



Facility Name & ID Number WOODBRIIDGE NURSING PAVILION, LTD.

# 0034157 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	222	222	81,252	1
2	Skilled (SNF)			2
3	Skilled Pediatric (SNF/PED)			3
4	Intermediate (ICF)			4
5	Intermediate/DD			5
6	Sheltered Care (SC)			6
7	ICF/DD 16 or Less			7
7	222	222	81,252	7
<b>TOTALS</b>				

B. Census-For the entire report period.

1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
	Public Aid Recipient	Private Pay	Other	Total	
8 SNF	11,184	656	1,090	12,930	8
9 SNF/PED					9
10 ICF	56,742	4,160	31	60,933	10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	67,926	4,816	1,121	73,863	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.91%

D. How many bed-hold days during this year were paid by Public Aid? 2,048 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 8/1/88

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 8/1/88 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 33 and days of care provided 972

Medicare Intermediary Mutual of Omaha

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 **WOODBIDGE NURSING PAVILION, LT]** # **0034157** 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>1</b>	<b>A. General Services</b>										
1	Dietary	216,376	31,140	7,200	254,716		254,716	(788)	253,928		1
2	Food Purchase		276,340		276,340	(21,696)	254,644	(1,064)	253,580		2
3	Housekeeping		26,733	205,896	232,629		232,629	(788)	231,841		3
4	Laundry		19,535	103,860	123,395		123,395		123,395		4
5	Heat and Other Utilities			150,382	150,382		150,382	1,049	151,431		5
6	Maintenance	54,059	36,068	59,148	149,275		149,275	(3,984)	145,291		6
7	Other (specify):*							878	878		7
<b>8</b>	<b>TOTAL General Services</b>	<b>270,435</b>	<b>389,816</b>	<b>526,486</b>	<b>1,186,737</b>	<b>(21,696)</b>	<b>1,165,041</b>	<b>(4,697)</b>	<b>1,160,344</b>		<b>8</b>
<b>9</b>	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	1,944,164	83,695	80,677	2,108,536		2,108,536	(1,113)	2,107,423		10
10a	Therapy			7,989	7,989		7,989		7,989		10a
11	Activities	112,854	5,302	3,545	121,701		121,701	(80)	121,621		11
12	Social Services	14,362	(100)	3,943	18,205		18,205		18,205		12
13	Nurse Aide Training							162	162		13
14	Program Transportation										14
15	Other (specify):*										15
<b>16</b>	<b>TOTAL Health Care and Programs</b>	<b>2,071,380</b>	<b>88,897</b>	<b>99,754</b>	<b>2,260,031</b>		<b>2,260,031</b>	<b>(1,031)</b>	<b>2,259,000</b>		<b>16</b>
<b>17</b>	<b>C. General Administration</b>										
17	Administrative	146,244		191,622	337,866		337,866	69,235	407,101		17
18	Directors Fees										18
19	Professional Services			313,182	313,182	(4,700)	308,482	(258,598)	49,884		19
20	Dues, Fees, Subscriptions & Promotions			104,731	104,731		104,731	(85,589)	19,142		20
21	Clerical & General Office Expenses	94,666	1,828	42,370	138,864		138,864	63,056	201,920		21
22	Employee Benefits & Payroll Taxes			429,755	429,755	21,696	451,451	(4,400)	447,051		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,844	2,844		2,844	429	3,273		24
25	Other Admin. Staff Transportation			5,572	5,572		5,572	39	5,611		25
26	Insurance-Prop.Liab.Malpractice			113,405	113,405		113,405	993	114,398		26
27	Other (specify):*							26,703	26,703		27
<b>28</b>	<b>TOTAL General Administration</b>	<b>240,910</b>	<b>1,828</b>	<b>1,203,481</b>	<b>1,446,219</b>	<b>16,996</b>	<b>1,463,215</b>	<b>(188,132)</b>	<b>1,275,083</b>		<b>28</b>
<b>29</b>	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,582,725</b>	<b>480,541</b>	<b>1,829,721</b>	<b>4,892,987</b>	<b>(4,700)</b>	<b>4,888,287</b>	<b>(193,860)</b>	<b>4,694,427</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.

WOODBIDGE NURSING PAVILION, LTD.

0034157

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V  
LINE #

22	EMPLOYEE BENEFITS	<u>21,696</u>	
2	FOOD		<u>21,696</u>

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

33	REAL ESTATE TAX	<u>4,700</u>	
19	PROFESSIONAL FEES		<u>4,700</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			37,629	37,629		37,629	16,978	54,607			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,805	35,805		35,805	(33,135)	2,670			32
33	Real Estate Taxes			249,510	249,510	4,700	254,210	2,469	256,679			33
34	Rent-Facility & Grounds			1,092,930	1,092,930		1,092,930		1,092,930			34
35	Rent-Equipment & Vehicles			8,038	8,038		8,038	10,270	18,308			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,423,912	1,423,912	4,700	1,428,612	(3,418)	1,425,194			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,985	46,946	76,931		76,931	(469)	76,462			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,878	121,878		121,878		121,878			42
43	Other (specify):*	9,200			9,200		9,200	(9,200)				43
44	<b>TOTAL Special Cost Centers</b>	9,200	29,985	168,824	208,009		208,009	(9,669)	198,340			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,591,925	510,526	3,422,457	6,524,908		6,524,908	(206,947)	6,317,961			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 **WOODBIDGE NURSING PAVILION, LTD.**

# **0034157**

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	12,589	30		9
10	Interest and Other Investment Income	(36,306)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(180)	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	(600)	21		18
19	Entertainment				19
20	Contributions	(4,620)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(80,759)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,575)	20		28
29	Other-Attach Schedule	(40,907)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (153,358)		\$	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)	(53,589)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (53,589)		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (206,947)		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  
 WOODBRIDGE NURSING PAVILION, LTD.

Page 5A

ID# 0034157

Report Period Beginning: 01/01/00

Ending: 12/31/00

	Amount	Sch. V Line Reference
1		6
2		21
3		20
4		43
5		6
6		19
7		6
8		10
9		20
10		2
11		17
12		24
13		22
14		11
15		2
16		1
17		3
18		20
19		20
20		19
21		21
22		22
23		23
24		24
25		25
26		26
27		27
28		28
29		29
30		30
31		31
32		32
33		33
34		34
35		35
36		36
37		37
38		38
39		39
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41		41
42		42
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47		47
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60		60
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62		62
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65		65
66		66
67		67
68		68
69		69
70		70
71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90		90
<b>Total</b>	<b>(40,907)</b>	

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODBRIGE NURSING PAVILION, LTD.# 0034157

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	(788)											(788)	1
2	Food Purchase	(1,064)											(1,064)	2
3	Housekeeping	(788)											(788)	3
4	Laundry													4
5	Heat and Other Utilities			1,049									1,049	5
6	Maintenance	(15,042)		5,361	5,697								(3,984)	6
7	Other (specify):*			151		727							878	7
8	<b>TOTAL General Services</b>	<b>(17,682)</b>		<b>6,561</b>	<b>5,697</b>	<b>727</b>							<b>(4,697)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(700)						(413)					(1,113)	10
10a	Therapy													10a
11	Activities	(80)											(80)	11
12	Social Services													12
13	Nurse Aide Training			162									162	13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(780)</b>		<b>162</b>				<b>(413)</b>					<b>(1,031)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(4,957)		(186,665)	260,857								69,235	17
18	Directors Fees													18
19	Professional Services	54		(258,652)									(258,598)	19
20	Fees, Subscriptions & Promotions	(86,900)	250	1,061									(85,589)	20
21	Clerical & General Office Expenses	(5,356)	(303)	63,382	5,333								63,056	21
22	Employee Benefits & Payroll Taxes	(4,400)											(4,400)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(420)		849									429	24
25	Other Admin. Staff Transportation			39									39	25
26	Insurance-Prop.Liab.Malpractice			993									993	26
27	Other (specify):*			8,401		18,302							26,703	27
28	<b>TOTAL General Administration</b>	<b>(101,979)</b>	<b>(53)</b>	<b>(370,592)</b>	<b>266,190</b>	<b>18,302</b>							<b>(188,132)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(120,441)</b>	<b>(53)</b>	<b>(363,869)</b>	<b>271,887</b>	<b>19,029</b>		<b>(413)</b>					<b>(193,860)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **WOODBIDGE NURSING PAVILION, LTD.** # **0034157** 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>	Depreciation	12,589		4,389									16,978	30
<b>31</b>	Amortization of Pre-Op. & Org.													31
<b>32</b>	Interest	(36,306)		3,171									(33,135)	32
<b>33</b>	Real Estate Taxes			2,469									2,469	33
<b>34</b>	Rent-Facility & Grounds													34
<b>35</b>	Rent-Equipment & Vehicles			10,270									10,270	35
<b>36</b>	Other (specify):*													36
<b>37</b>	<b>TOTAL Ownership</b>	<b>(23,717)</b>		<b>20,299</b>									<b>(3,418)</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							(469)					(469)	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):*	(9,200)											(9,200)	43
<b>44</b>	<b>TOTAL Special Cost Centers</b>	<b>(9,200)</b>						<b>(469)</b>					<b>(9,669)</b>	<b>44</b>
<b>45</b>	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(153,358)</b>	<b>(53)</b>	<b>(343,570)</b>	<b>271,887</b>	<b>19,029</b>		<b>(882)</b>					<b>(206,947)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				WoodbridgeBuilding LLC		Building Co.

**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	\$ 1,092,930	Woodbridge Building LLC	100.00%	\$	(1,092,930)	1
2	V	34 Rental Expense		Woodbridge Building LLC	100.00%	1,092,930	1,092,930	2
3	V	20 Franchise Tax		Woodbridge Building LLC	100.00%	250	250	3
4	V	21 Prior Period Expense		Woodbridge Building LLC	100.00%	(303)	(303)	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,092,930			\$ 1,092,877	\$ * (53)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 1,049	\$	1,049	15
16	V	6 REPAIRS & MAINT.				5,361		5,361	16
17	V	7 EMP.BEN. - GEN. SERVICES				151		151	17
18	V	13 NURSES AIDE TRAINING				162		162	18
19	V	19 PROFESSIONAL FEES				2,533		2,533	19
20	V	20 DUES AND SUBSCRIPTIONS				1,061		1,061	20
21	V	21 CLERICAL & GENERAL				63,382		63,382	21
22	V	24 SEMINARS AND TRAVEL				849		849	22
23	V	25 ADMIN. STAFF TRANS.				39		39	23
24	V	26 INSURANCE				993		993	24
25	V	27 EMP.BEN. - GEN. ADMIN.				8,401		8,401	25
26	V	30 DEPRECIATION				4,389		4,389	26
27	V	32 INTEREST				3,171		3,171	27
28	V	33 REAL ESTATE TAXES				2,469		2,469	28
29	V	35 EQUIPMENT RENTAL				10,270		10,270	29
30	V	0				0		0	30
31	V	17 MANAGEMENT FEES	186,665			0		(186,665)	31
32	V	19 BOOKKEEPING SERVICES	261,185			0		(261,185)	32
33	V	0				0		0	33
34	V	0							34
35	V	0							35
36	V								36
37	V								37
38	V								38
39	Total		\$ 447,850			\$ 104,280	\$ *	(343,570)	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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 5,697	\$	5,697	15
16	V	10 NURSING CMP - SUE G.				0			16
17	V	17 ADMIN. CMP. - M. MAUER				45,981		45,981	17
18	V	17 ADMIN. CMP. - M. AARON				58,806		58,806	18
19	V	17 ADMIN. CMP. - F. AARON				0			19
20	V	17 ADMIN. CMP. - A. STERN				37,073		37,073	20
21	V	17 ADMIN. CMP. - S. GOLDSTEIN				71,632		71,632	21
22	V	17 ADMIN. CMP. - S. KOPLIN				10,822		10,822	22
23	V	17 ADMIN. CMP. - D. MAGAFAS				0			23
24	V	17 ADMIN. CMP. - E. CASSON				0			24
25	V	17 ADMIN. CMP. - S. BOGEN				0			25
26	V	17 ADMIN. CMP. - S. LEVY				13,386		13,386	26
27	V	17 ADMIN. CMP. - A. STEINER				4,373		4,373	27
28	V	17 ADMIN. CMP. - NON-OWNER				18,784		18,784	28
29	V	21 CLERICAL CMP. - S. AARON				5,333		5,333	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	<b>Total</b>		\$			\$ 271,887	\$ *	271,887	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	7	EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 727	\$	727	15
16	V	15	EMP. BEN.- SUE G.				0			16
17	V	27	EMP. BEN.- M. MAUER				1,284		1,284	17
18	V	27	EMP. BEN.- M. AARON				1,491		1,491	18
19	V	27	EMP. BEN.- F. AARON				0			19
20	V	27	EMP. BEN.- S. GOLDSTEIN				7,406		7,406	20
21	V	27	EMP. BEN.- S. KOPLIN				2,304		2,304	21
22	V	27	EMP. BEN.- D. MAGAFAS				0			22
23	V	27	EMP. BEN.- E. CASSON				0			23
24	V	27	EMP. BEN.- S. BOGEN				0			24
25	V	27	EMP. BEN.- S. LEVY				1,834		1,834	25
26	V	27	EMP. BEN.- A. STEINER				726		726	26
27	V	27	EMP. BEN.- NON-OWNER				2,527		2,527	27
28	V	27	EMP. BEN.- S. AARON				730		730	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			\$			\$ 19,029	\$ *	19,029	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	10A THERAPY	\$ 7,989	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	\$ 7,989	\$	15
16	V	22 EMPLOYEE BENEFITS	0	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	0		16
17	V	39 ANCILLARY SERVICES	46,945	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	46,945		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		\$ 54,934			\$ 54,934	\$ *	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	20 DUES, FEES & SUBSCRIPTIONS	\$ 0	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	\$ 0		15
16	V	10 MEDICAL SUPPLIES	1,568	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	1,155	(413)	16
17	V	39 ANCILLARY EXPENSE	1,784	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	1,315	(469)	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		\$ 3,352			\$ 2,470	* (882)	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	10 NURSING & MEDICAL SUPPLY	\$ 11,328	PHARMCOR, L.L.C.	100.00%	\$ 11,328	\$	15
16	V	22 EMPLOYEE BENEFITS	0	PHARMCOR, L.L.C.	100.00%	0		16
17	V	39 ANCILLARY EXPENSE	20,874	PHARMCOR, L.L.C.	100.00%	20,874		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>		\$ 32,202			\$ 32,202	\$ *	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.

Facility Name & ID Number WOODBIDGE NURSING PAVILION, L # 0034157 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	Maury Aaron	Owner	Administration	24.86	see attached	4.7	9.40	Dynamic sal	\$ 58,806	17-7	1
2	Marshall Mauer	Owner	Administration	13.51	see attached	4.2	8.40	Dynamic sal	45,981	17-7	2
3	Abe Stern	Owner	Administration	4.50	see attached	0.84	1.68	Dynamic sal	37,073	17-7	3
4	Sharon Aaron	Relative	Clerical	0.00	see attached	4.22	10.55	Dynamic sal	5,333	21-7	4
5	Dennis Nehmer	Owner	Maintenance	0.59	see attached	4.22	10.55	Dynamic sal	5,697	6-7	5
6	Sue Koplín	Owner	Administration	0.59	see attached	7.19	15.98	Dynamic sal	10,822	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 163,712		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 WOODBIDGE NURSING PAVILION, LTD. # 0034157 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 WOODBIDGE NURSING PAVILION, LTD. # 0034157 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 DYNAMIC HEALTH CARE CONS.  
 Street Address 3359 W. MAIN STREET  
 City / State / Zip Code SKOKIE, IL. 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

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	5	UTILITIES	PATIENT DAYS	707,726	15	\$ 10,055	\$ 16,071	73,863	\$ 1,049	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	707,726	15	51,362		73,863	5,361	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	707,726	15	1,448		73,863	151	3
4	13	NURSES AIDE TRAINING	PATIENT DAYS	707,726	15	1,550		73,863	162	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	707,726	15	24,272		73,863	2,533	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	707,726	15	10,163		73,863	1,061	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	707,726	15	607,305	465,093	73,863	63,382	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	707,726	15	8,134		73,863	849	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	707,726	15	372		73,863	39	9
10	26	INSURANCE	PATIENT DAYS	707,726	15	9,517		73,863	993	10
11	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	707,726	15	80,498		73,863	8,401	11
12	30	DEPRECIATION	PATIENT DAYS	707,726	15	42,057		73,863	4,389	12
13	32	INTEREST	PATIENT DAYS	707,726	15	30,386		73,863	3,171	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	707,726	15	23,654		73,863	2,469	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	707,726	15	98,401		73,863	10,270	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 999,174	\$ 481,163		\$ 104,280	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION, LTD. # 0034157 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 DYNAMIC HEALTH CARE CONS.  
 Street Address 3359 W. MAIN STREET  
 City / State / Zip Code SKOKIE, IL. 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

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	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	14	54,000	54,000	4	5,697	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	32,209	32,209			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	14	435,842	435,842	4	45,981	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	45	14	558,156	558,156	5	58,806	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	50	7	160,040	160,040			5
6	17	ADMIN. CMP. - A. STERN	WGHTD. AVG. HOURS	8	14	351,664		1	37,073	6
7	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	50	3	179,079	179,079	20	71,632	7
8	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	45	10	67,732	67,732	7	10,822	8
9	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	10	82,127	82,127			9
10	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	45	2	47,882	47,882			10
11	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	3	119,320	119,320			11
12	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	55	14	126,974	126,974	6	13,386	12
13	17	ADMIN. CMP. - A. STEINER	WGHTD. AVG. HOURS	45	14	41,511	41,511	5	4,373	13
14	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	14	178,292	178,292	5	18,784	14
15	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	14	50,548	50,548	4	5,333	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,485,376	\$ 2,133,711		\$ 271,887	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION, LTD. # 0034157 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 DYNAMIC HEALTH CARE CONS.  
 Street Address 3359 W. MAIN STREET  
 City / State / Zip Code SKOKIE, IL. 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

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	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	6,887		4	727	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40	2,883				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	12,175		4	1,284	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	45	14,155		5	1,491	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	50	19,744				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	50	18,514		20	7,406	6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	45	14,423		7	2,304	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	13,516				8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	45	10,284				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45	7,029				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	55	17,400		6	1,834	11
12	27	EMP. BEN.- A. STEINER	WGHTD. AVG. HOURS	45	6,891		5	726	12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	23,984		5	2,527	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	6,917		4	730	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 174,802	\$		\$ 19,029	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION, LTD. # 0034157 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 DYNAMIC REHAB CONSULTANTS, L.L.C.  
 Street Address 3359 W. MAIN STREET  
 City / State / Zip Code SKOKIE, IL. 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

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	10A	THERAPY	DIRECT ALLOCATION					7,989	1
2	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						2
3	39	ANCILLARY SERVICES	DIRECT ALLOCATION					46,945	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				\$	\$		\$ 54,934	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION, LTD. # 0034157 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 LINCOLN MEDICAL SUPPLIES, INC.  
 Street Address 3359 W. MAIN STREET  
 City / State / Zip Code SKOKIE, IL. 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

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	20	DUES, FEES & SUBSCRIPTION	DIRECT ALLOCATION						1	
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION					1,155	2	
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					1,315	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					\$	\$	\$	2,470	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION, LTD. # 0034157 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 PHARMCOR, L.L.C.  
 Street Address 3116 S. OAK PARK  
 City / State / Zip Code BERWYN, IL 60402  
 Phone Number (708)795-7701  
 Fax Number ( )

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	10	NURSING & MEDICAL SUPPL	DIRECT ALLOCATION					11,328	1
2	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					20,874	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					\$	\$	\$ 32,202	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION, LTD. # 0034157 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 WOODBIDGE NURSING PAVILION, LTD. # 0034157 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 WOODBIDGE NURSING PAVILION, LTD. # 0034157 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

**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										
										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																			
2																			
3																			
4																			
5																			
<b>Working Capital</b>																			
6	LaSalle National Bank		X	Line of Credit				670,000		9,5000	35,805	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>							\$ 670,000			\$ 35,805	9							
<b>B. Non-Facility Related*</b>																			
10	Supplemental Schedule											10							
11	Interest Income										(36,306)	11							
12	Allocation from Dynamic										3,171	12							
13												13							
14	<b>TOTAL Non-Facility Related</b>							\$			\$ (33,135)	14							
15	<b>TOTALS (line 9+line14)</b>							\$ 670,000			\$ 2,670	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 WOODBIDGE NURSING PAVILION, LTD.

# 0034157

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		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
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				

Facility Name & ID Number **WOODBIDGE NURSING PAVILION, LTD.**  
 IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)  
 B. Real Estate Taxes

# **0034157** Report Period Beginning: **01/01/00** Ending: **12/31/00**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>256,000</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>251,979</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(4,021)</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>256,000</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>	\$	<b>4,700</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>256,679</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	<b>209,920</b>	8
	1996	<b>215,085</b>	9
	1997	<b>246,815</b>	10
	1998	<b>251,196</b>	11
	1999	<b>249,510</b>	12
<b>2000 Accrual = 1999 Tax + 3%</b>			
<b>\$249,510 x 103% = \$256,000 (rounded)</b>			
<b>Dynamic Allocation = \$2469 (included in line 2)</b>			

  

	<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

NOTES:

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

Facility Name & ID Number WOODBRIDGE NURSING PAVILION, LTD.

# 0034157 Report Period Beginning:

01/01/00 Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,560 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ 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. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number **WOODBIDGE NURSING PAVILION, LTD.**# **0034157**

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	Various		1989		3,000	95	20	150	55	1,712	9
10	Various		1990		20,717	658	20	1,036	378	11,262	10
11	Various		1991		11,182	355	20	559	204	5,356	11
12	Various		1992		14,078	446	20	704	258	6,016	12
13	Various		1993		122,812	3,195	20	6,140	2,945	47,125	13
14	Various		1995		20,549	526	20	1,028	502	5,433	14
15	ELECTRIC PANEL		1996		1,150	29	20	58	29	280	15
16	ELECTRONIC VALVE		1996		3,058	78	20	153	75	689	16
17	CEILING TILES		1996		2,574	66	20	129	63	623	17
18	LIGHT FIXTURES		1996		1,549	40	20	77	37	372	18
19	ROOF REPAIR		1997		9,800	251	20	490	239	1,838	19
20	BUILDING REHAB ROOM		1997		629	16	20	31	15	114	20
21	BUILDING REHAB ROOM		1997		800	21	20	40	19	150	21
22	FRONT OFFICE IMPRV		1997		2,300	59	20	115	56	393	22
23	FIRE ALARM		1997		3,384	87	20	169	82	563	23
24											24
25	PAGE 12-1 REP TOTALS				46,297	1,187		1,323	136	9,700	25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				48,715	2,273		1,814	(459)	1,814	32
33	PAGE 12C TOTALS				49,632	979		2,476	1,497	3,623	33
34	PAGE 12B TOTALS				64,328	1,647		3,220	1,573	6,769	34
35	PAGE 12A TOTALS				32,325	828		1,617	789	5,354	35
36	TOTAL (lines 4 thru 35)				\$ 458,879	\$ 12,836		\$ 21,329	\$ 8,493	\$ 109,186	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 **WOODBIDGE NURSING PAVILION, LTD.**# **0034157**

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		<b>WHIRLPOOL WORK</b>		1997	731	19	20	37	18	130	9
10		<b>INSTAL OF SLIDE DOOR</b>		1997	1,136	29	20	57	28	200	10
11		<b>BUILDING REHAB ROOM</b>		1997	1,973	51	20	99	48	355	11
12		<b>BUILDING REHAB ROOM</b>		1997	1,092	28	20	55	27	211	12
13		<b>BUILDING REHAB ROOM</b>		1997	2,565	66	20	128	62	491	13
14		<b>BUILDING REHAB ROOM</b>		1997	132	3	20	7	4	26	14
15		<b>BUILDING REHAB ROOM</b>		1997	180	5	20	9	4	35	15
16		<b>BUILDING REHAB ROOM</b>		1997	885	23	20	44	21	172	16
17		<b>INSTALL OF WORLPOOL</b>		1997	2,741	70	20	137	67	491	17
18		<b>BUILDING REHAB ROOM</b>		1997	168	4	20	8	4	31	18
19		<b>BUILDING REHAB ROOM</b>		1997	650	17	20	33	16	124	19
20		<b>BUILDING REHAB ROOM</b>		1997	460	12	20	23	11	88	20
21		<b>BUILDING REHAB ROOM</b>		1997	364	9	20	18	9	68	21
22		<b>BUILDING REHAB ROOM</b>		1997	1,162	30	20	58	28	222	22
23		<b>BUILDING REHAB ROOM</b>		1997	448	11	20	22	11	81	23
24		<b>PLUMBING WORK</b>		1997	2,046	52	20	102	50	400	24
25		<b>BUILDING REHAB ROOM</b>		1997	787	20	20	39	19	150	25
26		<b>ZINC SHELVES</b>		1997	1,106	28	20	55	27	174	26
27		<b>BUILDING REHAB ROOM</b>		1997	374	10	20	19	9	73	27
28		<b>GREASE TRAP</b>		1998	1,984	51	20	99	48	281	28
29		<b>TILES</b>		1998	1,495	38	20	75	37	213	29
30		<b>SHEERS</b>		1998	1,915	49	20	96	47	224	30
31		<b>FIRE DAMPERS</b>		1998	495	13	20	25	12	58	31
32		<b>TILES</b>		1998	1,234	32	20	62	30	186	32
33		<b>WALL CLAY PROCESS</b>		1998	595	15	20	30	15	80	33
34		<b>TILES</b>		1998	2,278	58	20	114	56	333	34
35		<b>ROOF</b>		1998	3,329	85	20	166	81	457	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 32,325	\$ 828		\$ 1,617	\$ 789	\$ 5,354	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 **WOODBIDGE NURSING PAVILION, LTD.**# **0034157**

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		<b>FRAME &amp; DRYWALL</b>	1998		750	19	20	38	19	101	9
10		<b>HANDRAIL W/BUMPER</b>	1998		11,827	303	20	591	288	1,478	10
11		<b>BRICK WORK</b>	1998		9,222	236	20	461	225	1,383	11
12		<b>BRICK WORK</b>	1998		632	16	20	32	16	91	12
13		<b>BRICK WORK</b>	1998		589	15	20	29	14	82	13
14		<b>FIRE ALARM</b>	1998		2,035	52	20	102	50	264	14
15		<b>REMODELING</b>	1998		11,872	304	20	594	290	1,337	15
16		<b>DOOR/WALL REPAIRS</b>	1999		690	18	20	35	17	55	16
17		<b>ROOM SIGNS</b>	1999		3,722	95	20	186	91	372	17
18		<b>SHOWER WALLS</b>	1999		720	18	20	36	18	51	18
19		<b>CORNER GUARDS</b>	1999		750	19	20	38	19	63	19
20		<b>INSTALL CERAMIC TILE</b>	1999		720	18	20	36	18	51	20
21		<b>TILING</b>	1999		3,870	99	20	194	95	275	21
22		<b>DRYWALL SUPPLIES</b>	1999		142	4	20	7	3	10	22
23		<b>WOOD DOORS</b>	1999		350	9	20	18	9	26	23
24		<b>DRYWALL SUPPLIES</b>	1999		106	3	20	5	2	7	24
25		<b>DRYWALL SUPPLIES</b>	1999		43	1	20	2	1	3	25
26		<b>CEILING TILES</b>	1999		1,315	34	20	66	32	77	26
27		<b>DOOR/TILING</b>	1999		735	19	20	37	18	62	27
28		<b>INSTALL CERAMIC TILE</b>	1999		720	18	20	36	18	57	28
29		<b>DRYWALL SUPPLIES</b>	1999		731	19	20	37	18	52	29
30		<b>VCT</b>	1999		1,551	40	20	78	38	111	30
31		<b>LIGHT FIXTURES</b>	1999		1,696	43	20	85	42	120	31
32		<b>WALL TILE</b>	1999		773	20	20	39	19	55	32
33		<b>DOOR RESTRICT DEVICE</b>	1999		5,220	134	20	261	127	348	33
34		<b>LIGHTING FIXTURE</b>	1999		2,049	53	20	102	49	119	34
35		<b>TILING</b>	1999		1,498	38	20	75	37	119	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 64,328	\$ 1,647		\$ 3,220	\$ 1,573	\$ 6,769	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 **WOODBIDGE NURSING PAVILION, LTD.**# **0034157**

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		<b>HANDRAILS/GUARDS</b>	1999		570	15	20	29	14	56	9
10		<b>TILING</b>	1999		9,796	251	20	490	239	694	10
11		<b>DRAPES/CORNICES</b>	1999		699	18	20	35	17	70	11
12		<b>CIRCUITS/OUTLETS</b>	1999		1,350	35	20	68	33	119	12
13		<b>DOOR MAGNETS</b>	1999		915	23	20	46	23	81	13
14		<b>FIRE ALARM SYSTEM</b>	1999		2,440	63	20	122	59	224	14
15		<b>TILES/LIGHTS</b>	1999		1,492	38	20	75	37	138	15
16		<b>WALLPAPER</b>	1999		3,929		20	196	196	196	16
17		<b>DOOR SYSTEM</b>	1999		800	21	20	40	19	73	17
18		<b>SECURITY</b>	1999		2,345	60	20	117	57	127	18
19		<b>BOILER TUBING</b>	1999		2,846	73	20	142	69	284	19
20		<b>CARPETING</b>	1999		440	11	20	22	11	44	20
21		<b>FIXTURES</b>	1999		1,058	27	20	53	26	106	21
22		<b>FLOORING</b>	1999		2,599	67	20	130	63	260	22
23		<b>DOOR MAGNETS</b>	1999		645	17	20	32	15	56	23
24		<b>MICROSCAN UNIT</b>	1999		1,323	34	20	66	32	132	24
25		<b>DOOR MAGNETS</b>	1999		2,034	52	20	102	50	179	25
26		<b>PAINT &amp; DECORATIONS</b>	1999		4,239		20	212	212	230	26
27		<b>DOORS/CLOSETS</b>	1999		1,321	34	20	66	32	121	27
28		<b>PAINT/BORDERS</b>	2000		2,885		20	144	144	144	28
29		<b>HANDRAILS &amp; BUMPERS</b>	2000		1,670	41	20	84	43	84	29
30		<b>DUCT DETECTORS</b>	2000		489	11	20	22	11	22	30
31		<b>NEW COIL</b>	2000		1,320	30	20	61	31	61	31
32		<b>REPAIR WALLS</b>	2000		1,611	39	20	81	42	81	32
33		<b>CUBICLE TRACK</b>	2000		175	4	20	9	5	9	33
34		<b>CUBICLE TRACK</b>	2000		125	3	20	6	3	6	34
35		<b>CUBICLE CURTAINS</b>	2000		516	12	20	26	14	26	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 49,632	\$ 979		\$ 2,476	\$ 1,497	\$ 3,623	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 **WOODBIDGE NURSING PAVILION, LTD.**# **0034157**

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		<b>HANDRAILS &amp; BUMPERS</b>	2000		461	12	20	23	11	23	9
10		<b>INSTALL COIL</b>	2000		710	16	20	33	17	33	10
11		<b>FIRE ALARM REPAIRS</b>	2000		362	8	20	17	9	17	11
12		<b>DUCT DETECTORS</b>	2000		986	22	20	45	23	45	12
13		<b>FIRE ALARM REPAIRS</b>	2000		1,361	31	20	62	31	62	13
14		<b>RAILS &amp; COVE BASE</b>	2000		6,000	148	20	300	152	300	14
15		<b>COVE BASE</b>	2000		358	9	20	18	9	18	15
16		<b>PHONE SYSTEM</b>	2000		10,894	1,557	20	136	(1,421)	136	16
17		<b>PAINT/WALLPAPER</b>	2000		780		20	33	33	33	17
18		<b>ELECTRICAL FEED</b>	2000		700	2	20	6	4	6	18
19		<b>WINDOW TREATMENTS</b>	2000		1,377	31	20	63	32	63	19
20		<b>VERTICAL BLINDS</b>	2000		543	13	20	27	14	27	20
21		<b>FIRE ALARM REPAIR</b>	2000		815	11	20	24	13	24	21
22		<b>INSTALL DYNALOCK</b>	2000		1,453	5	20	12	7	12	22
23		<b>CARPETING</b>	2000		2,790	69	20	140	71	140	23
24		<b>WALLPAPER</b>	2000		1,472		20	74	74	74	24
25		<b>CARPETING</b>	2000		7,671	189	20	384	195	384	25
26		<b>ARTWORK</b>	2000		1,813		20	76	76	76	26
27		<b>HVAC REPAIR</b>	2000		893		20	15	15	15	27
28		<b>ELEVATOR CARPET</b>	2000		1,230	28	20	57	29	57	28
29		<b>FIXTURES</b>	2000		793	19	20	40	21	40	29
30		<b>WALLPAPER</b>	2000		483		20	20	20	20	30
31		<b>INSTALL TEST HEADER</b>	2000		2,146	44	20	89	45	89	31
32		<b>CARPET &amp; COVE BASE</b>	2000		2,624	59	20	120	61	120	32
33											33
34											34
35											35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 48,715	\$ 2,273		\$ 1,814	\$ (459)	\$ 1,814	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 **WOODBIDGE NURSING PAVILION, LTD.**

# **0034157**

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	<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.

Facility Name & ID Number **WOODBIDGE NURSING PAVILION, LTD.**

# **0034157**

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	<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.

Facility Name & ID Number **WOODBIDGE NURSING PAVILION, LTD.**

# **0034157**

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 **WOODBIDGE NURSING PAVILION, LTD.**

# **0034157**

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 **WOODBIDGE NURSING PAVILION, LTD.**

# **0034157**

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 **WOODBIDGE NURSING PAVILION, LTD.**

# **0034157**

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	<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.

Facility Name & ID Number **WOODBIDGE NURSING PAVILION, LTD.**

# **0034157**

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			1993	Dynamic alloc	\$ 46,297	\$ 1,187	35	\$ 1,323	\$ 136	\$ 9,700	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>				\$ 46,297	\$ 1,187		\$ 1,323	\$ 136	\$ 9,700	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 **WOODBIDGE NURSING PAVILION, LTD.**

# **0034157**

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	<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.

Facility Name & ID Number WOODBIDGE NURSING PAVILION, LTD. # 0034157 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	\$ 212,836	\$ 14,235	\$ 24,441	\$ 10,206		\$ 117,475	37
38	Current Year Purchases	74,323	12,953	5,726	(7,227)		5,726	38
39	Fully Depreciated Assets	95,401		2,834	2,834		95,401	39
40								40
41	TOTALS	\$ 382,560	\$ 27,188	\$ 33,001	\$ 5,813		\$ 218,602	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 Business	1993 Dodge Truck	1993	\$ 24,451	\$ 1,675	\$	\$ (1,675)	3	\$ 24,451	42
43	Allocation from Dynamic			1,659	319	277	(42)		277	43
44										44
45										45
46	TOTALS			\$ 26,110	\$ 1,994	\$ 277	\$ (1,717)		\$ 24,728	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)	\$ 867,549	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 42,018	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 54,607	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 12,589	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 352,516	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.

WOODBRIDGE NURSING PAVILION, LTD.  
0034157  
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>					
Woodbridge Nursing Pavilion	187,457	11,704	21,955	10,251	105,434
Dynamic Healthcare	25,379	2,531	2,486	(45)	12,041
<b>TOTALS</b>	212,836	14,235	24,441	10,206	117,475

<b>LINE 29: CURRENT YEAR</b>					
Woodbridge Nursing Pavilion	72,564	12,601	5,638	(6,963)	5,638
Dynamic Healthcare	1,759	352	88	(264)	88
<b>TOTALS</b>	74,323	12,953	5,726	(7,227)	5,726

<b>LINE 30: FULLY DEPRECIATED</b>					
Woodbridge Nursing Pavilion	95,401		2,834	2,834	95,401
Dynamic Healthcare					
<b>TOTALS</b>	95,401		2,834	2,834	95,401

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

Woodbridge Nursing Pavilion	355,422	24,305	30,427	6,122	206,473
Dynamic Healthcare	27,138	2,883	2,574	(309)	12,129
<b>TOTALS</b>	382,560	27,188	33,001	5,813	218,602

Facility Name & ID Number **WOODBIDGE NURSING PAVILION, LTD.**

# **0034157**

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: **Woodbridge Building LLC leasing from Palmer Building LLC**

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:		222		\$ 1,092,930			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		222		\$ 1,092,930			7

10. Effective dates of current rental agreement:

Beginning 7/1/1995

Ending 6/30/2015

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

Fiscal Year Ending                      Annual Rent

12.	<u>12/31/2001</u>	\$ <u>1,092,930</u>
13.	<u>12/31/2002</u>	\$ <u>1,092,930</u>
14.	<u>12/31/2003</u>	\$ <u>1,092,930</u>

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

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

9. Option to Buy:  YES  NO Terms: 3/1/2005-2015 \*

**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: \$ 18,308

Description: see attached

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <b>0</b>	21

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

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

**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 checked="" type="checkbox"/> YES <input 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				Dynamic
8 Nurse Aide Competency Tests				allocation
9 TOTALS	\$	\$	\$	\$ 162
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**

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

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

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

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

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	\$		\$ 17,991	\$		\$ 17,991	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,870			2,870	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			26,085			26,085	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				22,537		22,537	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					7,448		7,448	13
14	<b>TOTAL</b>			\$ 0		\$ 46,946	\$ 29,985		\$ 76,931	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	2,238
2 Rentals	4,032
3 Radiology	55
4 Laboratory	1,123
5	
6	
7	
8	
9	
10	
	<u>7,448</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>

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	\$ 226,622	\$ 226,712	1
2 Cash-Patient Deposits	110,646	110,646	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,325,907	1,325,907	3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	47,572	47,572	6
7 Other Prepaid Expenses	925	925	7
8 Accounts Receivable (owners or related parties)	618,563	628,563	8
9 Other(specify): See supplemental schedule	76,053	76,053	9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 2,406,288</b>	<b>\$ 2,416,378</b>	<b>10</b>
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cos	357,795	357,795	15
16 Equipment, at Historical Cost	422,031	422,031	16
17 Accumulated Depreciation (book methods)	(391,713)	(391,713)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	7,949	7,949	19
20 Accumulated Amortization - Organization & Pre-Operating Costs	(7,949)	(7,949)	20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): See supplemental schedule	570	570	23
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 388,683</b>	<b>\$ 388,683</b>	<b>24</b>
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 2,794,971</b>	<b>\$ 2,805,061</b>	<b>25</b>

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 396,321	\$ 396,321	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	110,646	110,646	28
29 Short-Term Notes Payable	670,000	670,000	29
30 Accrued Salaries Payable	284,400	284,400	30
31 Accrued Taxes Payable (excluding real estate taxes)	3,246	3,246	31
32 Accrued Real Estate Taxes(Sch.IX-B)	256,000	256,000	32
33 Accrued Interest Payable	5,270	5,270	33
34 Deferred Compensation			34
35 Federal and State Income Taxes	13,673	13,673	35
<b>Other Current Liabilities(specify):</b>			
36 See supplemental schedule	97,401	97,401	36
37			37
<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 1,836,957</b>	<b>\$ 1,836,957</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43 See supplemental schedule			43
44			44
<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$</b>	<b>45</b>
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 1,836,957</b>	<b>\$ 1,836,957</b>	<b>46</b>
47 <b>TOTAL EQUITY</b> (page 18, line 24)	<b>\$ 958,014</b>	<b>\$ #REF!</b>	<b>47</b>
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 2,794,971</b>	<b>\$ #REF!</b>	<b>48</b>

\*(See instructions.)

STATE OF ILLINOIS

Facility Name & ID Number **WOODBIDGE NURSING PAVILION, LTD.**  
**SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES**

# **0034157**  
 As of **12/31/00**

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

Ending: **12/31/00**

OTHER CURRENT ASSETS:

	<u>Amount</u>	<u>Amount</u>
Real Estate Tax Escrow	74,102	74,102
Employee Loans	1,951	1,951
	<u>76,053</u>	<u>76,053</u>

OTHER CURRENT LIABILITIES:

	<u>Amount</u>	<u>Amount</u>
Due to Other	97,401	97,401
	<u>97,401</u>	<u>97,401</u>

OTHER NON CURRENT ASSETS:

Security Deposit	570	570
	<u>570</u>	<u>570</u>

OTHER NON CURRENT LIABILITIES:

	<u>          </u>	<u>          </u>
--	-------------------	-------------------

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,123,373</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>1999 late journal entry - State Income Tax</b>	<b>(6,459)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,116,914</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>829,000</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>(987,900)</b>	<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>(158,900)</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>958,014</b>	<b>24</b> *

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



**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,216,516	1
2	Discounts and Allowances for all Levels	(273,788)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,942,728	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	211,020	6
7	Oxygen	3,325	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 214,345	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	33,805	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,411	19
20	Radiology and X-Ray	83	20
21	Other Medical Services	122,868	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 158,167	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	36,306	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 36,306	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See supplemental schedule	2,362	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,362	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,353,908	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,186,737	31
32	Health Care	2,260,031	32
33	General Administration	1,446,219	33
<b>B. Capital Expense</b>			
34	Ownership	1,423,912	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	86,131	35
36	Provider Participation Fee	121,878	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,524,908	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	829,000	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 829,000	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 Discounts Earned (adjusted out on page 5)	2,362
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u><u>2,362</u></u>

Facility Name & ID Number **WOODBIDGE NURSING PAVILION, LTD.**

# 0034157

Report Period Beginning: 01/01/00

Ending:

12/31/00

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,990	2,171	\$ 72,431	\$ 33.36	1
2	Assistant Director of Nursing	1,542	1,707	43,159	25.28	2
3	Registered Nurses	34,507	37,317	685,779	18.38	3
4	Licensed Practical Nurses	19,730	21,662	361,899	16.71	4
5	Nurse Aides & Orderlies	93,227	98,975	758,919	7.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,015	2,164	19,566	9.04	9
10	Activity Assistants	15,984	16,358	93,288	5.70	10
11	Social Service Workers	984	992	14,362	14.48	11
12	Dietician					12
13	Food Service Supervisor	3,654	3,851	56,970	14.79	13
14	Head Cook	5,663	6,347	47,093	7.42	14
15	Cook Helpers/Assistants	17,663	18,731	112,312	6.00	15
16	Dishwashers					16
17	Maintenance Workers	5,426	5,820	54,059	9.29	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,931	2,171	82,235	37.88	20
21	Assistant Administrator	2,401	3,403	64,009	18.81	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,775	10,279	94,666	9.21	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	1,944	2,216	21,975	9.92	31
32	Other Health Care(specify)					32
33	Other(specify)	629	653	9,200	14.09	33
34	TOTAL (lines 1 - 33)	219,065	234,817	\$ 2,591,922 *	\$ 11.04	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	349	\$ 7,200	1-3	35
36	Medical Director	72	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,910	10-3	39
40	Physical Therapy Consultant	107	3,736	10A-3	40
41	Occupational Therapy Consultant	89	3,098	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	33	1,155	10A-3	43
44	Activity Consultant	81	3,545	11-3	44
45	Social Service Consultant	76	3,943	12-3	45
46	Other(specify)				46
47	Utilization Review	24	1,200	10-3	47
48					48
49	TOTAL (lines 35 - 48)	831	\$ 30,387		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	5,827	76,567	10-3	52
53	TOTAL (lines 50 - 52)	5,827	\$ 76,567		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>
Marketing	629	653	\$ 9,200	\$ 14.09
	<u>629</u>	<u>653</u>	<u>\$ 9,200</u>	<u>\$ 14.09</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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number **WOODBIDGE NURSING PAVILION, LTD.**# **0034157**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 \$7437
- (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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,394 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? X YES \_\_\_\_\_ NO \_\_\_\_\_
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 121,878  
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. \$ 21,696 Has any meal income been offset against related costs? NO 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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? NONE  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
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: \_\_\_\_\_ 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.