



Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a

# 0042044 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 02/07/00

	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	226	Skilled (SNF)	228	83,386	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	226	TOTALS	228	83,386	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF	69,651	3,766	4,154	77,571	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,651	3,766	4,154	77,571	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.03%

D. How many bed-hold days during this year were paid by Public Aid? 2,769 (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)  
N/A

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 10/24/96

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/24/96 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 28 and days of care provided 3,592

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

Facility Name & ID Number **WASHINGTON HEIGHTS CARE CENTER** # **0042044** 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>8</b>	<b>TOTAL General Services</b>	<b>682,013</b>	<b>420,483</b>	<b>565,349</b>	<b>1,667,845</b>	<b>(33,599)</b>	<b>1,634,246</b>	<b>22,404</b>	<b>1,656,650</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,500	5,500		5,500		5,500		9
10	Nursing and Medical Records	2,466,875	89,507	16,406	2,572,788		2,572,788	12,019	2,584,807		10
10a	Therapy	64,576	1,103	22,491	88,170		88,170	(7,608)	80,562		10a
11	Activities	132,025	8,454	5,827	146,306		146,306	(929)	145,377		11
12	Social Services	90,410		4,004	94,414		94,414	(1,048)	93,366		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							12,998	12,998		15
<b>16</b>	<b>TOTAL Health Care and Programs</b>	<b>2,753,886</b>	<b>99,064</b>	<b>54,228</b>	<b>2,907,178</b>		<b>2,907,178</b>	<b>15,432</b>	<b>2,922,610</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	63,032		283,602	346,634		346,634	44,520	391,154		17
18	Directors Fees										18
19	Professional Services			385,216	385,216		385,216	(308,717)	76,499		19
20	Dues, Fees, Subscriptions & Promotions			76,033	76,033		76,033	(40,381)	35,652		20
21	Clerical & General Office Expenses	123,678	26,690	220,323	370,691		370,691	20,093	390,784		21
22	Employee Benefits & Payroll Taxes			579,559	579,559	33,599	613,158	(30,991)	582,166		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,255	5,255		5,255	6,126	11,381		24
25	Other Admin. Staff Transportation			9,795	9,795		9,795	(9,159)	636		25
26	Insurance-Prop.Liab.Malpractice			216,354	216,354		216,354	1,407	217,761		26
27	Other (specify):*							32,791	32,791		27
<b>28</b>	<b>TOTAL General Administration</b>	<b>186,710</b>	<b>26,690</b>	<b>1,776,137</b>	<b>1,989,537</b>	<b>33,599</b>	<b>2,023,136</b>	<b>(284,311)</b>	<b>1,738,825</b>		<b>28</b>
<b>29</b>	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,622,609</b>	<b>546,237</b>	<b>2,395,714</b>	<b>6,564,560</b>		<b>6,564,560</b>	<b>(246,475)</b>	<b>6,318,085</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.

WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a

0042044

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V  
LINE #

22	EMPLOYEE BENEFITS	<u>33,599</u>
2	FOOD	<u>33,599</u>

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	<u>                    </u>
19	PROFESSIONAL FEES	<u>                    </u>

To reclass cost of appealing real estate taxes

## 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	
30	D. Ownership											
	Depreciation			43,216	43,216		43,216	580,687	623,903			30
31	Amortization of Pre-Op. & Org.			1,310	1,310		1,310	10,047	11,357			31
32	Interest			48,931	48,931		48,931	733,760	782,691			32
33	Real Estate Taxes			351,326	351,326		351,326	2,861	354,187			33
34	Rent-Facility & Grounds			1,266,222	1,266,222		1,266,222	(1,260,750)	5,472			34
35	Rent-Equipment & Vehicles			5,137	5,137		5,137	4,506	9,643			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,716,142	1,716,142		1,716,142	71,111	1,787,253			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,136	212,663	356,799		356,799	(3,903)	352,896			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			125,172	125,172		125,172		125,172			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		144,136	337,835	481,971		481,971	(3,903)	478,068			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,622,609	690,373	4,449,691	8,762,673		8,762,673	(179,267)	8,583,406			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	237,486	30		9
10	Interest and Other Investment Income	(208,268)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(132)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,000)	21		24
25	Fund Raising, Advertising and Promotional	(19,659)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,625)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(96)	20		28
29	Other-Attach Schedule	(19,821)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (104,365)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(74,902)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (74,902)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (179,267)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0042044

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

	Amount	Sch. V Line Reference
1		6 1
2		21 2
3		21 3
4		21 4
5		20 5
6		21 6
7		39 7
8		19 8
9		19 9
10		10
11		11
12		12
13		13
14		14
15		15
16		16
17		17
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73		73
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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		90
<b>Total</b>	(19,821)	

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a

# 0042044

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary			6,573	(8,316)		417						(1,326)	1
2	Food Purchase	(132)		(1,398)			1,887						357	2
3	Housekeeping			2,754									2,754	3
4	Laundry													4
5	Heat and Other Utilities			2,113									2,113	5
6	Maintenance			17,292	(1,535)		9						15,766	6
7	Other (specify):*			2,647			93						2,740	7
8	<b>TOTAL General Services</b>	<b>(132)</b>		<b>29,981</b>	<b>(9,851)</b>		<b>2,406</b>						<b>22,404</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			33,353	(69,345)	59,564	1		(11,554)				12,019	10
10a	Therapy			6,443	(14,051)								(7,608)	10a
11	Activities			2,794	(3,723)								(929)	11
12	Social Services			2,463	(3,511)								(1,048)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			5,748		7,250							12,998	15
16	<b>TOTAL Health Care and Programs</b>			<b>50,801</b>	<b>(90,630)</b>	<b>66,814</b>	<b>1</b>		<b>(11,554)</b>				<b>15,432</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			44,471	(79,427)	79,427	49						44,520	17
18	Directors Fees													18
19	Professional Services	(6,600)	6,600	11,708	(320,440)		15						(308,717)	19
20	Fees, Subscriptions & Promotions	(21,314)		1,719	(20,790)		4						(40,381)	20
21	Clerical & General Office Expenses	(105,506)	(800)	158,384	(32,034)		49						20,093	21
22	Employee Benefits & Payroll Taxes				(30,991)								(30,991)	22
23	Inservice Training & Education													23
24	Travel and Seminar			6,123			3						6,126	24
25	Other Admin. Staff Transportation			272	(9,516)		85						(9,159)	25
26	Insurance-Prop.Liab.Malpractice			1,407									1,407	26
27	Other (specify):*			23,399		9,392							32,791	27
28	<b>TOTAL General Administration</b>	<b>(133,420)</b>	<b>5,800</b>	<b>247,483</b>	<b>(493,198)</b>	<b>88,819</b>	<b>205</b>						<b>(284,311)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(133,552)</b>	<b>5,800</b>	<b>328,265</b>	<b>(593,679)</b>	<b>155,633</b>	<b>2,612</b>		<b>(11,554)</b>				<b>(246,475)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a # 0042044 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 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	237,486	328,424	14,777									580,687	30
31	Amortization of Pre-Op. & Org.		10,047										10,047	31
32	Interest	(208,268)	926,026	15,999			3						733,760	32
33	Real Estate Taxes			2,861									2,861	33
34	Rent-Facility & Grounds		(1,266,222)	5,472									(1,260,750)	34
35	Rent-Equipment & Vehicles			4,502			4						4,506	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	29,218	(1,725)	43,611			7						71,111	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(31)					(3,872)						(3,903)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>	(31)					(3,872)						(3,903)	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(104,365)	4,075	371,876	(593,679)	155,633	(1,253)		(11,554)				(179,267)	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
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				WASHINGTON HEIGHTS PROPERTY, LLC		BLDG. PARTNER

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	34 RENT	\$ 1,266,222	WASHINGTON HEIGHTS PROPERTY, L.L.C.	100.00%	\$	\$ (1,266,222)	1
2	V	32 INTEREST	48,931	WASHINGTON HEIGHTS PROPERTY, L.L.C.	100.00%	974,957	926,026	2
3	V	31 AMORTIZATION		WASHINGTON HEIGHTS PROPERTY, L.L.C.	100.00%	10,047	10,047	3
4	V	19 ARCHITECT FEES		WASHINGTON HEIGHTS PROPERTY, L.L.C.	100.00%	2,100	2,100	4
5	V	30 DEPRECIATION		WASHINGTON HEIGHTS PROPERTY, L.L.C.	100.00%	328,424	328,424	5
6	V	21 OFFICE EXPENSE		WASHINGTON HEIGHTS PROPERTY, L.L.C.	100.00%	200	200	6
7	V	19 APPRAISAL FEE		WASHINGTON HEIGHTS PROPERTY, L.L.C.	100.00%	4,500	4,500	7
8	V	21 MISC. INCOME	1,000	WASHINGTON HEIGHTS PROPERTY, L.L.C.			(1,000)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,316,153			\$ 1,320,228	\$ * 4,075	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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization						
15	V	1	DIETARY	\$	CARE CENTERS, INC.	100.00%	\$ 6,573	\$	6,573	15
16	V	2	FOOD				(1,398)		(1,398)	16
17	V	3	HOUSEKEEPING				2,754		2,754	17
18	V	5	UTILITIES				2,113		2,113	18
19	V	6	REPAIRS AND MAINT.				17,292		17,292	19
20	V	7	EMP. BEN. - GEN. SERV.				2,647		2,647	20
21	V	10	NURSING				33,353		33,353	21
22	V	10A	THERAPY				6,443		6,443	22
23	V	11	ACTIVITIES				2,794		2,794	23
24	V	12	SOCIAL SERVICES				2,463		2,463	24
25	V	15	EMP. BEN. - HEALTHCARE				5,748		5,748	25
26	V	17	ADMINISTRATIVE				44,471		44,471	26
27	V	19	PROFESSIONAL FEES				11,708		11,708	27
28	V	20	DUES, SUBSCRIPTIONS				1,719		1,719	28
29	V	21	CLERICAL AND GENERAL				158,384		158,384	29
30	V	24	SEMINARS				6,123		6,123	30
31	V	25	AUTO EXPENSE				272		272	31
32	V	26	INSURANCE				1,407		1,407	32
33	V	27	EMP. BEN. - GEN. ADMIN.				23,399		23,399	33
34	V	30	DEPRECIATION				14,777		14,777	34
35	V	32	INTEREST	0			15,999		15,999	35
36	V	33	REAL ESTATE TAXES				2,861		2,861	36
37	V	34	BUILDING RENT - UNRELATED				5,472		5,472	37
38	V	35	EQUIPMENT RENTAL				4,502		4,502	38
39	Total			\$			\$ 371,876	\$ *	371,876	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 DIETARY CONS	\$ 8,316	CARE CENTERS, INC.	100.00%	\$ 0	\$	(8,316) 15
16	V	19 ACCOUNTING	15,000			0		(15,000) 16
17	V	19 ANCIL ADMIN FEE	27,340			0		(27,340) 17
18	V	19 BOOKEEPING	46,478			0		(46,478) 18
19	V	19 DATA PROCESSING	8,202			0		(8,202) 19
20	V	19 LEGAL	20,790			0		(20,790) 20
21	V	19 MANAGEMENT FEE	191,380			0		(191,380) 21
22	V	19 PROFESSIONAL FEES	11,250			0		(11,250) 22
23	V	20 ADVERTISING	20,790			0		(20,790) 23
24	V	25 REBILL BUS	9,516			0		(9,516) 24
25	V	0				0		0 25
26	V	22 HOME OFFICE PAYROLL TAX	30,991			0		(30,991) 26
27	V	1 REBILL. PAYROLL DIETARY	0			0		0 27
28	V	3 REBILL. PAYROLL HSKPNG	0			0		0 28
29	V	6 REBILL. PAYROLL MAINT.	1,535			0		(1,535) 29
30	V	10 REBILL. PAYROLL NURSING	69,345			0		(69,345) 30
31	V	10A REBILL. PAYROLL THPY CONS.	14,051			0		(14,051) 31
32	V	11 REBILL. PAYROLL ACTIVITIES	3,723			0		(3,723) 32
33	V	12 REBILL. PAYROLL SOC. SERV.	3,511			0		(3,511) 33
34	V	17 REBILL. PAYROLL ADMIN.	79,427			0		(79,427) 34
35	V	21 REBILL. PAYROLL CLERICAL	32,034			0		(32,034) 35
36	V							0 36
37	V							0 37
38	V							0 38
39	Total		\$ 593,679			\$ 0	\$ *	(593,679) 39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization						
15	V	10	NURSING	\$	CARE CENTERS, INC.	100.00%	\$ 59,564	\$	59,564	15
16	V	15	EMP. BEN HEALTHCARE				7,250		7,250	16
17	V	17	ADMINISTRATIVE				79,427		79,427	17
18	V	27	EMP. BEN GEN. ADMIN.				9,392		9,392	18
19	V	0					0		0	19
20	V	0					0		0	20
21	V	0					0		0	21
22	V	0					0		0	22
23	V	0					0		0	23
24	V	0					0		0	24
25	V	0					0		0	25
26	V	0					0		0	26
27	V	0					0		0	27
28	V	0					0		0	28
29	V	0					0		0	29
30	V	0					0		0	30
31	V	0					0		0	31
32	V	0					0		0	32
33	V	0					0		0	33
34	V	0								34
35	V	0		0						35
36	V									36
37	V									37
38	V									38
39	Total			\$			\$ 155,633	\$ *	155,633	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)			
		Item	Amount	Name of Related Organization							
15	V	1	DIETARY	\$		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	\$ 974	\$ 974	15	
16	V	2	FOOD					1,887	1,887	16	
17	V	6	MAINTENANCE					9	9	17	
18	V	7	EMP. BEN. - GEN. SERV.					93	93	18	
19	V	10	NURSING					1	1	19	
20	V	17	ADMINISTRATIVE					49	49	20	
21	V	19	PROFESSIONAL FEES					15	15	21	
22	V	20	DUES, FEES, SUB.					4	4	22	
23	V	21	CLERICAL & GENERAL					49	49	23	
24	V	24	SEMINARS					3	3	24	
25	V	25	TRAVEL					85	85	25	
26	V	32	INTEREST					3	3	26	
27	V	35	RENT - EQUIPMENT & VEHICLES					4	4	27	
28	V	39	ANCILLARY ENTERAL SUPPLIES					64	64	28	
29	V	1	DIETARY SUPP		557			0	(557)	29	
30	V	39	ANCILLARY SUPP		3,936			0	(3,936)	30	
31	V	0						0		31	
32	V	0						0		32	
33	V	0						0		33	
34	V	0								34	
35	V	0			0					35	
36	V									36	
37	V									37	
38	V									38	
39	Total			\$	4,493			\$ 3,240	\$ *	(1,253)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 CLERICAL AND GENERAL	\$	CARE CENTERS, INC.	100.00%	\$ 0	\$	15
16	V	27 EMP. BEN. - GEN. SERV. EMP. BEN.				0		16
17	V	0				0		17
18	V	0				0		18
19	V	0				0		19
20	V	0				0		20
21	V	0				0		21
22	V	0				0		22
23	V	0				0		23
24	V	0				0		24
25	V	0				0		25
26	V	0				0		26
27	V	0				0		27
28	V	0				0		28
29	V	0				0		29
30	V	0				0		30
31	V	0				0		31
32	V	0				0		32
33	V	0				0		33
34	V	0						34
35	V	0	0					35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

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

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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)			
		Item	Amount	Name of Related Organization							
15	V	10	MEDICALSUPPLIES	\$		XCEL MEDICAL SUPPLY LLC	100.00%	\$ 60,909	\$ 60,909	15	
16	V									16	
17	V									17	
18	V									18	
19	V	10	MEDICALSUPPLIES		72,463					(72,463)	19
20	V										20
21	V										21
22	V										22
23	V										23
24	V										24
25	V										25
26	V										26
27	V										27
28	V										28
29	V										29
30	V										30
31	V										31
32	V										32
33	V										33
34	V										34
35	V										35
36	V										36
37	V										37
38	V										38
39	Total			\$	72,463			\$ 60,909	\$ *	(11,554)	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V	22	EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 49,815	\$ 49,815	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	49,815				(49,815)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 49,815			\$ 49,815	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number      WASHINGTON HEIGHTS CARE CENTE      #      0042044      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	Eric Rothner	Relative	Administrative	0%	See Attached	2.51	3.49%	Mgt. Fee	\$ 180,000	17-3	1
2	Norm Goldberg	Owner	Administrative	1.77%	See Attached	2.57	5.14%	Alloc Salary	4,661	17-7	2
3	David Aronin	Owner	Administrative	0.89%	See Attached	2.57	5.14%	Alloc Salary	4,497	17-7	3
4	Gordon Brown	Owner	Administrative	0.89%	See Attached	2.57	5.14%	Alloc Salary	3,263	17-7	4
5	Jim Goodsite	CFO	Administrative	1.77%	See Attached	2.57	5.14%	Alloc Salary	6,677	17-7	5
6	Mark Steinberg	Relative	Administrative	0%	See Attached	2.57	5.14%	Alloc Salary	2,276	17-7	6
7	Alan Abrams	Owner	Administrative	8.85%	See Attached	1	2.86%	Mgt. Fee	12,000	17-3	7
8	Ron Abrams	Owner	Administrative	8.85%	See Attached	1	2.86%	Mgt. Fee	12,000	17-3	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 225,374		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 WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b # 0042044 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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number (\_\_\_\_\_) \_\_\_\_\_  
 Fax Number (\_\_\_\_\_) \_\_\_\_\_

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

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b # 0042044 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

Name of Related Organization CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number ( 708)449-9090  
 Fax Number ( 708)449-7070

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	1,512,231	32	\$ 128,135	\$ 128,055	77,571	\$ 6,573	1
2	2	FOOD	1,512,231	32	(27,254)		77,571	(1,398)	2
3	3	HOUSEKEEPING	1,512,231	32	53,695	52,345	77,571	2,754	3
4	5	UTILITIES	1,512,231	32	41,192		77,571	2,113	4
5	6	REPAIRS AND MAINT.	1,512,231	32	337,107	220,731	77,571	17,292	5
6	7	EMP. BEN. - GEN. SERV.	1,512,231	32	51,593		77,571	2,647	6
7	10	NURSING	1,512,231	32	650,209	657,173	77,571	33,353	7
8	10A	THERAPY	1,512,231	32	125,600	125,524	77,571	6,443	8
9	11	ACTIVITIES	1,512,231	32	54,474	54,163	77,571	2,794	9
10	12	SOCIAL SERVICES	1,512,231	32	48,011	48,011	77,571	2,463	10
11	15	EMP. BEN. - HEALTHCARE	1,512,231	32	112,058		77,571	5,748	11
12	17	ADMINISTRATIVE	1,512,231	32	866,963	862,068	77,571	44,471	12
13	19	PROFESSIONAL FEES	1,512,231	32	228,254		77,571	11,708	13
14	20	DUES, SUBSCRIPTIONS	1,512,231	32	33,513		77,571	1,719	14
15	21	CLERICAL AND GENERAL	1,512,231	32	3,087,659	2,709,599	77,571	158,384	15
16	24	SEMINARS	1,512,231	32	119,372		77,571	6,123	16
17	25	AUTO EXPENSE	1,512,231	32	5,310		77,571	272	17
18	26	INSURANCE	1,512,231	32	27,429		77,571	1,407	18
19	27	EMP. BEN. - GEN. ADMIN.	1,512,231	32	456,163		77,571	23,399	19
20	30	DEPRECIATION	1,512,231	32	288,068		77,571	14,777	20
21	32	INTEREST	1,512,231	32	311,903		77,571	15,999	21
22	33	REAL ESTATE TAXES	1,512,231	32	55,780		77,571	2,861	22
23	34	BUILDING RENT - UNRELATE	1,512,231	32	106,673		77,571	5,472	23
24	35	EQUIPMENT RENTAL	1,512,231	32	87,772		77,571	4,502	24
25	TOTALS				\$ 7,249,679	\$ 4,857,669		\$ 371,876	25

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b # 0042044 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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b # 0042044 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 CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number ( 708)449-9090  
 Fax Number ( 708)449-7070

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION	9	307,262	298,696		59,564	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION	9	39,980			7,250	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION	24	1,436,904	1,436,850		79,427	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION	24	191,316			9,392	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				\$ 1,975,462	\$ 1,735,546		\$ 155,633	25

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b # 0042044 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 CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number ( 708)449-9090  
 Fax Number ( 708)449-7070

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC. 2,287,765	28	496,134	378,284	4,493	974	1
2	2	FOOD	HEALTH SYSTEMS INC. 2,287,765	28	960,501		4,493	1,887	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC. 2,287,765	28	4,392		4,493	9	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC. 2,287,765	28	47,282		4,493	93	4
5	10	NURSING	HEALTH SYSTEMS INC. 2,287,765	28	700		4,493	1	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC. 2,287,765	28	25,000		4,493	49	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC. 2,287,765	28	7,428		4,493	15	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC. 2,287,765	28	1,836		4,493	4	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC. 2,287,765	28	24,796		4,493	49	9
10	24	SEMINARS	HEALTH SYSTEMS INC. 2,287,765	28	1,526		4,493	3	10
11	25	TRAVEL	HEALTH SYSTEMS INC. 2,287,765	28	43,326		4,493	85	11
12	32	INTEREST	HEALTH SYSTEMS INC. 2,287,765	28	1,489		4,493	3	12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC. 2,287,765	28	2,182		4,493	4	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC. 2,287,765	28	32,397		4,493	64	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,648,989	\$ 378,284		\$ 3,240	25

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b # 0042044 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 CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number ( 708)449-9090  
 Fax Number ( 708)449-7070

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075		1
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401			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					\$ 35,476	\$ 31,075		\$ 25

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b # 0042044 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 XCEL MEDICAL SUPPLY LLC  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number ( 708)449-2330  
 Fax Number ( 708)449-3236

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 60,909	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				\$	\$		\$ 60,909	25

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b # 0042044 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 CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 674-1180  
 Fax Number ( 847) 673-7741

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION		\$	\$		\$ 49,815	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				\$	\$		\$ 49,815	25

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b # 0042044 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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b # 0042044 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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	<b>BUILDING PARTNERSHIP</b>	<b>X</b>		<b>MORTGAGE</b>			\$	\$			\$	<b>48,931</b>						
2																		
3																		
4																		
5																		
<b>Working Capital</b>																		
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$			\$	<b>48,931</b>						
<b>B. Non-Facility Related*</b>																		
10	<b>Supplemental Schedule</b>							<b>12,658,086</b>				<b>733,757</b>						
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	<b>12,658,086</b>			\$	<b>733,757</b>						
15	<b>TOTALS (line 9+line14)</b>						\$	<b>12,658,086</b>			\$	<b>782,688</b>						

\* 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 WASHINGTON HEIGHTS CARE CENTER, I # 0042044 Report Period Beginning: 01/01/00 Ending: 12/31/00

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

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

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC-BLDG PARTNERSHIP	X		MORTGAGE			\$	\$ 12,658,086			\$ 974,957	1
2	INTEREST EXPENSE										(208,268)	2
3	ALLOC -CARE CENTERS	X									15,999	3
4	INTEREST INCOME-BLD PS	X									(48,931)	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							\$	\$ 12,658,086			\$ 733,757	21

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>374,070</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>356,713</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(17,357)</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>371,545</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes 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 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<b>354,188</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	<b>2,146</b>	8
	1996	<b>88,579</b>	9
	1997	<b>349,971</b>	10
	1998	<b>356,222</b>	11
	1999	<b>353,852</b>	12
<b>FOR OFF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION\$	16
<b>2000 ACCRUAL =1999 R/E Tax Bill 353852 * 1.05 = 371545</b>			
<b>Allocation From Care Centers Inc \$2,861(Included in line 2)</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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,255 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 3

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).

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: 2,772 2. Number of Years Over Which it is Being Amortized: Org. Costs-5 Yrs; Fin Fees-2yrs  
 3. Current Period Amortization: 10,803 4. Dates Incurred: 1996

Nature of Costs: Organization Costs, Financing Fees  
 (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>85,244</u>	<u>1994</u>	<u>\$ 251,898</u>	1
2	<u>ALLOC FROM CCI</u>			<u>3,283</u>	2
3	<b>TOTALS</b>	<b>85,244</b>		<b>\$ 255,181</b>	<b>3</b>

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a# 0042044

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1996	1996	\$ 10,226,094	\$ 262,207	35	\$ 511,305	\$ 249,098	\$ 2,159,108	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		<b>SIDEWALK</b>		1996	1,892	49	20	95	46	396	9
10		<b>TELEPHONE SYSTEM</b>		1996	18,573	2,043	20	929	(1,114)	4,180	10
11		<b>TELEPHONE EQUIP</b>		1996	1,057	114	20	53	(61)	221	11
12		<b>HVAC RENOVATION</b>		1997	686	18	20	34	16	119	12
13		<b>PLUMB RENOV</b>		1997	2,935	75	20	147	72	466	13
14		<b>ELEC RENOV</b>		1997	5,976	153	20	299	146	1,022	14
15		<b>PLUMBING RENOV</b>		1997	2,601	67	20	130	63	509	15
16		<b>CABLING</b>		1997	6,941	178	20	347	169	1,182	16
17		<b>LOCKS &amp; KEYS</b>		1997	654	17	20	33	16	129	17
18		<b>FENCE</b>		1997	19,040	488	20	952	464	3,411	18
19		<b>Security System</b>		1997	18,793	2,136	20	940	(1,196)	3,367	19
20		<b>LANDSCAPING</b>		1997	2,890	74	20	145	71	508	20
21		<b>STAINED GLASS</b>		1997	1,460	37	20	73	36	292	21
22		<b>FIRE ALARM COVERS</b>		1997	2,149	55	20	107	52	375	22
23		<b>FIRE ALARM COVERS</b>		1997	1,182	30	20	59	29	202	23
24											24
25		<b>PAGE 12-I REP TOTALS</b>			73,137	1,946		2,424	478	9,740	25
26											26
27											27
28											28
29											29
30											30
31		<b>PAGE 12E TOTALS</b>			9,056	502		263	(239)	263	31
32		<b>PAGE 12D TOTALS</b>			95,080	3,303		3,564	261	3,591	32
33		<b>PAGE 12C TOTALS</b>			41,079	4,039		2,054	(1,985)	2,864	33
34		<b>PAGE 12B TOTALS</b>			65,391	1,886		3,270	1,384	7,584	34
35		<b>PAGE 12A TOTALS</b>			131,617	3,374		6,583	3,209	21,810	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 10,728,283	\$ 282,791		\$ 533,806	\$ 251,015	\$ 2,221,339	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.

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a# 0042044

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		ELEC RENOV		1997	1,292	33	20	65	32	222	9
10		CABLING		1997	6,941	178	20	347	169	1,243	10
11		FLOORING		1997	1,910	49	20	96	47	320	11
12		PANELING		1997	697	18	20	35	17	125	12
13		BOILER RENOV		1997	590	15	20	30	15	100	13
14		IMPROVE/UPGRADE		1997	895	23	20	45	22	161	14
15		LANDSCAPING		1997	9,846	252	20	492	240	1,599	15
16		FLOORING		1997	20,000	513	20	1,000	487	3,250	16
17		PANELING		1997	744	19	20	37	18	114	17
18		HVAC RENOV		1997	599	15	20	30	15	95	18
19		FIRE ALARM		1997	4,457	114	20	223	109	762	19
20		HVAC RENOV		1997	513	13	20	26	13	82	20
21		ELEV RENOV		1997	4,998	128	20	250	122	813	21
22		CARPETING		1997	37,000	949	20	1,850	901	6,871	22
23		FLOORING		1997	20,000	513	20	1,000	487	3,083	23
24		PLUMBING RENOV		1997	1,485	38	20	74	36	228	24
25		PLUMB RENOV		1997	1,342	34	20	67	33	207	25
26		PAINT		1997	765	20	20	38	18	120	26
27		ELECTRICAL		1998	605	16	20	30	14	78	27
28		ELECTRICAL		1998	782	20	20	39	19	117	28
29		ENTRANCE DOOR		1998	2,040	52	20	102	50	298	29
30		PLUMBING RENOV.		1998	2,095	54	20	105	51	298	30
31		PAINT		1998	532	14	20	27	13	79	31
32		FLOOR REPAIRS		1998	1,400	36	20	70	34	193	32
33		ELEV RENOV		1998	1,594	41	20	80	39	200	33
34		SECURITY SYSTEM		1998	4,345	111	20	217	106	597	34
35		SECURITY SYSTEM		1998	4,150	106	20	208	102	555	35
36		TOTAL (lines 4 thru 35)			\$ 131,617	\$ 3,374		\$ 6,583	\$ 3,209	\$ 21,810	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.

Facility Name &amp; ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a

# 0042044

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		CARPETING	1998		12,575	322	20	629	307	1,782	9
10		SECURITY	1998		2,800	72	20	140	68	362	10
11		POWER SUPP. LINE	1998		1,046	27	20	52	25	143	11
12		PANELING	1998		987	25	20	49	24	123	12
13		EXHAUST FAN	1998		652	17	20	33	16	83	13
14		ELECTRICAL	1998		581	15	20	29	14	77	14
15		SYSTEM TREATMENT	1998		4,946	127	20	247	120	576	15
16		TILING	1998		538	14	20	27	13	68	16
17		LANDSCAPING	1998		6,654	171	20	333	162	805	17
18		REPLACE DUCT	1998		772	20	20	39	19	94	18
19		AUTO DRAIN	1998		681	17	20	34	17	79	19
20		DOORS	1998		1,261	32	20	63	31	147	20
21		AVAIRY	1998		4,409	113	20	220	107	477	21
22		FIRE ALARM	1998		961	25	20	48	23	112	22
23		PLASTER	1998		650	17	20	33	16	74	23
24		LANDSCAPING	1998		3,705	95	20	185	90	416	24
25		MONITOR SYSTEM	1998		6,435	165	20	322	157	725	25
26		ART	1998		671	17	20	34	17	74	26
27		CERTIFICATE OF NEED	1998		1,881		20	94	94	188	27
28		SLAB	1998		1,600	41	20	80	39	200	28
29		BOILER	1998		545	14	20	27	13	65	29
30		PLUMBING RENOV	1999		2,727	70	20	136	66	238	30
31		LANDSCAPING	1999		2,326	60	20	116	56	232	31
32		LANDSCAPING	1999		2,610	67	20	131	64	207	32
33		RODDING	1999		600	15	20	30	15	43	33
34		THERMOSTAT	1999		1,028	283	20	51	(232)	55	34
35		OVERHANG LOGO	1999		1,750	45	20	88	43	139	35
36		TOTAL (lines 4 thru 35)			\$ 65,391	\$ 1,886		\$ 3,270	\$ 1,384	\$ 7,584	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.

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a# 0042044

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		DUCT HEATER		1999	1,884	48	20	94	46	125	9
10		WINDOW RENOV		1999	845	22	20	42	20	67	10
11		RODDING		1999	1,786	46	20	89	43	134	11
12		DOOR RENOV		1999	2,496	64	20	125	61	198	12
13		LANDSCAPING		1999	870	22	20	44	22	66	13
14		RODDING		1999	1,000	26	20	50	24	75	14
15		RODDING		1999	1,223	31	20	61	30	86	15
16		INSULATION		1999	780	20	20	39	19	55	16
17		PLUMBING		1999	840	22	20	42	20	60	17
18		LANDSCAPING		1999	870	22	20	44	22	59	18
19		INSULATION		1999	780	20	20	39	19	52	19
20		DOOR		1999	1,064	27	20	53	26	106	20
21		RODDING		1999	549	14	20	27	13	36	21
22		FLOOD CLEANING		1999	2,927	75	20	146	71	170	22
23		WANDERER SYSTEM		1999	7,956	3,023	20	398	(2,625)	498	23
24		PLUMBIN		1999	1,800	46	20	90	44	135	24
25		AQUARIUM RENOV		1999	1,801	46	20	90	44	105	25
26		STEEL DOOR		1999	2,496	64	20	125	61	167	26
27		SEWER RENOV		1999	745	19	20	37	18	46	27
28		ELECTRICAL RENOV		1999	950	24	20	48	24	64	28
29		REDDING		1999	625	16	20	31	15	41	29
30		WELL TANK		1999	669	200	20	33	(167)	58	30
31		SIGN OVERHANG		1999	1,750	45	20	88	43	147	31
32		SEWER RENOV		1999	844	22	20	42	20	53	32
33		LANDSCAPING		1999	2,079	53	20	104	51	165	33
34		LANDSCAPING		1999	870	22	20	44	22	48	34
35		RODS		1999	580		20	29	29	48	35
36		TOTAL (lines 4 thru 35)			\$ 41,079	\$ 4,039		\$ 2,054	\$ (1,985)	\$ 2,864	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.

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a# 0042044

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		COMPRESSOR RENOV		1999	621	211	20	31	(180)	41	9
10		3 POLE CONTRACTOR		1999	680	231	20	34	(197)	45	10
11		MOTOR RENOV		1999	688	18	20	34	16	40	11
12		GENERATOR RENOV		2000	551	110	20	55	(55)	55	12
13		SEWER RENOV		2000	1,330	33	20	67	34	67	13
14		SEWER RENOV		2000	503	11	20	23	12	23	14
15		SEWER INSTALL		2000	8,200	184	20	376	192	376	15
16		PLUMBING RENOV		2000	1,370	31	20	63	32	63	16
17		BEDSPREADS		2000	1,717	39	20	79	40	79	17
18		CLEANING		2000	3,471	78	20	160	82	160	18
19		DOORS		2000	2,500	357	20	229	(128)	229	19
20		SIGNS		2000	1,683	20	20	42	22	42	20
21		PIPE INSTALLATION		2000	11,000	200	20	413	213	413	21
22		RODDING		2000	2,030	37	20	77	40	77	22
23		FENCE REPAIR		2000	850	14	20	29	15	29	23
24		ELECTRICAL RENOV		2000	885	177	20	59	(118)	59	24
25		FIRE ALARM PANEL		2000	4,064	813	20	237	(576)	237	25
26		BEDSPREADS		2000	5,421	110	20	226	116	226	26
27		BASEMENT FLOOR		2000	34,650	481	20	1,011	530	1,011	27
28		DOORS		2000	1,614	15	20	34	19	34	28
29		HOT WATER HEATERS		2000	1,847	41	20	84	43	84	29
30		OFFICE		2000	3,260	25	20	54	29	54	30
31		LANDSCAPING		2000	1,200	14	20	30	16	30	31
32		LANDSCAPING		2000	2,085	24	20	52	28	52	32
33		HVAC REPAIR		2000	595	6	20	13	7	13	33
34		RODDING		2000	1,280	12	20	27	15	27	34
35		ELECTRIC WIRING		2000	985	11	20	25	14	25	35
36		TOTAL (lines 4 thru 35)			\$ 95,080	\$ 3,303		\$ 3,564	\$ 261	\$ 3,591	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)**

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		BACKFLOW CERTIFICATI	2000		840	8	20	18	10	18	9
10		INSPECT UNDERGROUND	2000		1,270	10	20	21	11	21	10
11		HVAC REPAIR	2000		698	7	20	15	8	15	11
12		HVAC REPAIR	2000		(329)	(2)	20	(5)	(3)	(5)	12
13		DOOR FRAMES	2000		2,000	15	20	33	18	33	13
14		WATER HEATER REPAIR	2000		2,144	429	20	107	(322)	107	14
15		HVAC REPAIR	2000		638	5	20	11	6	11	15
16		PLUMBING RENOV	2000		875	21	20	44	23	44	16
17		REPAIR & CLEAN DRAPE	2000		920	9	20	19	10	19	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		TOTAL (lines 4 thru 35)			\$ 9,056	\$ 502		\$ 263	\$ (239)	\$ 263	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)**

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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)**

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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)**

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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)**

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	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)**

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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)**

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	CCI ALLOC		1996		\$ 58,099	\$ 1,490	35	\$ 1,660	\$ 170	\$ 6,778	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	CARE CENTERS ALLOCATION		2000		70	1	20	3	2	3	9
10	CARE CENTERS ALLOCATION		1999		1,040	27	20	52	25	98	10
11	CARE CENTERS ALLOCATION		1998		429	11	20	21	10	57	11
12	CARE CENTERS ALLOCATION		1997		6,094	139	20	336	197	1,629	12
13	CARE CENTERS ALLOCATION		1997		707	164	20	30	(134)	69	13
14	CARE CENTERS ALLOCATION		1996		6,698	88	20	322	234	1,106	14
15	CARE CENTERS ALLOCATION		1994			20	20		(20)		15
16	CARE CENTERS ALLOCATION		1993			6	20		(6)		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	<b>TOTAL (lines 4 thru 35)</b>				\$ 73,137	\$ 1,946		\$ 2,424	\$ 478	\$ 9,740	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)**

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	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	\$ 839,727	\$ 92,419	\$ 84,377	\$ (8,042)		\$ 360,226	37
38	Current Year Purchases	25,629	5,054	1,289	(3,765)		1,289	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 865,356	\$ 97,473	\$ 85,666	\$ (11,807)		\$ 361,515	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	CCI ALLOCATION			\$ 27,597	\$ 5,979	\$ 4,257	\$ (1,722)	5	\$ 9,554	42
43										43
44										44
45										45
46	TOTALS			\$ 27,597	\$ 5,979	\$ 4,257	\$ (1,722)		\$ 9,554	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)	\$ 11,876,417	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 386,243	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 623,729	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 237,486	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,592,408	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	TOTALS	\$	\$	\$	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.

WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a  
0042044  
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE  
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
<b>LINE 28: PRIOR YEARS</b>					
CARE CENTERS	49,272	6,375	5,327	(1,048)	22,842
WASHINGTON HEIGHTS	122,136	19,827	12,218	(7,609)	37,682
BUILDING PARTNERSHIP	668,319	66,217	66,832	615	299,702
<b>TOTALS</b>	<b>839,727</b>	<b>92,419</b>	<b>84,377</b>	<b>(8,042)</b>	<b>360,226</b>

<b>LINE 29: CURRENT YEAR</b>					
CARE CENTERS	2,776	477	65	(412)	65
WASHINGTON HEIGHTS	22,853	4,577	1,224	(3,353)	1,224
BUILDING PARTNERSHIP					
<b>TOTALS</b>	<b>25,629</b>	<b>5,054</b>	<b>1,289</b>	<b>(3,765)</b>	<b>1,289</b>

<b>LINE 30: FULLY DEPRECIATED</b>					
CARE CENTERS					
WASHINGTON HEIGHTS					
BUILDING PARTNERSHIP					
<b>TOTALS</b>					

**TOTALS (Should Tie to Totals on Page 13)**

CARE CENTERS	52,048	6,852	5,392	(1,460)	22,907
WASHINGTON HEIGHTS	144,989	24,404	13,442	(10,962)	38,906
BUILDING PARTNERSHIP	668,319	66,217	66,832	615	299,702
<b>TOTALS</b>	<b>865,356</b>	<b>97,473</b>	<b>85,666</b>	<b>(11,807)</b>	<b>361,515</b>

**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:		228		\$			3
4	Additions							4
5	CCI ALLOC				5,472			5
6								6
7	TOTAL		228		\$ 5,472			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2001                      \$ \_\_\_\_\_

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

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

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: \$ 9,644 Description: SEE ATTACHED SCHEDULE

(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

\* 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

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

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 88,361	\$		\$ 88,361	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			33,169			33,169	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			91,132			91,132	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				70,386		70,386	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>**SEE SUPPLEMENTAL SCHEDULE**</b>	39-2					73,751		73,751	13
14	<b>TOTAL</b>			\$		\$ 212,662	\$ 144,137		\$ 356,799	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.

**SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES**

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	31,141
2 AIR FLUIDIZED BED	30,639
3 RESPIRATORY SUPPLIES	1,696
4 ENTERALS	5,884
5 LAB EXP	2,292
6 X-RAY	2,099
7	
8	
9	
10	
	<u>73,751</u>

<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 P	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u>          </u>
	<u>          </u>

Facility Name & ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a # 0042044 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	\$ 6,083	\$ 15,870 1
2	Cash-Patient Deposits	42,460	42,460 2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,876,495	1,876,495 3
4	Supply Inventory (priced at )		
5	Short-Term Investments		
6	Prepaid Insurance	324,027	324,027 6
7	Other Prepaid Expenses	38,856	38,856 7
8	Accounts Receivable (owners or related parties)	(627,506)	(632,618) 8
9	Other(specify): <u>See supplemental schedule</u>	2,124,586	2,124,586 9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,785,001	\$ 3,789,676 10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		
12	Long-Term Investments		
13	Land		251,898 13
14	Buildings, at Historical Cost		10,226,094 14
15	Leasehold Improvements, at Historical Cos	367,068	367,068 15
16	Equipment, at Historical Cost	205,089	873,409 16
17	Accumulated Depreciation (book methods)	(155,926)	(1,755,011) 17
18	Deferred Charges		
19	Organization & Pre-Operating Costs	616	3,388 19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(504)	(2,720) 20
21	Restricted Funds		
22	Other Long-Term Assets (specify):	3,309	3,309 22
23	Other(specify): <u>See supplemental schedule</u>		76,738 23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 419,652	\$ 10,044,173 24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,204,653	\$ 13,833,849 25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 919,070	\$ 291,564 26
27	Officer's Accounts Payable		(15,170) 27
28	Accounts Payable-Patient Deposits	41,157	41,157 28
29	Short-Term Notes Payable		
30	Accrued Salaries Payable	191,188	191,188 30
31	Accrued Taxes Payable (excluding real estate taxes)	27,093	27,093 31
32	Accrued Real Estate Taxes(Sch.IX-B)	371,545	371,545 32
33	Accrued Interest Payable		82,016 33
34	Deferred Compensation	240	240 34
35	Federal and State Income Taxes	26,072	26,072 35
<b>Other Current Liabilities(specify):</b>			
36	<u>See supplemental schedule</u>	2,422	2,422 36
37			
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,578,787	\$ 1,018,127 38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		12,658,086 39
40	Mortgage Payable		
41	Bonds Payable		
42	Deferred Compensation		
<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See supplemental schedule</u>		
44			
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 12,658,086 45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,578,787	\$ 13,676,213 46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,625,866	\$ #REF! 47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,204,653	\$ #REF! 48

\*(See instructions.)

OTHER CURRENT ASSETS:	<u>Amount</u>	<u>Amount</u>	OTHER CURRENT LIABILITIES:	<u>Amount</u>	<u>Amount</u>
Real Estate Tax Escrow	129,161	129,161			
Short - Term Notes Receivable	1,995,425	1,995,425	Employee Loans	2,422	2,422
	<u>2,124,586</u>	<u>2,124,586</u>		<u>2,422</u>	<u>2,422</u>
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
AMORTIZATION FEES		(18,195)			
FINANCING FEES		94,933			
		<u>76,738</u>			

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,751,897	1
2	Restatements (describe):		2
3	<u>Schedule attached</u>	(2,484)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,749,413	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	872,453	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(996,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (123,547)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,625,866	24 *

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

Facility Name & ID Number WASHINGTON HEIGHTS CARE CEI# 0042044 Report Period Beginning: 01/01/00 Ending: 12/31/00

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Balance per General Ledger 2,749,413

Adjustments:

-

-

-

Medicare Settlement Prior 2,484

Total adjustments 2,484

Balance - Beginning of Year 2,751,897

Equity(Deficit) from Page 17 Col 1 2,625,866

Related Party  
Equity(Deficit) -2464154  
Income -4075

(2,468,229)

Combined Equity - End of Year 157,637

**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	\$ 9,218,715	1
2	Discounts and Allowances for all Levels	(946,280)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,272,435	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	855,116	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 855,116	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	69,370	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	79,003	19
20	Radiology and X-Ray	2,827	20
21	Other Medical Services	148,007	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 299,207	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	208,268	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 208,268	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See supplemental schedule	100	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 100	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,635,126	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,667,845	31
32	Health Care	2,907,178	32
33	General Administration	1,989,537	33
<b>B. Capital Expense</b>			
34	Ownership	1,716,142	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	356,799	35
36	Provider Participation Fee	125,172	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,762,673	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	872,453	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 872,453	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

SUPPLEMENTAL SCHEDULE OF REVENUES  
12/31/00

DESCRIPTION	AMOUNT
1 Misc. Income(adjusted out on p.5A)	100
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u>100</u>

**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	1,910	2,193	\$ 59,564	\$ 27.16	1
2	Assistant Director of Nursing	2,200	2,600	57,249	22.02	2
3	Registered Nurses	6,134	7,278	149,776	20.58	3
4	Licensed Practical Nurses	60,212	67,135	1,142,504	17.02	4
5	Nurse Aides & Orderlies	119,017	133,951	1,036,284	7.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,801	6,215	64,576	10.39	8
9	Activity Director	2,085	2,385	26,357	11.05	9
10	Activity Assistants	14,468	15,497	105,668	6.82	10
11	Social Service Workers	8,554	9,359	90,410	9.66	11
12	Dietician	1,956	2,130	27,545	12.93	12
13	Food Service Supervisor	1,892	2,258	27,445	12.15	13
14	Head Cook	5,476	6,116	51,587	8.43	14
15	Cook Helpers/Assistants	27,810	30,618	210,756	6.88	15
16	Dishwashers					16
17	Maintenance Workers	6,216	6,921	77,653	11.22	17
18	Housekeepers	27,720	30,343	198,449	6.54	18
19	Laundry	12,421	13,549	88,578	6.54	19
20	Administrator					20
21	Assistant Administrator	3,423	3,866	63,032	16.30	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,772	12,325	123,678	10.03	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	1,565	2,042	21,498	10.53	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	319,632	356,781	\$ 3,622,609 *	\$ 10.15	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	460	\$ 20,706	1-3	35
36	Medical Director	44	5,500	9-3	36
37	Medical Records Consultant	96	3,360	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	3,265	10-3	39
40	Physical Therapy Consultant	93	4,650	10-3	40
41	Occupational Therapy Consultant	58	2,875	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	575	10-3	43
44	Activity Consultant	53	2,104	11-3	44
45	Social Service Consultant	80	4,004	12-3	45
46	Other(specify)				46
47	CCI Costs	See Attached	27,895		47
48					48
49	TOTAL (lines 35 - 48)	1,015	\$ 74,934		49

**C. CONTRACT NURSES**

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

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
		\$	\$
<u>0</u>	<u>0</u>	\$ <u>0</u>	\$ <u>#DIV/0!</u>





Facility Name &amp; ID Number WASHINGTON HEIGHTS CARE CENTER, L.L.C. d/b/a

# 0042044

Report Period Beginning: 01/01/00

Ending: 12/31/00

## 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? YES  
If YES, give association name and amount. IL COUNCIL ON LTC-6248
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,593 Line 10
- (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 \_\_\_\_\_ NO X
- (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. \$ 125,172  
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 benefit on Schedule V. \$ 33,599 Has any meal income been offset against related costs? NO 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 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.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette  
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

**WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.**

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 1/2 by 14 size white paper with an 8 1/2 by 14 image on the paper. To ensure an 8 1/2 by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 1/2 by 11. We cannot accept a report with an 8 1/2 by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

#### **Notes Applicable only to Lotus users**

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

#### **Notes Applicable only to Excel users**

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

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