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,357	1,133	3,364	14,854	8
9	SNF/PED					9
10	ICF	11,149	938		12,087	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,506	2,071	3,364	26,941	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.26%

D. How many bed-hold days during this year were paid by the Department?

None (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 1st Oct 1997

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 40 and days of care provided 3,325Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 31st Dec 2005 Fiscal Year: 31st Dec 2005

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

Facility Name & ID Number      Dolton Healthcare Centre      #      0043141      Report Period Beginning:      1-Jan-05      Ending:      31-Dec-05

**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	170,626	30,419	5,160	206,205		206,205		206,205			1
2	Food Purchase		141,203		141,203	(12,022)	129,181	(98)	129,083			2
3	Housekeeping	83,423	26,910		110,333		110,333		110,333			3
4	Laundry	65,556	24,872	971	91,399		91,399		91,399			4
5	Heat and Other Utilities			88,582	88,582		88,582		88,582			5
6	Maintenance	29,148	26,945	54,319	110,412		110,412	3,781	114,193			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>348,753</b>	<b>250,349</b>	<b>149,032</b>	<b>748,134</b>	<b>(12,022)</b>	<b>736,112</b>	<b>3,683</b>	<b>739,795</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,273,216	153,741	5,579	1,432,536		1,432,536		1,432,536			10
10a	Therapy			168	168		168		168			10a
11	Activities	77,583	7,012	1,848	86,443		86,443		86,443			11
12	Social Services	43,444		2,403	45,847		45,847		45,847			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,394,243</b>	<b>160,753</b>	<b>15,998</b>	<b>1,570,994</b>		<b>1,570,994</b>		<b>1,570,994</b>			16
	<b>C. General Administration</b>											
17	Administrative	69,786		127,680	197,466		197,466	(59,295)	138,171			17
18	Directors Fees											18
19	Professional Services			32,151	32,151		32,151	7,762	39,913			19
20	Dues, Fees, Subscriptions & Promotions			29,090	29,090		29,090	(18,541)	10,549			20
21	Clerical & General Office Expenses	53,812	15,441	46,137	115,390		115,390	11,263	126,653			21
22	Employee Benefits & Payroll Taxes			304,857	304,857	12,022	316,879	23,544	340,423			22
23	Inservice Training & Education			2,427	2,427		2,427	518	2,945			23
24	Travel and Seminar			2,349	2,349		2,349	2,224	4,573			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			4,177	4,177		4,177		4,177			26
27	Other (specify):* <b>*Payroll Taxes (Sch.VII)**</b>							8,297	8,297			27
28	<b>TOTAL General Administration</b>	<b>123,598</b>	<b>15,441</b>	<b>548,868</b>	<b>687,907</b>	<b>12,022</b>	<b>699,929</b>	<b>(24,228)</b>	<b>675,701</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,866,594</b>	<b>426,543</b>	<b>713,898</b>	<b>3,007,035</b>		<b>3,007,035</b>	<b>(20,545)</b>	<b>2,986,490</b>			29

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

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

Facility Name & ID Number Dolton Healthcare Centre #0043141 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			56,588	56,588		56,588	16,445	73,033			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(436)	(436)			32
33	Real Estate Taxes			188,292	188,292		188,292		188,292			33
34	Rent-Facility & Grounds			347,647	347,647		347,647		347,647			34
35	Rent-Equipment & Vehicles			803	803		803		803			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			593,330	593,330		593,330	16,009	609,339			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,605	213,245	286,850		286,850		286,850			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		73,605	257,045	330,650		330,650		330,650			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,866,594	500,148	1,564,273	3,931,015		3,931,015	(4,536)	3,926,479			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 Dolton Healthcare Centre

# 0043141

Report Period Beginning: 1-Jan-05

Ending: 31-Dec-05

**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	16,204	30		9
10	Interest and Other Investment Income	(22,030)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(98)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,110)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,101)	21		24
25	Fund Raising, Advertising and Promotional	(29,779)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(922)	20		28
29	Other-Attach Schedule <b>**Page 5A attached</b>	3,781	6		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (60,055)		\$	30

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)	55,519	Page 6	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 55,519		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (4,536)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

OHF USE ONLY						
48		49		50		51
						52

Dolton Healthcare Centre

ID# 0043141

Report Period Beginning: 1-Jan-05

Ending: 31-Dec-05

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance Cost (incurred in 2005)	\$ 0	6 1
2	Deferred Maintenance Cost (allocated for 2005)	3,781	6 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>	3,781	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Dolton Healthcare Centre

# 0043141

Report Period Beginning:

1-Jan-05

Ending:

31-Dec-05

**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	(98)	0	0	0	0	0	0	0	0	0	0	(98)	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	3,781	0	0	0	0	0	0	0	0	0	0	3,781	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>3,683</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>3,683</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	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	CNA 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>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>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(59,295)	0	0	0	0	0	0	0	0	0	(59,295)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,762	0	0	0	0	0	0	0	0	0	7,762	19
20	Fees, Subscriptions & Promotions	(30,701)	12,160	0	0	0	0	0	0	0	0	0	(18,541)	20
21	Clerical & General Office Expenses	(26,101)	37,364	0	0	0	0	0	0	0	0	0	11,263	21
22	Employee Benefits & Payroll Taxes	0	23,544	0	0	0	0	0	0	0	0	0	23,544	22
23	Inservice Training & Education	0	518	0	0	0	0	0	0	0	0	0	518	23
24	Travel and Seminar	(1,110)	3,334	0	0	0	0	0	0	0	0	0	2,224	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):*	0	8,297	0	0	0	0	0	0	0	0	0	8,297	27
28	<b>TOTAL General Administration</b>	<b>(57,912)</b>	<b>33,684</b>	<b>0</b>	<b>(24,228)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(54,229)</b>	<b>33,684</b>	<b>0</b>	<b>(20,545)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Dolton Healthcare Centre

# 0043141

Report Period Beginning:

1-Jan-05 Ending:

Summary B

31-Dec-05

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	16,204	241	0	0	0	0	0	0	0	0	0	16,445	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,030)	21,594	0	0	0	0	0	0	0	0	0	(436)	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	<b>TOTAL Ownership</b>	<b>(5,826)</b>	<b>21,835</b>	<b>0</b>	<b>16,009</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> (sum of lines 29, 37 & 44)	<b>(60,055)</b>	<b>55,519</b>	<b>0</b>	<b>(4,536)</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

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	17 Officers' Salaries	\$	Lancaster, Ltd.	100.00%	\$ 50,696	\$ 50,696	1
2	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	8,297	8,297	2
3	V	17 Management Fee Income	127,680	Lancaster, Ltd.	100.00%		(127,680)	3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	7,762	7,762	4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	37,364	37,364	5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	23,544	23,544	6
7	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	3,334	3,334	7
8	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	17,689	17,689	8
9	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	11,582	11,582	9
10	V	32 Interest		Lancaster, Ltd.	100.00%	21,594	21,594	10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	241	241	11
12	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	578	578	12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	518	518	13
14	Total		\$ 127,680			\$ 183,199	\$ * 55,519	14

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

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

## 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	Laurence Zung	Executive Officer	Administrative	50.0%	See Attached	2	4.17%	Lancaster	\$ 8,750	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0.0%	See Attached	6	12.5%	Lancaster	20,973	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	0.0%	See Attached	6	12.5%	Lancaster	20,973	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 50,696		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 Dolton Healthcare Centre

# 0043141

Report Period Beginning:

1-Jan-05

Ending: 1-Dec-05

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 Lancaster, Ltd.  
 Street Address 5061 N. Pulaski Road  
 City / State / Zip Code Chicago, IL 60630  
 Phone Number ( 773 )604-4416  
 Fax Number ( 773 )478-1192

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Laurence Zung	Hours Worked	48	7	\$ 210,000	\$ 210,000	2	\$ 8,750	1
2	27	Laurence Zung-payroll tax	Hours Worked	48	7	9,553		2	398	2
3	17	Christopher Vicere	Hours Worked	48	7	167,782	167,782	6	20,973	3
4	27	Christopher Vicere-payroll tax	Hours Worked	48	7	8,941		6	1,118	4
5	17	Cheryl Morris	Hours Worked	48	7	167,782	167,782	6	20,973	5
6	27	Cheryl Morris-payroll tax	Hours Worked	48	7	8,941		6	1,118	6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,140,820	7	130,152		127,680	7,762	13
14	21	Clerical Expenses	Management Fees	2,140,820	7	626,489	553,344	127,680	37,364	14
15	22	Employee Benefits	Management Fees	2,140,820	7	394,769		127,680	23,544	15
16	24	Seminars & Travel	Management Fees	2,140,820	7	55,902		127,680	3,334	16
17	17	Administrative Consulting	Management Fees	2,140,820	7	296,590	296,590	127,680	17,689	17
18	20	Marketing and Fees	Management Fees	2,140,820	7	194,202	180,270	127,680	11,582	18
19	32	Interest	Management Fees	2,140,820	7	(7,314)		127,680	(436)	19
20	30	Depreciation	Management Fees	2,140,820	7	4,042		127,680	241	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,140,820	7	9,684		127,680	578	21
22	27	Payroll Taxes	Management Fees	2,140,820	7	94,951		127,680	5,663	22
23	23	Education & Inservice	Management Fees	2,140,820	7	8,681		127,680	518	23
24	32	*Direct Interest*							22,030	24
25	TOTALS					\$ 2,381,147	\$ 1,575,768		\$ 183,199	25

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1					\$	\$			\$	1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	JP Morgan Chase Bank		X	Working Capital					(436)	6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>				\$	\$			(436)	9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>				\$	\$				14										
15	<b>TOTALS (line 9+line14)</b>				\$	\$			(436)	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		<b>Important</b> , 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.)			\$ <b>188,292</b>	2														
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>188,292</b>	3														
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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 _____ 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>188,292</b>	7														
Real Estate Tax History:																		
Real Estate Tax Bill for Calendar Year:																		
2000	<u>152,961</u>	<u>8</u>	<table border="1"> <tr> <td colspan="2"><b>FOR OHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2004 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR OHF USE ONLY</b>																		
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13																
14	PLUS APPEAL COST FROM LINE 5 \$	14																
15	LESS REFUND FROM LINE 6 \$	15																
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																
2001	<u>171,367</u>	<u>9</u>																
2002	<u>170,647</u>	<u>10</u>																
2003	<u>174,711</u>	<u>11</u>																
2004	<u>188,292</u>	<u>12</u>																

NOTES:

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Dolton Healthcare Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0043141

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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>29-02-414-056-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>169,702.50</u>	\$ <u>169,702.50</u>
2. <u>29-02-422-001-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>18,589.54</u>	\$ <u>18,589.54</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>188,292.04</u>	\$ <u>188,292.04</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 17,952 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ 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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

\_\_\_\_\_  
 \_\_\_\_\_  
 \*\*\* NONE \*\*\*  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name &amp; ID Number Dolton Healthcare Centre

# 0043141

Report Period Beginning:

1-Jan-05

Ending:

31-Dec-05

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

	1 Beds*	FOR BHF 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	80				\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Excavation and Site Work		2000	36,732	2,291	20	2,291		16,129	9
10		Concrete Work		2000	23,650	606	20	606		3,359	10
11		Masonry Work		2000	35,757	917	20	917		5,081	11
12		Steel and Erection		2000	24,818	636	20	636		3,525	12
13		Roofing		2000	15,130	388	20	388		2,150	13
14		Storm Drainage		2000	15,740	981	20	981		6,910	14
15		Plumbing		2000	38,800	995	20	995		5,514	15
16		Fire Alarm System & Protection		2000	33,664	863	20	863		4,783	16
17		Heating & Cooling		2000	26,640	683	20	683		3,785	17
18		Electrical		2000	58,592	1,502	20	1,502		8,325	18
19		Nurses' Call System		2000	12,691	325	20	325		1,802	19
20		Phase I Expansion		2000	257,605	6,605	20	6,605		36,603	20
21		Hand Rails		2001	5,424	139	20	139		631	21
22		Alarm Systems		2001	3,734	96	20	96		436	22
23		Electrical		2001	2,149	55	20	55		250	23
24		Wall Coverings		2001	7,602	195	20	195		886	24
25		Fire Proofing		2001	4,301	110	20	110		500	25
26		Construction		2001	125,945	3,229	20	3,229		14,667	26
27		Interior Design		2001	22,500	577	20	577		2,620	27
28		Architectural		2001	40,401	1,036	20	1,036		4,705	28
29		Flooring		2001	4,478	115	20	115		522	29
30		Signage		2001	3,832	98	20	98		445	30
31		Plumbing		2001	2,400	62	20	62		281	31
32		Fire Dampers		2001	8,462	217	20	217		895	32
33		Fire Security Board		2002	4,500	363	20	643	280	2,411	33
34		Roofing		2002	10,820	277	20	1,082	805	3,517	34
35		MDP Panel/Ducting		2002	4,159	107	20	416	309	1,283	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Dolton Healthcare Centre

# 0043141

Report Period Beginning:

1-Jan-05

Ending:

31-Dec-05

**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	Roofing Stage 1	2003	\$ 8,020	\$ 206	10	\$ 802	\$ 596	\$ 2,206	37
38	Walkway	2003	968	25	10	97	72	259	38
39	Gutters & Scuppers	2003	6,460	166	10	646	480	1,669	39
40	Roofing Stage 2	2003	10,400	267	10	1,040	773	2,427	40
41	Electronic Egress Door	2004	3,007	77	10	301	224	577	41
42	6 Steel Doors & Frames	2004	10,152	260	10	1,015	755	1,353	42
43	Vinyl Tiles in Corridor	2004	1,939	50	10	194	144	242	43
44	2 Steel Doors	2004	4,489	115	10	449	334	561	44
45	Refurbishing of 22 Rooms	2004	10,900	279	10	1,090	811	2,089	45
46	Magnetic Lock Door	2005	2,245	41	10	168	127	168	46
47	Garden Landscaping	2005	14,835	206	10	865	659	865	47
48	Patio & Retaining Wall	2005	17,430	242	10	1,017	775	1,017	48
49	Ornamental Steel Fence	2005	4,595	54	10	230	176	230	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)		\$ 925,966	\$ 25,456		\$ 32,776	\$ 7,320	\$ 145,678	70

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

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

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	\$ 218,587	\$ 25,686	\$ 33,472	\$ 7,786	5	\$ 103,258	71
72	Current Year Purchases	12,688	2,537	1,379	(1,158)	5	1,379	72
73	Fully Depreciated Assets	161,888	2,909	5,165	2,256	5	161,888	73
74	**Lancaster Allocation**		241	241			241	74
75	TOTALS	\$ 393,163	\$ 31,373	\$ 40,257	\$ 8,884		\$ 266,766	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,319,129	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 56,829	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,033	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,204	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 412,444	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: Dolton Associates (an unrelated entity)

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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>345,427</u>			3
4	Additions							4
5			<u>** Off-site public storage space **</u>		<u>2,220</u>			5
6								6
7	<b>TOTAL</b>				\$ <u>347,647</u>			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>12/31/2006</u>	\$ <u>354,597</u>
13.	<u>12/31/2007</u>	\$ <u>354,597</u>
14.	<u>12/31/2008</u>	\$ <u>354,597</u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 803 Description: Dish Washing Machine @63.95 per month through May '05 and \$68.05 per month effective June '05

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <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 CNA _____</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 CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA 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 CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs 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 CNAs.

Facility Name & ID Number Dolton Healthcare Centre# 0043141 Report Period Beginning:

1-Jan-05 Ending:

31-Dec-05

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 104,231	\$		\$ 104,231	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,114			6,114	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			102,900			102,900	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				52,718		52,718	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>**Medical Supplies**</b>	39-2					13,069		13,069	13
	<b>**Specialty Beds**</b>	39-2					7,818		7,818	13
14	<b>TOTAL</b>			\$		\$ 213,245	\$ 73,605		\$ 286,850	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 CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Dolton Healthcare Centre# 0043141Report Period Beginning: 1-Jan-05

Ending:

31-Dec-05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-05

(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	\$ 150	\$	1
2	Cash-Patient Deposits	21,461		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,189,667		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,100		6
7	Other Prepaid Expenses	579		7
8	Accounts Receivable (owners or related parties)	838,119		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,071,076	\$	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	925,967		15
16	Equipment, at Historical Cost	393,164		16
17	Accumulated Depreciation (book methods)	(449,672)		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>	\$ 869,459	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,940,535	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 77,249	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,461		28
29	Short-Term Notes Payable	65,170		29
30	Accrued Salaries Payable	231,925		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,374		31
32	Accrued Real Estate Taxes(Sch.IX-B)			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>	\$ 407,179	\$	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>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 407,179	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,533,356	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,940,535	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,878,930</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,878,930</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>654,426</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>654,426</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>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,533,356</b>	<b>24</b> *

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

Facility Name & ID Number **Dolton Healthcare Centre**

# **0043141**

Report Period Beginning: **1-Jan-05**

Ending: **31-Dec-05**

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

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,658,005	1
2	Discounts and Allowances for all Levels	(722,738)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,935,267	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	542,263	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 542,263	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA 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	66,545	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,034	19
20	Radiology and X-Ray	6,230	20
21	Other Medical Services	7,735	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 84,544	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	22,030	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 22,030	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending Commissions</b>	1,337	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,337	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,585,441	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	748,134	31
32	Health Care	1,570,994	32
33	General Administration	687,907	33
<b>B. Capital Expense</b>			
34	Ownership	593,330	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	286,850	35
36	Provider Participation Fee	43,800	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,931,015	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	654,426	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 654,426	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. \*Cash Basis Taxpayer

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

\*\*Adjusted on Pg.5\*\*

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

Facility Name & ID Number Dolton Healthcare Centre

# 0043141

Report Period Beginning:

1-Jan-05

Ending:

31-Dec-05

**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	1,837	2,006	\$ 65,651	\$ 32.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,349	11,780	318,335	27.02	3
4	Licensed Practical Nurses	14,633	15,786	345,552	21.89	4
5	CNAs & Orderlies	52,627	55,931	543,678	9.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,900	2,086	25,241	12.10	9
10	Activity Assistants	5,586	6,321	52,342	8.28	10
11	Social Service Workers	3,315	3,445	43,444	12.61	11
12	Dietician					12
13	Food Service Supervisor	2,037	2,211	41,042	18.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,279	15,571	129,584	8.32	15
16	Dishwashers					16
17	Maintenance Workers	1,842	1,922	29,148	15.17	17
18	Housekeepers	8,480	9,424	83,423	8.85	18
19	Laundry	6,475	7,183	65,556	9.13	19
20	Administrator	1,978	2,086	69,786	33.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,498	4,836	53,812	11.13	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)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>130,836</b>	<b>140,588</b>	<b>\$ 1,866,594 *</b>	<b>\$ 13.28</b>	<b>34</b>

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	107	\$ 5,160	1-3	35
36	Medical Director	180	6,000	9-3	36
37	Medical Records Consultant	29	1,456	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	20	660	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	168	10a-3	43
44	Activity Consultant	38	1,848	11-3	44
45	Social Service Consultant	68	2,403	12-3	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>445</b>	<b>\$ 17,695</b>		<b>49</b>

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	112	\$ 3,463	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	<b>TOTAL (lines 50 - 52)</b>	<b>112</b>	<b>\$ 3,463</b>		<b>53</b>

Facility Name & ID Number Dolton Healthcare Centre

# 0043141

Report Period Beginning: 1-Jan-05

Ending: 31-Dec-05

**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	
Safet Kaljalic	Administrator	N/A	\$ 69,786	Workers' Compensation Insurance	\$ 30,362	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	32,194	Advertising: Employee Recruitment	1,402	
				FICA Taxes	140,196	Health Care Worker Background Check	1,909	
				Employee Health Insurance	84,472	(Indicate # of checks performed <u>106</u> )		
				Employee Meals	12,022	**Advertising & Promotions**	19,119	
				Illinois Municipal Retirement Fund (IMRF)*		**Licenses and Fees**	5,329	
				**Misc. Employee Benefits**	9,114	**Dues & Subscriptions**	336	
				**Retirement Plan Contribution**	1,974	**Lancaster Allocation**	12,160	
				**Holiday Expenses**	6,545			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 69,786	**Lancaster Allocation**	23,544	Less: Public Relations Expense	(11,582)	
(List each licensed administrator separately.)						Non-allowable advertising	(18,197)	
						Yellow page advertising	(922)	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 340,423	
Description			Amount	TOTAL (agree to Sch. V, line 20, col. 8)				
Management Fees - Lancaster, Ltd.			\$ 127,680					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 127,680	G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)				Description				
				Amount				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Vendor/Payee	Type	Amount	Description	Line #	Amount			
Frost Ruttenberg & Rothblatt	Accounting	\$ 330				Out-of-State Travel		
Richard Peelo	Accounting	2,250						
Personnel Planners	Payroll tax Consultant	1,750						
Caffarelli & Siegal	Legal	10,207				In-State Travel		
Stone, Pogrund & Korey	Legal	6,027						
E Health Data Solutions	Data Processing	2,430	** N/A **					
Accu-Med Services, Inc.	Data Processing	3,000				Seminar Expense		
HealthData Systems, Inc.	Data Processing	6,015						
Emdeon Business Services	Data Processing	142				**Lancaster Allocation**		
						Entertainment Expense		
						(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 32,151	TOTAL			\$ 4,573	
(If total legal fees exceed \$2500 attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Dolton Healthcare Centre

Report Period Beginning: 1-Jan-05 Ending:

**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 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	Painting & Decorating	10/2001	\$ 11,652	3	\$ 3,884	\$ 3,884	\$ 3,884	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	7/2003	11,344	3		1,891	3,781	3,781	1,891				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 22,996		\$ 3,884	\$ 5,775	\$ 7,665	\$ 3,781	\$ 1,891	\$	\$	\$	\$

