



Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333 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 2/20/00

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	115	Intermediate (ICF)	125	45,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	125	45,250	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Public Aid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	37,832	4,681		42,513
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	37,832	4,681		42,513

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.95%

D. How many bed-hold days during this year were paid by Public Aid? 1,261 (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 08/31/96

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 08/31/96 NO

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

Medicare Intermediary \_\_\_\_\_

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 WINFIELD HEALTHCARE CENTER, L.L. # 0042333 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	148,092	14,233	7,863	170,188		170,188		170,188		1
2	Food Purchase		178,116		178,116	(7,302)	170,814	(195)	170,619		2
3	Housekeeping	193,961	37,302		231,263		231,263		231,263		3
4	Laundry	31,285	12,920		44,205		44,205		44,205		4
5	Heat and Other Utilities			106,804	106,804		106,804		106,804		5
6	Maintenance	14,150	3,437	207,029	224,616		224,616	(23,750)	200,866		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	387,488	246,008	321,696	955,192	(7,302)	947,890	(23,945)	923,945		8
<b>B. Health Care and Programs</b>											
9	Medical Director										9
10	Nursing and Medical Records	944,800	39,494	34,627	1,018,921		1,018,921		1,018,921		10
10a	Therapy			4,752	4,752		4,752		4,752		10a
11	Activities	118,694	8,528		127,222		127,222		127,222		11
12	Social Services	72,374		6,738	79,112		79,112		79,112		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,135,868	48,022	46,117	1,230,007		1,230,007		1,230,007		16
<b>C. General Administration</b>											
17	Administrative	150,350		340,749	491,099		491,099	34,604	525,703		17
18	Directors Fees										18
19	Professional Services			72,280	72,280		72,280	(75)	72,205		19
20	Dues, Fees, Subscriptions & Promotions			31,667	31,667		31,667	(4,515)	27,152		20
21	Clerical & General Office Expenses	36,533		75,897	112,430		112,430	(28,317)	84,113		21
22	Employee Benefits & Payroll Taxes			252,681	252,681	7,302	259,983		259,983		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,380	3,380		3,380		3,380		24
25	Other Admin. Staff Transportation			1,475	1,475		1,475		1,475		25
26	Insurance-Prop.Liab.Malpractice			41,482	41,482		41,482		41,482		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	186,883		819,611	1,006,494	7,302	1,013,796	1,697	1,015,493		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,710,239	294,030	1,187,424	3,191,693		3,191,693	(22,248)	3,169,445		29

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

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

WINFIELD HEALTHCARE CENTER, L.L.C.  
0042333  
COST REPORT RECLASSIFICATIONS  
01/01/00  
12/31/00

SCHEDULE V  
LINE #

22	EMPLOYEE BENEFITS	<u>7,302</u>
2	FOOD	<u>7,302</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							293,072	293,072			30
31	Amortization of Pre-Op. & Org.							2,393	2,393			31
32	Interest							317,896	317,896			32
33	Real Estate Taxes			40,767	40,767		40,767		40,767			33
34	Rent-Facility & Grounds			724,000	724,000		724,000	(724,000)				34
35	Rent-Equipment & Vehicles			29,840	29,840		29,840	(2,274)	27,566			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			794,607	794,607		794,607	(112,913)	681,694			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,861	67,861		67,861		67,861			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			67,861	67,861		67,861		67,861			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,710,239	294,030	2,049,892	4,054,161		4,054,161	(135,161)	3,919,000			45

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

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

Report Period Beginning: 01/01/00

Ending: 12/31/00

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	109,241	30		9
10	Interest and Other Investment Income	(24,937)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(195)	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	(10,317)	21		18
19	Entertainment	(181)	20		19
20	Contributions	(1,128)	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	(18,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,015)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	5,814			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 57,282		\$	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)	(192,443)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (192,443)		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (135,161)		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.

		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

STATE OF ILLINOIS  
WINFIELD HEALTHCARE CENTER, L.L.C.

Page 5A

ID# 0042333

Report Period Beginning: 01/01/00

Ending: 12/31/00

	Amount	Sch. V Line Reference
1		6
2		17
3		20
4		19
5		19
6		6
7		35
8		8
9		9
10		10
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86		86
87		87
88		88
89		89
90	5,814	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333 Report Period Beginning:

01/01/00

Ending: 12/31/00

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(195)											(195)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(23,750)											(23,750)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(23,945)</b>											<b>(23,945)</b>	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													16
	<b>C. General Administration</b>													
17	Administrative	34,604											34,604	17
18	Directors Fees													18
19	Professional Services	(2,575)	2,500										(75)	19
20	Fees, Subscriptions & Promotions	(4,515)											(4,515)	20
21	Clerical & General Office Expenses	(28,317)											(28,317)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(803)</b>	<b>2,500</b>										<b>1,697</b>	28
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(24,748)</b>	<b>2,500</b>										<b>(22,248)</b>	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 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>30</b>	<b>D. Ownership</b>													
	Depreciation	109,241	183,831										293,072	30
<b>31</b>	Amortization of Pre-Op. & Org.		2,393										2,393	31
<b>32</b>	Interest	(24,937)	342,833										317,896	32
<b>33</b>	Real Estate Taxes													33
<b>34</b>	Rent-Facility & Grounds		(724,000)										(724,000)	34
<b>35</b>	Rent-Equipment & Vehicles	(2,274)											(2,274)	35
<b>36</b>	Other (specify):*													36
<b>37</b>	<b>TOTAL Ownership</b>	<b>82,030</b>	<b>(194,943)</b>										<b>(112,913)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
<b>38</b>	Medically Necessary Transportation													38
<b>39</b>	Ancillary Service Centers													39
<b>40</b>	Barber and Beauty Shops													40
<b>41</b>	Coffee and Gift Shops													41
<b>42</b>	Provider Participation Fee													42
<b>43</b>	Other (specify):*													43
<b>44</b>	<b>TOTAL Special Cost Centers</b>													<b>44</b>
<b>45</b>	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>57,282</b>	<b>(192,443)</b>										<b>(135,161)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DONALD SIMONSEN	99%	LYDIA HEALTHCARE	ROBBINS	WINFIELD	WINFIELD	BUILDING CO
SUSAN SIMONSEN	1%				WINFIELD	BUILDING
						PARTNERSHIP
						L.L.C.

**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	Rental Income	\$ 724,000	WINFIELD BUILDING	100%	\$	\$ (724,000)	1
2	V	33	Rental Income - R/E taxes	40,767	WINFIELD BUILDING	100%		(40,767)	2
3	V	32	Interest Expense - Mortgage		WINFIELD BUILDING	100%	343,922	343,922	3
4	V	32	Interest Expense - Auto Lease		WINFIELD BUILDING	100%	852	852	4
5	V	33	Real Estate Taxes		WINFIELD BUILDING	100%	43,600	43,600	5
6	V	33	Real Estate Taxes - Prior Year	2,833	WINFIELD BUILDING	100%		(2,833)	6
7	V	30	Depreciation - Building		WINFIELD BUILDING	100%	76,962	76,962	7
8	V	30	Depreciation - Building Improvement		WINFIELD BUILDING	100%	49,288	49,288	8
9	V	30	Depreciation - Equipment		WINFIELD BUILDING	100%	52,581	52,581	9
10	V	30	Depreciation - Auto		WINFIELD BUILDING	100%	5,000	5,000	10
11	V	31	Amortization		WINFIELD BUILDING	100%	2,393	2,393	11
12	V	19	Professional Fees		WINFIELD BUILDING	100%	2,500	2,500	12
13	V	32	Interest Income	1,941	WINFIELD BUILDING	100%		(1,941)	13
14	Total		\$ 769,541				\$ 577,098	\$ * (192,443)	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						\$	\$	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.

**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	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		\$				\$	\$	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.

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	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		\$				\$	\$	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	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		\$				\$		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 WINFIELD HEALTHCARE CENTER, L.I # 0042333 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	ARNOLD SIMONSEN	Administrator	Administrative	99.00%	See Attached	10	25.00%	MGMT FEES	\$ 340,749	17-3	1
2	SUSAN SIMONSEN	Executive Director	Administrative	1.00%	See Attached	40	80.00%	SALARY	150,350	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 491,099		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 WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 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	TOTALS				\$	\$		\$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 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 WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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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 WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 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	TOTALS				\$	\$		\$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 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

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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 WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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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 WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 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 WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 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 WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 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

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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 WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 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

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	AMERICAN NAT'L BANK		X	MORTGAGE	\$39,695.00	12/9/98	\$ 5,200,000	\$ 4,721,779		\$ 343,922	1									
2	CHEVY VAN		X	AUTO LEASE	\$619.00	7/27/99	27,374			852	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	DUE TO AFFILIATE-BLDG C	X						706,570			6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>				\$40,314.00		\$ 5,227,374	\$ 5,428,349		\$ 344,774	9									
<b>B. Non-Facility Related*</b>																				
10	Supplemental Schedule									(26,878)	10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (26,878)	14									
15	<b>TOTALS (line 9+line14)</b>						\$ 5,227,374	\$ 5,428,349		\$ 317,896	15									

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C. # 0042333 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	INTEREST INCOME		X				\$	\$			\$ (24,937)	1
2	INTEREST INC -BLDG CO.	X									(1,941)	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							\$	\$			\$ (26,878)	21



X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,991 B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 2

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>20,991</u>	<u>1996</u>	<u>\$ 276,000</u>	1
2					2
3	<b>TOTALS</b>	<b>20,991</b>		<b>\$ 276,000</b>	3

Facility Name &amp; ID Number WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

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	115		1996		\$ 3,001,500	\$ 76,962	20	\$ 150,075	\$ 73,113	\$ 662,831	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		ECONOCARE-CURTAINS	1996		2,542	281	20	127	(154)	529	9
10		SEXAUER-PLUMBING	1996		4,344	111	20	217	106	904	10
11		CLOSING COSTS	1996		390	10	20	20	10	88	11
12		ECONOCARE-CURTAINS	1996		2,465	272	20	123	(149)	523	12
13		BLINDS-ECONOCARE	1996		1,273	141	20	64	(77)	272	13
14		SEXAUER-SHWR	1996		830	92	20	42	(50)	171	14
15		SIGMA	1996		2,230	57	20	112	55	485	15
16		BLINDS-ECONOCARE	1996		1,072	118	20	54	(64)	230	16
17		BLINDS-ECONOCARE	1996		1,007	111	20	50	(61)	213	17
18		SEXAUER-PLUMBING	1996		1,934	50	20	97	47	404	18
19		SEXAUER-PLUMBING	1996		1,132	29	20	57	28	233	19
20		LANDSCAPING	1997		113	3	20	6	3	21	20
21		NURSES STATION	1997		2,300	59	20	115	56	460	21
22		ELECTRICAL	1997		45,000	1,154	20	2,250	1,096	9,000	22
23		RADIATOR COVER REPLA	1997		9,000	231	20	450	219	1,800	23
24											24
25											25
26											26
27											27
28											28
29		PAGE 12G TOTALS			64,238	477		2,140	1,663	2,140	29
30		PAGE 12F TOTALS			211,648	4,908		10,526	5,618	23,214	30
31		PAGE 12E TOTALS			112,810	3,030		5,641	2,611	15,197	31
32		PAGE 12D TOTALS			663,206	18,356		33,161	14,805	125,647	32
33		PAGE 12C TOTALS			537,994	13,795		26,900	13,105	106,267	33
34		PAGE 12B TOTALS			203,502	7,013		10,175	3,162	39,031	34
35		PAGE 12A TOTALS			185,756	4,763		9,288	4,525	33,986	35
36		TOTAL (lines 4 thru 35)			\$ 5,056,286	\$ 132,023		\$ 251,690	\$ 119,667	\$ 1,023,646	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 WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

Report Period Beginning:

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## 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		HANDRAIL REFINISHING		1997	6,000	154	20	300	146	1,200	9
10		MAIN ENTRANCE-APIC		1997	16,183	415	20	809	394	3,169	10
11		LANDSCAPING		1997	25,000	641	20	1,250	609	4,479	11
12		ENGINEERS		1997	5,513	141	20	276	135	874	12
13		ARCHITECT		1997	502	13	20	25	12	77	13
14		ARCHITECT		1997	1,604	41	20	80	39	253	14
15		SERVICE SINK		1997	921	24	20	46	22	150	15
16		ENGINEERS		1997	2,370	63	20	124	61	455	16
17		BLACK TOP		1997	18,929	485	20	946	461	3,311	17
18		CONCRETE PATIO-APIC		1997	15,000	385	20	750	365	2,938	18
19		LANDSCAPING		1997	2,026	52	20	101	49	345	19
20		LANDSCAPING		1997	3,204	82	20	160	78	547	20
21		WHEEL CHAIR CARRIER		1997	128	3	20	6	3	22	21
22		MECH REVISIONS		1997	2,145	55	20	107	52	383	22
23		SEXAUER		1997	3,728	96	20	186	90	682	23
24		METERING FAUCET		1997	639	16	20	32	16	115	24
25		SHOWER ARM		1997	27	1	20	1		4	25
26		ELEVATOR REPAIR		1997	4,440	114	20	222	108	814	26
27		ELEVATOR REPAIR		1997	4,560	117	20	228	111	874	27
28		SEXAUER		1997	847	22	20	42	20	137	28
29		SEXAUER		1997	2,274	58	20	114	56	418	29
30		SEXAUER		1997	574	15	20	29	14	92	30
31		PAVING		1997	34,170	876	20	1,709	833	5,982	31
32		FIRE EXT/CABINETS		1997	593	15	20	30	15	100	32
33		ARCHITECT		1997	1,674	43	20	84	41	287	33
34		ARCHITECT FEES		1997	24,171	620	20	1,209	589	4,836	34
35		LANDSCAPING		1997	8,434	216	20	422	206	1,442	35
36		TOTAL (lines 4 thru 35)			\$ 185,756	\$ 4,763		\$ 9,288	\$ 4,525	\$ 33,986	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 WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

Report Period Beginning:

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## 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	ENGINEER		1997		2,000	51	20	100	49	308	9
10	REFRIGERATION SYS		1997		10,781	2,070	20	539	(1,531)	1,617	10
11	BEVERAGE COUNTER		1997		3,129	80	20	156	76	481	11
12	SHOWER HEAD		1997		140	4	20	7	3	28	12
13	COMMON AREAS		1997		17,500	449	20	875	426	3,500	13
14	ESCUTCHEON-SEXAUER		1997		125	3	20	6	3	24	14
15	ARCHITECT		1997		1,380	35	20	69	34	253	15
16	SEXAUER		1997		326	8	20	16	8	59	16
17	PLUMBING-SEXAUER		1997		804	21	20	40	19	157	17
18	LAVATORY-SEXAUER		1997		659	17	20	33	16	129	18
19	LAVATORY-SEXAUER		1997		314	8	20	16	8	63	19
20	ELONGATED BOWL-SEXAU		1997		968	25	20	48	23	188	20
21	TOILET-SEXAUER		1997		124	3	20	6	3	24	21
22	SINK-SEKAUER		1997		142	4	20	7	3	27	22
23	NEW LOBBY-APIC		1997		13,085	336	20	654	318	2,562	23
24	SEXAUER		1997		895	23	20	45	22	165	24
25	ARCHITECT		1997		1,551	40	20	78	38	273	25
26	CONCRETE PATIO-APIC		1997		8,900	228	20	445	217	1,743	26
27	FAUCETS-SEXAUER		1997		259	7	20	13	6	51	27
28	SIGMA-ROOF		1997		36,170	927	20	1,809	882	7,387	28
29	CERAMIC TILE-BATHROO		1997		21,250	545	20	1,063	518	4,163	29
30	PAINT REAR STAIRWELL		1997		5,000	128	20	250	122	979	30
31	PAINTING & CEILING R		1997		28,500	731	20	1,425	694	5,700	31
32	SUSPENDED CEILING		1997		17,000	436	20	850	414	3,400	32
33	VANITY REPAIR/PLUMBI		1997		9,500	244	20	475	231	1,900	33
34	CURTAIN TRACK		1997		3,000	77	20	150	73	600	34
35	HVAC SYSTEM		1997		20,000	513	20	1,000	487	3,250	35
36	TOTAL (lines 4 thru 35)				\$ 203,502	\$ 7,013		\$ 10,175	\$ 3,162	\$ 39,031	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 WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

Report Period Beginning:

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## 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		CERAMIC TILE		1997	24,000	615	20	1,200	585	4,800	9
10		PVC TILE & RUBBER BA		1997	6,500	167	20	325	158	1,300	10
11		WZO		1997	25,000	641	20	1,250	609	5,417	11
12		WINDOWS-SIGMA		1997	29,000	744	20	1,450	706	5,679	12
13		PLUMBING		1997	120,000	3,077	20	6,000	2,923	23,500	13
14		TOILETS-SEXAUER		1997	657	17	20	33	16	132	14
15		ENGINEERING-MGN CONS		1997	2,229	57	20	111	54	435	15
16		ARCHITECT-CHARLES HU		1997	867	22	20	43	21	168	16
17		ARCHITECT-CHARLES HU		1997	464	12	20	23	11	90	17
18		ROOF-SIGMA ELECTRIC		1997	50,000	1,282	20	2,500	1,218	9,792	18
19		PATIO CANOPY-APIC		1997	10,950	281	20	548	267	2,146	19
20		NEW FIRE ALARM THROU		1997	46,250	1,186	20	2,313	1,127	9,059	20
21		SPRINKLERS MOD-IST		1997	36,250	929	20	1,813	884	7,101	21
22		ARCHITECT		1997	3,778	97	20	189	92	677	22
23		TILES		1997	504	13	20	25	12	90	23
24		MGM CONSULTING		1997	28,660	735	20	1,433	698	5,732	24
25		BATHROOM HARDWARE		1997	10,625	272	20	531	259	2,080	25
26		ARCHITECT		1997	156	4	20	8	4	30	26
27		DOORS & HARDWARE		1997	43,000	1,103	20	2,150	1,047	8,600	27
28		BATHROOM HARDWARE IN		1997	12,000	308	20	600	292	2,400	28
29		DEMOLITION & RUBBISH		1997	17,900	459	20	895	436	3,580	29
30		PLUMBING FIXTURES		1997	12,500	321	20	625	304	2,500	30
31		WHEEL CHAIR CARRIER		1997	1,909	49	20	95	46	348	31
32		ENGINEERS		1997	7,295	187	20	365	178	1,308	32
33		PVC TILE & RUBBER BA		1997	35,625	913	20	1,781	868	6,976	33
34		RELOCATION OF WINDOW		1997	4,375	112	20	219	107	858	34
35		HANDRAIL INSTALL-IST		1997	7,500	192	20	375	183	1,469	35
36		TOTAL (lines 4 thru 35)			\$ 537,994	\$ 13,795		\$ 26,900	\$ 13,105	\$ 106,267	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 WINFIELD HEALTHCARE CENTER, L.L.C.

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Report Period Beginning:

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## 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		NEW GLASS/VISION PAN		1997	5,750	147	20	288	141	1,128	9
10		NEW CABINETS		1997	11,250	288	20	563	275	2,205	10
11		SUSPENDED CEILING		1997	66,875	1,715	20	3,344	1,629	13,097	11
12		NEW LIGHTWEIGHT CONC		1997	14,375	369	20	719	350	2,876	12
13		CABINET REPAIR & PAI		1997	9,000	231	20	450	219	1,800	13
14		DRYWALL INSTALL		1997	59,000	1,513	20	2,950	1,437	11,800	14
15		INSTALL NEW PARTITIO		1997	80,000	2,051	20	4,000	1,949	15,667	15
16		DEMOLITION & REMOVAL		1997	24,500	628	20	1,225	597	4,798	16
17		HVAC		1997	85,000	2,179	20	4,250	2,071	16,646	17
18		NEW REINFORCED CONCR		1997	15,000	385	20	750	365	3,000	18
19		ELECTRICAL		1997	110,000	2,821	20	5,500	2,679	21,542	19
20		DOORS & HARDWARE		1997	71,000	1,821	20	3,550	1,729	13,904	20
21		CURTAIN TRACK-NEW RE		1997	5,000	128	20	250	122	979	21
22		INSTALL NEW WALLS		1997	15,625	401	20	781	380	3,059	22
23		1ST FLR REMODELING		1998	45,402	1,164	20	2,270	1,106	6,621	23
24		ELECTRICAL RPRS		1998	3,479		20	174	174	464	24
25		FIRE SYSTEM		1998	1,130	29	20	57	28	157	25
26		ARCHITECT		1998	148	4	20	7	3	19	26
27		PARKING LOT		1998	3,030	78	20	152	74	418	27
28		BLINDS		1998	3,525	677	20	176	(501)	513	28
29		SERVICE SINK		1998	743	142	20	37	(105)	108	29
30		HVAC SYSTEM		1998	10,000	256	20	500	244	1,458	30
31		COUNTERS		1998	560	14	20	28	14	77	31
32		HEPA FILETER/EXHAUST		1998	10,948		20	547	547	1,641	32
33		GENERATOR RPRS		1998	1,208		20	60	60	170	33
34		REFRIGERATION SYS		1998	6,260	1,202	20	313	(889)	913	34
35		PANELS-BVG COUNTER		1998	4,398	113	20	220	107	587	35
36		TOTAL (lines 4 thru 35)			\$ 663,206	\$ 18,356		\$ 33,161	\$ 14,805	\$ 125,647	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 WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

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## 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		DUMPSTER RENTAL	1998		675	17	20	34	17	96	9
10		REMODELING NORTH WIN	1998		3,522	90	20	176	86	499	10
11		PLUMBING	1998		2,054		20	103	103	292	11
12		LAVATORY	1998		486	12	20	24	12	64	12
13		SEXAUER	1998		1,517	39	20	76	37	228	13
14		ARCHITECT	1998		184	5	20	9	4	26	14
15		HEPA FILETER/EXHAUST	1998			262	20		(262)		15
16		SEXAUER	1998		3,009	77	20	150	73	450	16
17		ARCHITECT	1998		300	8	20	15	7	44	17
18		LANDSCAPING	1998		5,200	133	20	260	127	672	18
19		POWERTRON	1998		953	24	20	48	24	100	19
20		CONCRETE RPR	1998		1,295		20	65	65	173	20
21		SIGNS	1998		499	13	20	25	12	63	21
22		ARCHITECT	1998		353	9	20	18	9	54	22
23		CUBICAL CURTAINS	1998		2,827	72	20	141	69	329	23
24		PLUMBING RPRS	1998		7,920	203	20	396	193	1,023	24
25		REMODEL DIETARY-HVAC	1998		10,000	256	20	500	244	1,375	25
26		ARCHITECTURES	1998		3,552	91	20	178	87	401	26
27		WALK IN REFRIG	1998			1	20		(1)		27
28		WALK IN REFRIG	1998		663		20	33	33	85	28
29		SIGNS	1998		2,300	59	20	115	56	268	29
30		NURSE CALL SYS RPR	1998		807		20	40	40	93	30
31		REMODEL DIETARY	1998		52,784	1,353	20	2,639	1,286	7,257	31
32		NORTH PATIO PLANTS	1998		101	3	20	5	2	13	32
33		REMODEL DIETARY	1998		6,833	175	20	342	167	941	33
34		DRAIN TILE	1998		3,376	87	20	169	82	451	34
35		STONE BASE	1998		1,600	41	20	80	39	200	35
36		TOTAL (lines 4 thru 35)			\$ 112,810	\$ 3,030		\$ 5,641	\$ 2,611	\$ 15,197	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 WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

Report Period Beginning:

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## 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	NEW ROOF		1998		26,000	667	20	1,300	633	3,250	9
10	TILES		1998		597	15	20	30	15	73	10
11	HVAC CONSULTING		1998		3,600	92	20	180	88	435	11
12	ELEC REPAIRS		1998		7,122	183	20	356	173	920	12
13	NORTH PATIO PLANTS		1998		2,260	58	20	113	55	292	13
14	WINDOW TREATMENTS		1998		480		20	24	24	62	14
15	REMODELING NORTH WIN		1998		31,575	810	20	1,579	769	4,079	15
16	REMODELING NORTH WIN		1998		49,485	1,269	20	2,474	1,205	6,391	16
17	REMODEL DIETARY-HVAC		1998		26,450	678	20	1,323	645	3,638	17
18	PLUMBING		1999		1,934		20	97	97	97	18
19	1ST FLOOR REPAIRS		1999		1,449	37	20	72	35	132	19
20	HVAC REPAIRS		1999		1,106		20	55	55	87	20
21	HVAC REPAIRS		1999		1,029		20	51	51	81	21
22	BLINDS		1999				20				22
23	ROBERTS		1999		32,181		20	1,609	1,609	1,877	23
24	HVAC REPAIRS		1999				20				24
25	TRICOM-WIRING		1999		1,286		20	64	64	91	25
26	ROBERTS		1999		2,890		20	145	145	181	26
27	TOILET KIT		1999		1,130	29	20	57	28	100	27
28	OLYMPIC SIGNS		1999		581		20	29	29	29	28
29	LUMBER		1999		1,784	46	20	89	43	148	29
30	ELEVATOR REPAIRS		1999		1,625	42	20	81	39	142	30
31	REPAIRS 1ST FLOOR		1999		5,815	149	20	291	142	558	31
32	SPRINKLER SYSTEM		1999		6,550	168	20	328	160	355	32
33	BLINDS		1999		2,079	665	20	104	(561)	121	33
34	REMODELING		2000		1,700		20	71	71	71	34
35	CABLE & JACK INST		2000		940		20	4	4	4	35
36	TOTAL (lines 4 thru 35)				\$ 211,648	\$ 4,908		\$ 10,526	\$ 5,618	\$ 23,214	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		W/I FREEZER REPAIR	2000		535		20	20	20	20	9
10		BUILDING DEMOLITION	2000		13,500		20				10
11		CORNICE & BLINDS INS	2000		1,294		20	65	65	65	11
12		BLINDS FREIGHT	2000		55		20	3	3	3	12
13		IDPH PERMIT FEE	2000		5,760	105	20	216	111	216	13
14		SEALCOATING & STRIPE	2000		3,998		20	133	133	133	14
15		GAS LEAK REPAIR	2000		582		20	29	29	29	15
16		ELECTRIC WORK	2000		606		20	30	30	30	16
17		GLASS/FRAME INST	2000		700		20	29	29	29	17
18		VENTILATION	2000		2,898	65	20	133	68	133	18
19		PLUMBING	2000		920		20	12	12	12	19
20		SHELVES INSTALLATION	2000		600		20	5	5	5	20
21		A/C TEST & BALANCE	2000		8,500		20	567	567	567	21
22		FLOORING	2000		2,100		20	70	70	70	22
23		FIRE DOOR	2000		2,100		20	70	70	70	23
24		WINDOW INSTALLATION	2000		790		20	33	33	33	24
25		SPRINKLER INST	2000		3,000	10	20	25	15	25	25
26		COUNTER TOP INST	2000		500		20	2	2	2	26
27		REMODELING	2000		1,700		20	71	71	71	27
28		PLUMBING	2000		1,869	34	20	70	36	70	28
29		PLUMBING	2000		11,715	263	20	537	274	537	29
30		A/C REPAIR	2000		516		20	20	20	20	30
31											31
32											32
33											33
34											34
35											35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 64,238	\$ 477		\$ 2,140	\$ 1,663	\$ 2,140	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 WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

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
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.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

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
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.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

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
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.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

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
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)

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	\$ 348,641	\$ 41,893	\$ 34,921	\$ (6,972)		\$ 147,619	37
38	Current Year Purchases	19,534	3,908	1,463	(2,445)		1,463	38
39	Fully Depreciated Assets		1,009		(1,009)			39
40								40
41	TOTALS	\$ 368,175	\$ 46,810	\$ 36,384	\$ (10,426)		\$ 149,082	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	FACILITY	1999 CHEVY VAN	1999	\$ 27,374	\$ 5,000	\$ 5,000		5	\$ 8,060	42
43										43
44										44
45										45
46	TOTALS			\$ 27,374	\$ 5,000	\$ 5,000			\$ 8,060	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 5,727,835	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 183,833	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 293,074	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 109,241	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,180,788	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	DEPOSIT ON FURNITURE	\$ 7,817	58
59			59
60			60
61		\$ 7,817	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.

WINFIELD HEALTHCARE CENTER, L.L.C.  
0042333  
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>					
WINFIELD WOODS BUILDING	348,641	41,893	34,921	(6,972)	147,619
TOTALS	348,641	41,893	34,921	(6,972)	147,619

<b>LINE 29: CURRENT YEAR</b>					
WINFIELD WOODS BUILDING	19,534	3,908	1,463	(2,445)	1,463
TOTALS	19,534	3,908	1,463	(2,445)	1,463

<b>LINE 30: FULLY DEPRECIATED</b>					
WINFIELD WOODS BUILDING		1,009		(1,009)	
TOTALS		1,009		(1,009)	

<b>TOTALS (Should Tie to Totals on Page 13)</b>					
WINFIELD WOODS BUILDING	368,175	46,810	36,384	(10,426)	149,082
TOTALS	368,175	46,810	36,384	(10,426)	149,082

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

Report Period Beginning:

01/01/00

Ending: 12/31/00

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES  NO

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

\*\*

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 9,546 Description: COOLER RENTAL \$1,890; COPIER \$4,102; PLANT RENTAL \$2,414; WATER CONDITIONER \$1,140.

(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	<u>ADMINISTRATOR</u>	<u>2000 MERCEDES-BENZ</u>	\$ <u>826.00</u>	\$ <u>18,020</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>826.00</b>	\$ <b>18,020</b>	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

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

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

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

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

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

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)	
<b>TOTAL TRAINED</b>	

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

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

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

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	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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>SCHEDULE**</b>									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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	
2 Complex Medical Equip	
3 Oxygen	
4 Equipment Rental	
5	
6	
7	
8	
9	
10	
	<u>                    </u>
	<u>                    </u>

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

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	\$ 581,635	\$ 643,985 1
2	Cash-Patient Deposits	3,443	3,443 2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	502,499	502,499 3
4	Supply Inventory (priced at )		4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	18,651	18,651 7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): See supplemental schedule		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,106,228	\$ 1,168,578 10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land		289,500 13
14	Buildings, at Historical Cost		3,001,500 14
15	Leasehold Improvements, at Historical Cos		1,964,823 15
16	Equipment, at Historical Cost		431,124 16
17	Accumulated Depreciation (book methods)		(846,886) 17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify): See supplemental schedule		19,583 23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 4,859,644 24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,106,228	\$ 6,028,222 25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 173,508	\$ 190,581 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	3,442	3,442 28
29	Short-Term Notes Payable	1,000,788	706,570 29
30	Accrued Salaries Payable	7,198	7,198 30
31	Accrued Taxes Payable (excluding real estate taxes)	109	109 31
32	Accrued Real Estate Taxes(Sch.IX-B)		43,600 32
33	Accrued Interest Payable		28,363 33
34	Deferred Compensation		34
35	Federal and State Income Taxes	7,771	7,775 35
36	<b>Other Current Liabilities(specify):</b>		
37	See supplemental schedule	292,316	292,316 36
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,485,132	\$ 1,279,954 38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		39
40	Mortgage Payable		4,721,779 40
41	Bonds Payable		41
42	Deferred Compensation		42
43	<b>Other Long-Term Liabilities(specify):</b>		
44	See supplemental schedule		43
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,721,779 45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,485,132	\$ 6,001,733 46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (378,904)	\$ #REF! 47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,106,228	\$ #REF! 48

\*(See instructions.)

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:

<u>Amount</u>	<u>Amount</u>

OTHER CURRENT LIABILITIES:

<u>Amount</u>	<u>Amount</u>
Accrued Management Fees	292,316
	292,316

OTHER NON CURRENT ASSETS:

Financing Fees	16,751
Accumulated Amortization - Financing Fees	(4,985)
Construction in Progress	7,817
	19,583

OTHER NON CURRENT LIABILITIES:


**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(414,752)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Schedule attached</b>	<b>11,414</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(403,338)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>24,434</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>24,434</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(378,904)</b>	<b>24</b> *

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

Facility Name & ID Number WINFIELD HEALTHCARE CENTER, # 0042333 Report Period Beginning: 01/01/00 Ending: 12/31/00

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Balance per General Ledger (403,338)

Adjustments:

-

-

-

Prior Year Accounting Fee Adjustment (11,414)

Total adjustments (11,414)

Balance - Beginning of Year (414,752)

Equity(Deficit) from Page 17 Col 1 (378,904)

Related Party

Equity(Deficit) 212950

Income 192443

405,393

Combined Equity - End of Year 26,489

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

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

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,053,583	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,053,583	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	24,937	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 24,937	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See supplemental schedule	75	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 75	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,078,595	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	955,192	31
32	Health Care	1,230,007	32
33	General Administration	1,006,494	33
<b>B. Capital Expense</b>			
34	Ownership	794,607	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	67,861	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,054,161	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	24,434	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 24,434	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 Legal (Adjust out on Page 5)	75
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
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15	
16	
17	
18	
19	
20	
TOTALS	<u>75</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	2,064	2,269	\$ 58,808	\$ 25.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,440	9,276	156,096	16.83	3
4	Licensed Practical Nurses	12,840	14,114	246,274	17.45	4
5	Nurse Aides & Orderlies	38,983	42,850	462,585	10.80	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,736	9,603	118,694	12.36	10
11	Social Service Workers	5,700	6,266	72,374	11.55	11
12	Dietician					12
13	Food Service Supervisor	1,086	1,194	17,539	14.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,945	15,324	130,553	8.52	15
16	Dishwashers					16
17	Maintenance Workers	1,223	1,344	14,150	10.53	17
18	Housekeepers	23,389	25,709	193,961	7.54	18
19	Laundry	4,087	4,493	31,285	6.96	19
20	Administrator	2,080	2,080	150,350	72.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,710	2,979	36,533	12.26	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	1,909	2,099	21,037	10.02	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	127,192	139,600	\$ 1,710,239 *	\$ 12.25	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY \$ 7,863	1-3	35
36	Medical Director	MONTHLY 3,000	10-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	MONTHLY 1,300	10-3	39
40	Physical Therapy Consultant	60 2,868	10a-3	40
41	Occupational Therapy Consultant	MONTHLY 1,884	10a-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	225 6,738	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	285 \$ 23,653		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	963 30,327	10-3	52
53	TOTAL (lines 50 - 52)	963 \$ 30,327		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>



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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
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19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number WINFIELD HEALTHCARE CENTER, L.L.C.

# 0042333

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. Illinois Council on Long Term Care \$4,311
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 67,861  
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? N/A
- (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. \$ 7,302 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
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? N/A  
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? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of service performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees