



Facility Name & ID Number FONDULAC WOODS HEALTH CARE CENTER

# 0043554 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	98	Skilled (SNF)	98	35,868	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,868	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	17,400	4,343	1,966	23,709	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,400	4,343	1,966	23,709	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.10%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 2/7/98

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 2/7/98 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 17 and days of care provided 1,966

Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number **FONDULAC WOODS HEALTH CARE CEN** # **0043554** Report Period Beginning: **01/01/00** Ending: **12/31/00**

**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	110,856	11,871	5,745	128,472		128,472	(8,776)	119,696		1
2	Food Purchase		111,588		111,588		111,588		111,588		2
3	Housekeeping	86,683	10,788	449	97,920		97,920		97,920		3
4	Laundry	13,989	8,228	437	22,654		22,654		22,654		4
5	Heat and Other Utilities			86,877	86,877		86,877		86,877		5
6	Maintenance	27,281	10,564	35,902	73,747		73,747		73,747		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>238,809</b>	<b>153,039</b>	<b>129,410</b>	<b>521,258</b>		<b>521,258</b>	<b>(8,776)</b>	<b>512,482</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,950	4,950		4,950		4,950		9
10	Nursing and Medical Records	690,896	61,996	170,631	923,523		923,523	4,304	927,827		10
10a	Therapy	37	1,507	103,429	104,973		104,973		104,973		10a
11	Activities	46,751	1,352	857	48,960		48,960		48,960		11
12	Social Services	19,200		840	20,040		20,040	52	20,092		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>756,884</b>	<b>64,855</b>	<b>280,707</b>	<b>1,102,446</b>		<b>1,102,446</b>	<b>4,356</b>	<b>1,106,802</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			94,481	94,481		94,481	15,223	109,704		17
18	Directors Fees										18
19	Professional Services			5,846	5,846		5,846	30,598	36,444		19
20	Dues, Fees, Subscriptions & Promotions			26,411	26,411		26,411	(2,668)	23,743		20
21	Clerical & General Office Expenses	39,800	15,928	87,970	143,698		143,698	(14,293)	129,405		21
22	Employee Benefits & Payroll Taxes			144,452	144,452		144,452	66,726	211,178		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,923	6,923		6,923	3,370	10,293		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			35,668	35,668		35,668	20,371	56,039		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>39,800</b>	<b>15,928</b>	<b>401,751</b>	<b>457,479</b>		<b>457,479</b>	<b>119,327</b>	<b>576,806</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,035,493</b>	<b>233,822</b>	<b>811,868</b>	<b>2,081,183</b>		<b>2,081,183</b>	<b>114,907</b>	<b>2,196,090</b>		<b>29</b>

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

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			71,947	71,947		71,947		71,947			30
31	Amortization of Pre-Op. & Org.			248,710	248,710		248,710	(237,665)	11,045			31
32	Interest			376,764	376,764		376,764		376,764			32
33	Real Estate Taxes			43,901	43,901		43,901		43,901			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			33,443	33,443		33,443		33,443			35
36	Other (specify):* <b>Mtg. Guarantee</b>			70,635	70,635		70,635		70,635			36
37	<b>TOTAL Ownership</b>			845,400	845,400		845,400	(237,665)	607,735			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,727	42,527	62,254		62,254		62,254			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,802	53,802		53,802		53,802			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		19,727	96,329	116,056		116,056		116,056			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,035,493	253,549	1,753,597	3,042,639		3,042,639	(122,758)	2,919,881			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,776)	1		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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(56,434)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,668)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(243,440)	VAR		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (311,318)		\$	30

<b>OHF USE ONLY</b>					
48		49		50	
				51	
					52

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	188,560	VAR	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 188,560		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (122,758)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

ID# 0043554  
 Report Period Beginning: 01/01/00  
 Ending: 12/31/00

	Amount	Sch. V Line Reference
1 OTHER REVENUE	(295)	21 1
2 AMORT - GOODWILL	(237,665)	31 2
3 BUSINESS MEALS	(411)	21 3
4 EXTRAORDINARY ITEMS	(5,069)	21 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
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71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	(243,440)	90

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number FONDULAC WOODS HEALTH CARE CENTER# 0043554

Report Period Beginning:

01/01/00

Ending:

12/31/00**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	(8,776)	0	0	0	0	0	0	0	0	0	0	(8,776)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,776)</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>(8,776)</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	4,304	0	0	0	0	0	0	0	0	0	4,304	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	52	0	0	0	0	0	0	0	0	0	52	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>4,356</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>4,356</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	15,223	0	0	0	0	0	0	0	0	0	15,223	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	30,598	0	0	0	0	0	0	0	0	30,598	19
20	Fees, Subscriptions & Promotions	(2,668)	0	0	0	0	0	0	0	0	0	0	(2,668)	20
21	Clerical & General Office Expenses	(62,209)	1,908	46,008	0	0	0	0	0	0	0	0	(14,293)	21
22	Employee Benefits & Payroll Taxes	0	0	66,726	0	0	0	0	0	0	0	0	66,726	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,370	0	0	0	0	0	0	0	0	0	3,370	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	20,371	0	0	0	0	0	0	0	0	20,371	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(64,877)</b>	<b>20,501</b>	<b>163,703</b>	<b>0</b>	<b>119,327</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(73,653)</b>	<b>24,857</b>	<b>163,703</b>	<b>0</b>	<b>114,907</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FONDULAC WOODS HEALTH CARE CENTER # 0043554 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(237,665)	0	0	0	0	0	0	0	0	0	0	(237,665)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(237,665)</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>(237,665)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(311,318)</b>	<b>24,857</b>	<b>163,703</b>	<b>0</b>	<b>(122,758)</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
SEE ATTACHED LIST		SEE ATTACHED LIST		EDEN & ASSOC, INC	WILSON, WY	CONSULTING

**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	10		SENIOR LIVING PROPERTIES, LLC	100.00%	\$ 458	\$ 458	1	
2	V	10	28,791	SENIOR LIVING PROPERTIES, LLC	100.00%	30,549	1,758	2	
3	V	10		SENIOR LIVING PROPERTIES, LLC	100.00%	2,088	2,088	3	
4	V	12	840	SENIOR LIVING PROPERTIES, LLC	100.00%	892	52	4	
5	V	17	35,371	SENIOR LIVING PROPERTIES, LLC	100.00%	45,375	10,004	5	
6	V	17	59,111	SENIOR LIVING PROPERTIES, LLC	100.00%	64,330	5,219	6	
7	V	24	6,599	SENIOR LIVING PROPERTIES, LLC	100.00%	9,813	3,214	7	
8	V	21	216	SENIOR LIVING PROPERTIES, LLC	100.00%	505	289	8	
9	V	24	324	SENIOR LIVING PROPERTIES, LLC	100.00%	480	156	9	
10	V	21	9,537	SENIOR LIVING PROPERTIES, LLC	100.00%	9,965	428	10	
11	V	21	3,825	SENIOR LIVING PROPERTIES, LLC	100.00%	3,907	82	11	
12	V	21	2,566	SENIOR LIVING PROPERTIES, LLC	100.00%	2,582	16	12	
13	V	21	19,732	SENIOR LIVING PROPERTIES, LLC	100.00%	20,825	1,093	13	
14	Total		\$ 166,912			\$ 191,769	\$ *	24,857	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 EDP Services	\$	Senior Living Properties, LLC	100.00%	\$ 4,845	\$ 4,845	15
16	V	19 Legal Fees	5,846	Senior Living Properties, LLC	100.00%	16,450	10,604	16
17	V	19 Accounting Fees		Senior Living Properties, LLC	100.00%	19,994	19,994	17
18	V	26 Insurance - General Liability	32,527	Senior Living Properties, LLC	100.00%	36,143	3,616	18
19	V	26 Insurance - Property & Contents	2,941	Senior Living Properties, LLC	100.00%	19,546	16,605	19
20	V	26 Insurance - Other	200	Senior Living Properties, LLC	100.00%	350	150	20
21	V	22 Workers Compensation Claims	61,368	Senior Living Properties, LLC	100.00%	112,232	50,864	21
22	V	22 Health & Dental Insurance		Senior Living Properties, LLC	100.00%	15,862	15,862	22
23	V	21 Management Fees		Senior Living Properties, LLC	100.00%	41,163	41,163	23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 102,882			\$ 266,585	\$ * 163,703	39

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

Facility Name & ID Number **FONDULAC WOODS HEALTH CARE CE** # **0043554** Report Period Beginning: **01/01/00** Ending: **12/31/00**

**VII. RELATED PARTIES (continued)**

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								<b>TOTAL</b>	\$		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 FONDULAC WOODS HEALTH CARE CENTER # 0043554 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 SENIOR LIVING PROPERTIES, LLC  
 Street Address 3395 NORTH PINES DRIVE, SUITE 102  
 City / State / Zip Code WILSON, WYOMING 83014  
 Phone Number ( 307) 739-1209  
 Fax Number ( 307) 739-1217

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	10	Contract Services - RN	Resident Days (IL Only) 675,434	31	\$ 13,034	\$	23,709	\$ 458	1
2	10	Contract Services - RN	Resident Days (IL Only) 675,434	31	50,078		23,709	1,758	2
3	10	Contract Services - RN	Resident Days (IL Only) 675,434	31	59,476		23,709	2,088	3
4	12	Social Services Consultant	Resident Days (IL Only) 675,434	31	1,475		23,709	52	4
5	17	Contract Services - Business Office	Resident Days (Total) 1,728,555	88	729,382		23,709	10,004	5
6	17	Contract Services - Administrator	Resident Days (IL Only) 675,434	31	148,670		23,709	5,219	6
7	24	Travel	Resident Days (IL Only) 675,434	31	91,552		23,709	3,214	7
8	21	Business Meals	Resident Days (IL Only) 675,434	31	8,225		23,709	289	8
9	24	Seminars	Resident Days (IL Only) 675,434	31	4,452		23,709	156	9
10	21	Office Supplies	Resident Days (IL Only) 675,434	31	12,185		23,709	428	10
11	21	Supplies	Resident Days (IL Only) 675,434	31	2,350		23,709	82	11
12	21	Postage	Resident Days (IL Only) 675,434	31	466		23,709	16	12
13	21	Telephone	Resident Days (IL Only) 675,434	31	31,125		23,709	1,093	13
14	21	EDP Services	Resident Days (IL Only) 675,434	31	138,040		23,709	4,845	14
15	19	Legal Fees	Resident Days (Total) 1,728,555	88	737,379		23,709	10,114	15
16	19	Accounting Fees	Resident Days (Total) 1,728,555	88	1,457,713		23,709	19,994	16
17	26	Insurance - General Liability	Resident Days (Total) 1,728,555	88	263,635		23,709	3,616	17
18	26	Insurance - Property & Contents	Resident Days (Total) 1,728,555	88	1,210,642		23,709	16,605	18
19	26	Insurance - Other	Resident Days (Total) 1,728,555	88	10,924		23,709	150	19
20	22	Workers Compensation Claims	Resident Days (Total) 1,728,555	88	330,015		23,709	4,527	20
21	22	Health & Dental Insurance	Resident Days (Total) 1,728,555	88	1,156,469		23,709	15,862	21
22	21	Management Fees	Resident Days (Total) 1,728,555	88	1,721,509		23,709	23,612	22
23	19	Legal Fees	Resident Days (IL Only) 675,434	31	13,948		23,709	490	23
24	22	Workers Compensation Claims	Resident Days (IL Only) 675,434	31	1,320,062		23,709	46,337	24
25	TOTALS				\$ 9,512,806	\$		\$ 171,009	25

Facility Name & ID Number FONDULAC WOODS HEALTH CARE CENTER # 0043554 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 SENIOR LIVING PROPERTIES, LLC  
 Street Address 3395 NORTH PINES DRIVE, SUITE 102  
 City / State / Zip Code WILSON, WYOMING 83014  
 Phone Number ( 307) 739-1209  
 Fax Number ( 307) 739-1217

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	21	Management Fees	Resident Days (IL Only)	675,434	31	\$ 500,000	\$ 23,709	\$ 17,551	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 500,000	\$	\$ 17,551	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	GMAC COMM MORT CORP	X	ACQUISITION	\$27,240.00	2/6/98	\$ 3,885,052	\$ 3,618,121	2/1/08	0.0681	\$ 261,563	1									
2	COMPLETE CARE SERVICES	X	ACQUISITION	\$997.62	2/6/98	171,020	171,020	2/6/08	0.0700	21,648	2									
3	SEE ATTACHED	X	ACQUISITION	\$997.62	2/6/98	171,020	171,020	2/6/08	0.0700	21,648	3									
4											4									
5											5									
<b>Working Capital</b>																				
6	HEALTH CARE FINANCIAL PART	X	WORKING CAPITAL	NONE	2/6/98	66,189	72,645	DEMAND	PRIME + 2%	71,905	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>			\$29,235.24		\$ 4,293,281	\$ 4,032,806			\$ 376,764	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>					\$ 4,293,281	\$ 4,032,806			\$ 376,764	15									

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

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

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>33,797</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>43,901</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>10,104</b>	<b>3</b>
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>33,797</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For 19 <u>2000</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>43,901</b>	<b>7</b>
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	<b>57,166</b>	<b>8</b>
	1996	<b>61,288</b>	<b>9</b>
	1997	<b>62,708</b>	<b>10</b>
	1998	<b>71,893</b>	<b>11</b>
	1999	<b>43,901</b>	<b>12</b>
	<b>FOR OFF USE ONLY</b>		
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 1999 \$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>

**NOTES:**

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

Facility Name & ID Number FONDULAC WOODS HEALTH CARE CENTER

# 0043554

Report Period Beginning:

01/01/00

Ending:

12/31/00

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 24,928 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>225,205</u>	<u>1998</u>	<u>\$ 73,170</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>225,205</b>		<b>\$ 73,170</b>	<b>3</b>

Facility Name & ID Number **FONDULAC WOODS HEALTH CARE CENTER**

# **0043554**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Bed <sup>s</sup> *	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98		1998	1988	\$ 1,379,900	\$ 45,997	30	\$ 45,997	\$	\$ 134,157	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		WATER HEATER	1998	1988	8,025	268	10	268		1,739	9
10											10
11		SIGNAGE	1998	1988	464	15	10	15		120	11
12		LAND IMPROVEMENTS (PURCHASE PRICE)	1998	1988	30,533	679	15	679		5,937	12
13		MAIN DRAIN PLUMBING	1999	1988	1,355	30	15	30		181	13
14		UPGRADE PLUMBING	1999	1988	573	13	15	13		76	14
15		INSTALL FENCE	1999	1988	2,898	97	10	97		580	15
16		REPAIR WATER LEAK	1999	1988	1,374	46	10	46		263	16
17		NURSING STATION RENOVATION	1999	1988	3,750	83	15	83		479	17
18		COOLER COMPRESSOR	1999	1988	1,400	31	15	31		179	18
19		COUNTER TOP FOR NURSE WORK	1999	1988	3,750	83	15	83		335	19
20		STATION ALARM SYSTEM	1999	1988	1,075	36	10	36		170	20
21		PIPE REPAIR	1999	1988	896	12	25	12		54	21
22											22
23		TILE FLOOR	1999	1988	2,513	84	10	84		335	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		TOTAL (lines 4 thru 35)			\$ 1,438,506	\$ 47,474		\$ 47,474	\$	\$ 144,605	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.

**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	
37	Purchased in Prior Years	\$ 154,549	\$ 24,228	\$ 24,228	\$	VARIOUS	\$ 57,701	37
38	Current Year Purchases	7,322	245	245		VARIOUS	245	38
39	Fully Depreciated Assets							39
40								40
41	<b>TOTALS</b>	\$ 161,871	\$ 24,473	\$ 24,473	\$		\$ 57,946	41

**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	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	<b>TOTALS</b>			\$	\$	\$	\$		\$	46

**E. Summary of Care-Related Assets**

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,673,548	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 71,947	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 71,947	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 202,551	51

\*\*

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	<b>TOTALS</b>	\$	\$	\$	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5					N/A			5
6								6
7	TOTAL				\$ _____			7

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

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

9. Option to Buy:  YES  NO Terms: N/A \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 6,667 Description: DISHWASHER - \$2,570; COPIER - \$884; SCAFFOLDING TRUCK - \$3,213

(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			N/A		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. \_\_\_\_\_ /2001 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2002 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2003 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input 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 AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

\$

**D. NUMBER OF AIDES TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescripts			30	33,905		33,935	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>ANCILLARY SVCS.</b>	39.2, 39.3				3,621	24,698		28,319	13
14	<b>TOTAL</b>			\$		\$ 3,651	\$ 58,603		\$ 62,254	14

**NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.**

Facility Name & ID Number **FONDULAC WOODS HEALTH CARE CENTER**

# **0043554**

Report Period Beginning: **01/01/00**

Ending:

**12/31/00**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/00**

(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	\$ 5,603	\$	1
2	Cash-Patient Deposits	21,881		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>505,396</u> )	296,932		3
4	Supply Inventory (priced at <u>COST</u> )	20,936		4
5	Short-Term Investments			5
6	Prepaid Insurance	(32,020)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 313,332	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	73,170		13
14	Buildings, at Historical Cost	1,408,766		14
15	Leasehold Improvements, at Historical Cost	30,997		15
16	Equipment, at Historical Cost	160,615		16
17	Accumulated Depreciation (book methods)	(202,551)		17
18	Deferred Charges	2,105,200		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>	\$ 3,576,197	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,889,529	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 691,584	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,881		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,797		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>INTER CO SLP TEXAS</u>	(683,571)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 63,691	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	4,032,806		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>	\$ 4,032,806	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,096,497	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (206,968)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,889,529	\$	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>(314,395)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>AUDIT ADJUSTMENTS</b>	<b>1,173,077</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>858,682</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,065,650)</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>(1,065,650)</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>(206,968)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,760,535	1
2	Discounts and Allowances for all Levels	(1,166,904)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,593,631	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	253,865	6
7	Oxygen	5,898	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 259,763	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	740	13
14	Non-Patient Meals	8,776	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	65,730	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,568	19
20	Radiology and X-Ray	743	20
21	Other Medical Services	43,743	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 123,300	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>MISCELLANEOUS REVENUE</u>	295	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 295	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,976,989	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	521,258	31
32	Health Care	1,102,446	32
33	General Administration	457,479	33
<b>B. Capital Expense</b>			
34	Ownership	845,400	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	62,254	35
36	Provider Participation Fee	53,802	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,042,639	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,065,650)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,065,650)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? EXTENDED If not, please attach a reconciliation.

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

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

Facility Name & ID Number FONDULAC WOODS HEALTH CARE CENTER

# 0043554

Report Period Beginning: 01/01/00

Ending: 12/31/00

12/31/00

**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	
2	Assistant Director of Nursing				2	
3	Registered Nurses	6,205	7,239	124,576	17.21	3
4	Licensed Practical Nurses	12,186	14,217	209,906	14.76	4
5	Nurse Aides & Orderlies	34,800	40,600	356,451	8.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,939	2,262	21,941	9.70	9
10	Activity Assistants	3,189	3,721	24,810	6.67	10
11	Social Service Workers	2,079	2,426	19,200	7.92	11
12	Dietician					12
13	Food Service Supervisor	2,044	2,385	21,492	9.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,518	13,438	89,364	6.65	15
16	Dishwashers					16
17	Maintenance Workers	2,136	2,492	27,281	10.95	17
18	Housekeepers	12,182	14,212	86,683	6.10	18
19	Laundry	1,427	1,665	13,989	8.40	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	4,648	5,423	39,800	7.34	22
23	Office Manager					23
24	Clerical					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)	94,353	110,079	\$ 1,035,493 *	\$ 9.41	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY \$ 5,517	1.3	35
36	Medical Director	MONTHLY 4,950	9.3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	MONTHLY 75,159	10a.3	40
41	Occupational Therapy Consultant	MONTHLY 11,871	10a.3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	MONTHLY 16,399	10a.3	43
44	Activity Consultant	MONTHLY 857	11.3	44
45	Social Service Consultant	MONTHLY 840	12.3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 115,593		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	823 \$ 28,791	10.3	50
51	Licensed Practical Nurses	1,132 28,307	10.3	51
52	Nurse Aides	3,650 63,508	10.3	52
53	TOTAL (lines 50 - 52)	5,605 \$ 120,606		53





Facility Name & ID Number **FONDULAC WOODS HEALTH CARE CENTER**# **0043554**Report Period Beginning: **01/01/00**Ending: **12/31/00****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 53,802  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 8,776
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? IMMATE  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NO - MINOR  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees