



Facility Name & ID Number Dolton Healthcare Centre

# 0043141 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	7,033	482	3,164	10,679	8	
9	SNF/PED					9	
10	ICF	13,403	463		13,866	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	20,436	945	3,164	24,545	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.06%

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)  
None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 1st Oct 1997

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1st Oct 1997 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 3,138

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 31st Dec 2009 Fiscal Year: 31st Dec 2009

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

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	217,078	38,867	5,280	261,225		261,225		261,225		1
2	Food Purchase		170,542		170,542	(16,320)	154,222	(59)	154,163		2
3	Housekeeping	133,785	45,081		178,866		178,866		178,866		3
4	Laundry	49,822	12,898		62,720		62,720		62,720		4
5	Heat and Other Utilities			100,552	100,552		100,552		100,552		5
6	Maintenance	40,012	27,869	53,653	121,534		121,534	2,376	123,910		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	440,697	295,257	159,485	895,439	(16,320)	879,119	2,317	881,436		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	1,729,570	157,666	3,624	1,890,860		1,890,860		1,890,860		10
10a	Therapy										10a
11	Activities	82,928	15,539		98,467		98,467		98,467		11
12	Social Services	36,520		2,137	38,657		38,657		38,657		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,849,018	173,205	11,761	2,033,984		2,033,984		2,033,984		16
	<b>C. General Administration</b>										
17	Administrative	57,143		129,360	186,503		186,503	(47,186)	139,317		17
18	Directors Fees										18
19	Professional Services			60,518	60,518		60,518	1,849	62,367		19
20	Dues, Fees, Subscriptions & Promotions			45,543	45,543		45,543	(8,764)	36,779		20
21	Clerical & General Office Expenses	111,379	21,069	127,714	260,162		260,162	(59,803)	200,359		21
22	Employee Benefits & Payroll Taxes			361,990	361,990	16,320	378,310	4,408	382,718		22
23	Inservice Training & Education			2,596	2,596		2,596	1,445	4,041		23
24	Travel and Seminar			3,965	3,965		3,965	624	4,589		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			169,312	169,312		169,312		169,312		26
27	Other (specify):* <b>*Payroll Taxes (Sch VII)**</b>							10,912	10,912		27
28	<b>TOTAL General Administration</b>	168,522	21,069	900,998	1,090,589	16,320	1,106,909	(96,515)	1,010,394		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,458,237	489,531	1,072,244	4,020,012		4,020,012	(94,198)	3,925,814		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 &amp; ID Number

Dolton Healthcare Centre

#0043141

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			59,907	59,907		59,907	15,318	75,225			30
31	Amortization of Pre-Op. & Org.											31
32	Interest						(5,220)	(5,220)				32
33	Real Estate Taxes			230,624	230,624		230,624		230,624			33
34	Rent-Facility & Grounds			359,874	359,874		359,874		359,874			34
35	Rent-Equipment & Vehicles			887	887		887		887			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			651,292	651,292		651,292	10,098	661,390			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,520	293,217	398,737		398,737		398,737			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>		105,520	337,017	442,537		442,537		442,537			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,458,237	595,051	2,060,553	5,113,841		5,113,841	(84,100)	5,029,741			45

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



**Dolton Healthcare Centre**

ID# 0043141

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost (incurred in 2009)	\$ (1,539)	6	1
2	Deferred Maintenance Cost (allocated for 2009)	2,799	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>	1,260		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Dolton Healthcare Centre# 0043141

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(59)	0	0	0	0	0	0	0	0	0	0	(59)	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	1,260	1,116	0	0	0	0	0	0	0	0	0	2,376	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>1,201</b>	<b>1,116</b>	<b>0</b>	<b>2,317</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	(47,186)	0	0	0	0	0	0	0	0	0	(47,186)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,849	0	0	0	0	0	0	0	0	0	1,849	19
20	Fees, Subscriptions & Promotions	(35,195)	26,431	0	0	0	0	0	0	0	0	0	(8,764)	20
21	Clerical & General Office Expenses	(102,863)	43,060	0	0	0	0	0	0	0	0	0	(59,803)	21
22	Employee Benefits & Payroll Taxes	0	4,408	0	0	0	0	0	0	0	0	0	4,408	22
23	Inservice Training & Education	0	1,445	0	0	0	0	0	0	0	0	0	1,445	23
24	Travel and Seminar	0	624	0	0	0	0	0	0	0	0	0	624	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	10,912	0	0	0	0	0	0	0	0	0	10,912	27
28	<b>TOTAL General Administration</b>	<b>(138,058)</b>	<b>41,543</b>	<b>0</b>	<b>(96,515)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(136,857)</b>	<b>42,659</b>	<b>0</b>	<b>(94,198)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Dolton Healthcare Centre# 0043141

Report Period Beginning:

1-Jan-2009 Ending:

Summary B

31-Dec-2009

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

	Capital Expense	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>D. Ownership</b>													
30	Depreciation	13,830	1,488	0	0	0	0	0	0	0	0	0	15,318	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,717)	10,497	0	0	0	0	0	0	0	0	0	(5,220)	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>(1,887)</b>	<b>11,985</b>	<b>0</b>	<b>10,098</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(138,744)	54,644	0	0	0	0	0	0	0	0	0	(84,100)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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 Management Fee Income	\$ 129,360	Lancaster, Ltd.	100.00%	\$	(129,360)	1	
2	V	17 Officers' Salaries		Lancaster, Ltd.	100.00%	43,048	43,048	2	
3	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	10,912	10,912	3	
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	1,849	1,849	4	
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	43,060	43,060	5	
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	4,408	4,408	6	
7	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	624	624	7	
8	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	39,126	39,126	8	
9	V	20 Dues,Subscriptions & Marketing Fees		Lancaster, Ltd.	100.00%	26,431	26,431	9	
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	1,488	1,488	10	
11	V	32 Interest-Incl. Direct Interest		Lancaster, Ltd.	100.00%	10,497	10,497	11	
12	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	1,445	1,445	12	
13	V	6 Repairs & Maintenance		Lancaster, Ltd.	100.00%	1,116	1,116	13	
14	Total		\$ 129,360			\$ 184,004	\$ *	54,644	14

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

Facility Name &amp; ID Number

Dolton Healthcare Centre

# 0043141

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

## 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	Christopher Vicere	VP-Finance	Administrative		see attached	6	12.50	Lancaster	\$ 21,524	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		see attached	6	12.50	Lancaster	21,524	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,048		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-2009

Ending: -Dec-2009

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 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

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	Christopher Vicere	Hours Worked	48	7	\$ 172,189	\$ 172,189	6	\$ 21,524	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,309		6	1,164	2
3	17	Cheryl Morris	Hours Worked	48	7	172,189	172,189	6	21,524	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,309		6	1,164	4
5										5
6										6
7										7
8	19	Professional Services	Management Fees	2,190,720	7	31,315		129,360	1,849	8
9	21	Clerical Expenses	Management Fees	2,190,720	7	729,221	681,138	129,360	43,060	9
10	22	Employee Benefits	Management Fees	2,190,720	7	74,654		129,360	4,408	10
11	24	Seminars and Travel	Management Fees	2,190,720	7	10,564		129,360	624	11
12	17	Administrative Consulting	Management Fees	2,190,720	7	662,608	662,608	129,360	39,126	12
13	20	Marketing Fees	Management Fees	2,190,720	7	430,592	417,882	129,360	25,426	13
14	20	Dues, Fees and Subscriptions	Management Fees	2,190,720	7	17,027		129,360	1,005	14
15	30	Depreciation	Management Fees	2,190,720	7	25,194		129,360	1,488	15
16	32	Interest	Management Fees	2,190,720	7	57,668		129,360	3,405	16
17	23	Education & Inservice	Management Fees	2,190,720	7	24,476		129,360	1,445	17
18	6	Repairs and Maintenance	Management Fees	2,190,720	7	18,904		129,360	1,116	18
19	27	Payroll Taxes	Management Fees	2,190,720	7	145,366		129,360	8,584	19
20										20
21	32	*Direct Interest*							7,092	21
22										22
23										23
24										24
25	TOTALS					\$ 2,590,585	\$ 2,106,006		\$ 184,004	25

Facility Name & ID Number

Dolton Healthcare Centre

# 0043141

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

**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	<b>JP Morgan Chase Bank</b>		<b>X</b>	<b>Working Capital</b>							<b>3,405</b>	<b>6</b>								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	\$			\$ <b>3,405</b>	<b>9</b>								
	<b>B. Non-Facility Related*</b>																			
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	<b>14</b>								
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ <b>3,405</b>	<b>15</b>								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None      Line # N/A      Set Off Interest Income (8,625)  
 (See instructions.)      (5,220)  
**Page 4 Line 32**

\* 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 Dolton Healthcare Centre

# 0043141

Report Period Beginning:

1-Jan-2009 Ending:

31-Dec-2009

**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

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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	2,169	20	2,169		24,805	9
10		Concrete Work	2000		23,650	606	20	606		5,783	10
11		Masonry Work	2000		35,757	917	20	917		8,749	11
12		Steel and Erection	2000		24,818	636	20	636		6,069	12
13		Roofing	2000		15,130	388	20	388		3,702	13
14		Storm Drainage	2000		15,740	929	20	929		10,626	14
15		Plumbing	2000		38,800	995	20	995		9,494	15
16		Fire Alarm System & Protection	2000		33,664	863	20	863		8,235	16
17		Heating & Cooling	2000		26,640	683	20	683		6,517	17
18		Electrical	2000		58,592	1,502	20	1,502		14,333	18
19		Nurses' Call System	2000		12,691	325	20	325		3,102	19
20		Phase I Expansion	2000		257,605	6,605	20	6,605		63,023	20
21		Hand Rails	2001		5,424	139	20	139		1,187	21
22		Alarm Systems	2001		3,734	96	20	96		820	22
23		Electrical	2001		2,149	55	20	55		470	23
24		Wall Coverings	2001		7,602	195	20	195		1,666	24
25		Fire Proofing	2001		4,301	110	20	110		940	25
26		Construction	2001		125,945	3,229	20	3,229		27,583	26
27		Interior Design	2001		22,500	577	20	577		4,928	27
28		Architectural	2001		40,401	1,036	20	1,036		8,849	28
29		Flooring	2001		4,478	115	20	115		982	29
30		Signage	2001		3,832	98	20	98		837	30
31		Plumbing	2001		2,400	62	20	62		529	31
32		Fire Dampers	2001		8,462	217	20	217		1,763	32
33		Fire Security Board	2002		4,500		20	161	161	4,500	33
34		Roofing	2002		10,820	277	20	1,082	805	7,845	34
35		MDP Panel/Ducting	2002		4,159	107	20	416	309	2,947	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

**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	Roofing Stage 1	2003	\$ 8,020	\$ 206	10	\$ 802	\$ 596	\$ 5,414	37
38	Walkway	2003	968	25	10	97	72	647	38
39	Gutters & Scuppers	2003	6,460	166	10	646	480	4,253	39
40	Roofing Stage 2	2003	10,400	267	10	1,040	773	6,587	40
41	Electronic Egress Door	2004	3,007	77	10	301	224	1,781	41
42	6 Steel Doors & Frames	2004	10,152	260	10	1,015	755	5,413	42
43	Vinyl Tiles in Corridor	2004	1,939	50	10	194	144	1,018	43
44	2 Steel Doors	2004	4,489	115	10	449	334	2,357	44
45	Refurbishing of 22 Rooms	2004	10,900	279	10	1,090	811	6,449	45
46	Magnetic Lock Door	2005	2,245	58	10	225	167	1,068	46
47	Garden Landscaping	2005	14,835	1,027	10	1,484	457	6,801	47
48	Patio & Retaining Wall	2005	17,430	1,208	10	1,743	535	7,989	48
49	Ornamental Steel Fence	2005	4,595	318	10	460	142	2,070	49
50	Nursing Station & Laundry Room	2006	12,538	321	10	1,254	933	4,911	50
51	Rewiring of Laundry Room Electrical Circuit	2006	21,588	2,141	10	3,930	1,789	14,578	51
52	Construction of Therapy Room	2006	23,580	605	10	2,358	1,753	7,664	52
53	Exit Devices with Trim	2008	1,910	306	10	382	76	541	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	<b>TOTAL (lines 4 thru 69)</b>		\$ 985,582	\$ 30,360		\$ 41,676	\$ 11,316	\$ 309,825	70

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

**XI. OWNERSHIP COSTS (continued)**

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 176,778	\$ 17,329	\$ 27,881	\$ 10,552	5	\$ 109,218	71
72	Current Year Purchases	17,772	10,663	2,624	(8,039)	5	2,624	72
73	Fully Depreciated Assets	308,670	1,555	1,556	1	5	308,670	73
74	<b>**Lancaster Allocation**</b>		1,488	1,488			6,168	74
75	<b>TOTALS</b>	\$ 503,220	\$ 31,035	\$ 33,549	\$ 2,514		\$ 426,680	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 1,488,802	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,395	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,225	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,830	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 736,505	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	<b>TOTALS</b>	\$	\$	\$	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 Dolton Healthcare Centre

# 0043141

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-2009

**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>357,654</u>			3
4	Additions							4
5			<u>**Off-site Public Storage Space**</u>		<u>2,220</u>			5
6								6
7	TOTAL				\$ <u>359,874</u>			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: \$ 887 Description: New Dish Washer @73.95 per month eff. Sept'08 to December'09

(Attach a schedule detailing the breakdown of movable equipment)

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

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. 12/31/2010 \$ 366,825  
13. 12/31/2011 \$ 366,825  
14. 12/31/2012 \$ 366,825

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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.

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	\$		\$ 127,063	\$		\$ 127,063	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			29,889			29,889	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			136,265			136,265	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				87,645		87,645	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <b>**Medical Supplies**</b>	39-2					9,981		9,981	12
13	Other (specify): <b>**Speciality Beds**</b>	39-2					7,894		7,894	13
14	<b>TOTAL</b>			\$		\$ 293,217	\$ 105,520		\$ 398,737	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**# **0043141**Report Period Beginning: **1-Jan-2009**Ending: **31-Dec-2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **31-Dec-2009**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 150	\$	1
2	Cash-Patient Deposits	38,024		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,240,486		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,312		6
7	Other Prepaid Expenses	8,660		7
8	Accounts Receivable (owners or related parties)	543,658		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,850,290	\$	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	985,583		15
16	Equipment, at Historical Cost	503,220		16
17	Accumulated Depreciation (book methods)	(704,972)		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>	\$ 783,831	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,634,121	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 139,591	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,195		28
29	Short-Term Notes Payable	180,096		29
30	Accrued Salaries Payable	207,648		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,836		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>	\$ 573,366	\$	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>	\$ 573,366	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,060,755	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,634,121	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,607,054</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>2,607,054</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(546,299)	<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>(546,299)</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>2,060,755</b>	<b>24</b> *

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

Facility Name & ID Number Dolton Healthcare Centre# 0043141Report Period Beginning: 1-Jan-2009Ending: 31-Dec-2009

**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	\$ 4,936,761	1
2	Discounts and Allowances for all Levels	(1,156,313)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,780,448</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	658,150	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 658,150</b>	<b>8</b>
<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	93,370	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,798	19
20	Radiology and X-Ray	2,430	20
21	Other Medical Services	13,621	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 112,219</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	15,717	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 15,717</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>**Vending Commissions**</b>	<b>1,008</b>	<b>28</b>
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,008</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,567,542</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	895,439	31
32	Health Care	2,033,984	32
33	General Administration	1,090,589	33
<b>B. Capital Expense</b>			
34	Ownership	651,292	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	398,737	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>	<b>\$ 5,113,841</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(546,299)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (546,299)</b>	<b>43</b>

\* 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 Page 5 & 9

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

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

# **0043141**

Report Period Beginning:

**1-Jan-2009**

Ending:

**31-Dec-2009**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,037	2,246	\$ 84,997	\$ 37.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,455	22,448	655,328	29.19	3
4	Licensed Practical Nurses	11,533	12,336	304,431	24.68	4
5	CNAs & Orderlies	61,872	66,137	684,814	10.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,917	2,166	34,327	15.85	9
10	Activity Assistants	4,285	4,587	48,601	10.60	10
11	Social Service Workers	2,366	2,507	36,520	14.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,067	19,344	217,078	11.22	15
16	Dishwashers					16
17	Maintenance Workers	2,029	2,180	40,012	18.35	17
18	Housekeepers	13,107	13,963	133,785	9.58	18
19	Laundry	3,954	4,737	49,822	10.52	19
20	Administrator	1,963	2,110	57,143	27.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,618	8,539	111,379	13.04	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	TOTAL (lines 1 - 33)	151,203	163,300	\$ 2,458,237 *	\$ 15.05	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	165	\$ 5,280	1-3	35
36	Medical Director	200	6,000	9-3	36
37	Medical Records Consultant	53	1,536	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	76	2,137	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	494	\$ 14,953		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	87	\$ 2,088	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	87	\$ 2,088		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Angela Noland	Administrator	N/A	\$ 57,143	Workers' Compensation Insurance	\$ 35,551	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	15,526	Advertising: Employee Recruitment	3,093	
				FICA Taxes	184,388	Health Care Worker Background Check	470	
				Employee Health Insurance	114,452	(Indicate # of checks performed <u>17</u> )		
				Employee Meals	16,320	Patient Background Checks	30	
				Illinois Municipal Retirement Fund (IMRF)*		**Advertising & Promotions**	8,801	
				**Misc. Employee Benefits**	5,506	**Licenses and Fees**	31,668	
				**Retirement Plan Contribution**	1,808	**Dues & Subscriptions**	516	
				**Holiday Expenses**	1,189	**Lancaster Allocation**	26,431	
				**Employment Fees**				
				**Uniform Allowance**	3,570	Less: Public Relations Expense	(8,284)	
				**Lancaster Allocation**	4,408	Non-allowable advertising	(26,911)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 57,143	TOTAL (agree to Schedule V, line 22, col.8)	\$ 382,718	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 36,779	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Lancaster, Ltd.			\$ 129,360				Out-of-State Travel	\$
							In-State Travel	2,580
				** N/A **				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 129,360				Seminar Expense	1,385
							**Lancaster Allocation**	624
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Frost Ruttenberg & Rothblatt	Accounting		\$ 1,550				TOTAL	\$ 4,589
Richard Peelo	Accounting		2,250					
Personnel Planners	Payroll tax Consultant		2,704					
Kenneth A. Henry	Legal		2,405					
Myers, Miller & Krauskopf	Legal		23,909					
Polsinelli Shughart	Legal		12,673					
Law Offices of Carter Korey	Legal		6,095					
Accu-Med Services, Inc.	Data Processing		3,980					
HealthData Systems, Inc.	Data Processing		4,592					
Medi-Fax Edi, LLC.	Data Processing		360					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 60,518					

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	Painting & Decorating	10/2001	\$ 11,652	3	\$	\$	\$	\$	\$	\$	\$	\$												
2	Painting & Decorating	7/2003	11,344	3	1,891																			
3	Painting & Decorating	3/2006	8,720	3	1,453	2,907	2,907	1,453																
4	Painting & Decorating	1/2007	1,267	3		422	422	423																
5	Painting & Decorating	2/2007	726	3		242	242	242																
6	Painting & Decorating	10/2008	1,275	3			425	425	425															
7	Painting & Decorating	6/2009	1,539	3				256	513	513	257													
8																								
9																								
10																								
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20	<b>TOTALS</b>		\$ 36,523		\$ 3,344	\$ 3,571	\$ 3,996	\$ 2,799	\$ 938	\$ 513	\$ 257	\$												

Facility Name & ID Number Dolton Healthcare Centre# 0043141Report Period Beginning: 1-Jan-2009Ending: 31-Dec-2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (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? 8 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,946 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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 43,800  
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, 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. \$ 16,320 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**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: N/A
- (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 \$5,000, 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.