

		FOR OHF USE				

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0034157</u></p> <p>Facility Name: <u>Woodbridge Nursing Pavilion</u></p> <p>Address: <u>2242 N. Kedzie Ave.</u> <u>Chicago</u> <u>60647</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 486-7700</u> Fax # <u>(773) 486-7937</u></p> <p>IDPA ID Number: <u>363585796001</u></p> <p>Date of Initial License for Current Owners: <u>08/01/88</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 722">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 722 1281 828"></td> <td data-bbox="1281 722 1921 766">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1144 766 1281 828"></td> <td data-bbox="1281 766 1921 810">(Title) _____</td> </tr> <tr> <td data-bbox="1144 828 1281 1042">Paid Preparer</td> <td data-bbox="1281 828 1921 888">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 888 1281 1042"></td> <td data-bbox="1281 888 1921 932">(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u></td> </tr> <tr> <td data-bbox="1144 932 1281 1042"></td> <td data-bbox="1281 932 1921 1011">(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td data-bbox="1144 1011 1281 1042"></td> <td data-bbox="1281 1011 1921 1042">(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 N/A

	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	<u>222</u>	Skilled (SNF)	<u>222</u>	<u>81,030</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>222</u>	TOTALS	<u>222</u>	<u>81,030</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	<u>10,201</u>	<u>1,005</u>	<u>4,141</u>	<u>15,347</u>	8
9	SNF/PED					9
10	ICF	<u>53,566</u>	<u>4,020</u>		<u>57,586</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>63,767</u>	<u>5,025</u>	<u>4,141</u>	<u>72,933</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.01%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/01/88 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 25 and days of care provided 3,633

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: 12/31/03 Fiscal Year: 12/31/03

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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
	A. General Services										
1	Dietary	245,262	28,125	7,200	280,587		280,587	(218)	280,369		1
2	Food Purchase		309,268		309,268	(63,364)	245,904	(1,138)	244,766		2
3	Housekeeping	204,797	67,325		272,122		272,122	(880)	271,242		3
4	Laundry	103,135	29,451		132,586		132,586	(2,190)	130,396		4
5	Heat and Other Utilities			181,990	181,990		181,990	1,826	183,816		5
6	Maintenance	79,224	27,365	47,942	154,531		154,531	7,125	161,656		6
7	Other (specify):*							998	998		7
8	TOTAL General Services	632,418	461,534	237,132	1,331,084	(63,364)	1,267,720	5,523	1,273,243		8
	B. Health Care and Programs										
9	Medical Director			3,400	3,400		3,400		3,400		9
10	Nursing and Medical Records	2,336,086	143,749	27,278	2,507,113		2,507,113	(11,777)	2,495,336		10
10a	Therapy		1,173	43,449	44,622		44,622	(240)	44,382		10a
11	Activities	136,028	7,590	4,485	148,103		148,103		148,103		11
12	Social Services	62,148		1,238	63,386		63,386		63,386		12
13	Nurse Aide Training										13
14	Program Transportation			2,067	2,067		2,067		2,067		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,534,262	152,512	81,917	2,768,691		2,768,691	(12,017)	2,756,674		16
	C. General Administration										
17	Administrative	119,837		205,200	325,037		325,037	38,580	363,617		17
18	Directors Fees										18
19	Professional Services			395,134	395,134	(7,552)	387,582	(341,449)	46,133		19
20	Dues, Fees, Subscriptions & Promotions			72,094	72,094		72,094	(43,998)	28,096		20
21	Clerical & General Office Expenses	98,086	2,167	62,167	162,420		162,420	55,975	218,395		21
22	Employee Benefits & Payroll Taxes			547,850	547,850	63,364	611,214	(3,400)	607,814		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,136	1,136		1,136	1,006	2,142		24
25	Other Admin. Staff Transportation			1,710	1,710		1,710	(1,580)	130		25
26	Insurance-Prop.Liab.Malpractice			226,196	226,196		226,196	5,482	231,678		26
27	Other (specify):*							39,981	39,981		27
28	TOTAL General Administration	217,923	2,167	1,511,487	1,731,577	55,812	1,787,389	(249,403)	1,537,986		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,384,603	616,213	1,830,536	5,831,352	(7,552)	5,823,800	(255,897)	5,567,903		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			69,148	69,148		69,148	3,293	72,441			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,989	53,989		53,989	(41,215)	12,774			32
33	Real Estate Taxes			248,018	248,018	7,552	255,570	4,433	260,003			33
34	Rent-Facility & Grounds			1,092,930	1,092,930		1,092,930		1,092,930			34
35	Rent-Equipment & Vehicles			5,157	5,157		5,157	12,207	17,364			35
36	Other (specify):*											36
37	TOTAL Ownership			1,469,242	1,469,242	7,552	1,476,794	(21,282)	1,455,512			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	4,235	125,011	144,907	274,153		274,153	(9,735)	264,418			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,545	121,545		121,545		121,545			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	4,235	125,011	266,452	395,698		395,698	(9,735)	385,963			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,388,838	741,224	3,566,230	7,696,292		7,696,292	(286,914)	7,409,378			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/03

Ending: 12/31/03

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	(2,885)	30		9
10	Interest and Other Investment Income	(47,062)	32		10
11	Discounts, Allowances, Rebates & Refunds	(925)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(213)	02		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	(9,295)	21		18
19	Entertainment				19
20	Contributions	(901)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,306)	21		24
25	Fund Raising, Advertising and Promotional	(37,659)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,238)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,082)	20		28
29	Other-Attach Schedule	(30,050)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (141,616)		\$	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)	(145,298)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (145,298)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (286,914)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Woodridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/03
Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES	Amount	Reference
1 Non-allowable Legal	\$ (276)	19 1
2 I.C.U. COPR	(3,193)	29 2
3 PPA Dues, Fees & Subscriptions	(1,820)	29 3
4 PPA Professional Services Legal	(1,343)	19 4
5 PPA Employee Benefits	(3,400)	22 5
6 Capitalized Repairs & Maintenance	(5,252)	06 6
7 Collections Fees	(1,662)	21 7
8 Out Of State Travel	(767)	25 8
9 Non-allowable Travel	(812)	25 9
10 PPA Radiology Medicare	(3,670)	39 10
11 PPA OT Medicare	(450)	39 11
12 PPA Ambulance Expense Medicare	(383)	39 12
13 PPA Nursing Supplies	(2,423)	10 13
14 PPA Housekeeping Supplies	(880)	02 14
15 PPA Dietary Supplies	(416)	01 15
16 PPA Laundry Supplies	(2,190)	04 16
17 PPA Therapy Consultant	(240)	10a 17
18 PPA Repairs & Maintenance	(750)	06 18
19 Building Computers Franchise Tax	(200)	21 19
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101 Total	(30,850)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157 Report Period Beginning:

01/01/03

Ending:

12/31/03

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)	
	A. General Services													
1	Dietary	(218)											(218)	1
2	Food Purchase	(1,138)											(1,138)	2
3	Housekeeping	(880)											(880)	3
4	Laundry	(2,190)											(2,190)	4
5	Heat and Other Utilities				1,826								1,826	5
6	Maintenance	(6,042)			1,456	11,711							7,125	6
7	Other (specify):*						998						998	7
8	TOTAL General Services	(10,468)			3,282	11,711	998						5,523	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,423)		(9,354)									(11,777)	10
10a	Therapy	(240)											(240)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(2,663)		(9,354)									(12,017)	16
	C. General Administration													
17	Administrative				(205,200)	243,780							38,580	17
18	Directors Fees													18
19	Professional Services	(1,619)			(339,830)								(341,449)	19
20	Fees, Subscriptions & Promotions	(45,655)			1,657								(43,998)	20
21	Clerical & General Office Expenses	(21,701)	(46)		66,803	10,919							55,975	21
22	Employee Benefits & Payroll Taxes	(3,400)											(3,400)	22
23	Inservice Training & Education													23
24	Travel and Seminar				1,006								1,006	24
25	Other Admin. Staff Transportation	(1,580)											(1,580)	25
26	Insurance-Prop.Liab.Malpractice				5,482								5,482	26
27	Other (specify):*				11,420		28,561						39,981	27
28	TOTAL General Administration	(73,955)	(46)		(458,662)	254,699	28,561						(249,403)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(87,086)	(46)	(9,354)	(455,380)	266,410	29,559						(255,897)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **Woodbridge Nursing Pavilion**# **0034157**

Report Period Beginning:

01/01/03

Ending:

12/31/03

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)	
	D. Ownership													
30	Depreciation	(2,885)			6,178								3,293	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(47,062)			5,847								(41,215)	32
33	Real Estate Taxes				4,433								4,433	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles				12,207								12,207	35
36	Other (specify):*													36
37	TOTAL Ownership	(49,947)			28,665								(21,282)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(4,583)		(5,152)									(9,735)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(4,583)		(5,152)									(9,735)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(141,616)	(46)	(14,506)	(426,715)	266,410	29,559						(286,914)	45

Facility Name & ID Number **Woodbridge Nursing Pavilion**

0034157

Report Period Beginning:

01/01/03

Ending:

12/31/03

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		

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		\$	(1,092,930) 1
2	V	34 Rental Expense		Woodbridge Building, LLC		1,092,930	1,092,930 2
3	V	21 Franchise Tax		Woodbridge Building, LLC		200	200 3
4	V	21 Miscellaneous Income	246	Woodbridge Building, LLC			(246) 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		\$ 1,093,176			\$ 1,093,130	\$ * (46) 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 MEDICAL SUPPLIES	37,054	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	27,700	\$ (9,354)	15
16	V	39 ANCILLARY EXPENSE	20,408	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	15,256	(5,152)	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		\$ 57,462			\$ 42,956	\$ * (14,506)	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	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 1,826	\$ 1,826
16	V	6 REPAIRS & MAINT.				1,456	1,456
17	V	7 EMP.BEN. - GEN. SERVICES					
18	V	19 PROFESSIONAL FEES				4,970	4,970
19	V	20 DUES AND SUBSCRIPTIONS				1,657	1,657
20	V	21 CLERICAL & GENERAL				66,803	66,803
21	V	24 SEMINARS AND TRAVEL				1,006	1,006
22	V	26 INSURANCE				5,482	5,482
23	V	27 EMP.BEN. - GEN. ADMIN.				11,420	11,420
24	V	30 DEPRECIATION				6,178	6,178
25	V	32 INTEREST				5,847	5,847
26	V	33 REAL ESTATE TAXES				4,433	4,433
27	V	35 EQUIPMENT RENTAL				12,207	12,207
28	V						
29	V						
30	V	17 Management Fees	205,200				(205,200)
31	V	19 Bookkeeping Fees	344,800				(344,800)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 550,000			\$ 123,285	\$ * (426,715)

* 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%	\$ 11,711	\$ 11,711
16	V	17 ADMIN. CMP. - M. MAUER				65,106	65,106
17	V	17 ADMIN. CMP. - M. AARON				95,823	95,823
18	V	17 ADMIN. CMP. - F. AARON					
19	V	17 ADMIN. CMP. - S. GOLDSTEIN				12,375	12,375
20	V	17 ADMIN. CMP. - S. KOPLIN				17,990	17,990
21	V	17 ADMIN. CMP. - D. MAGAFAS					
22	V	17 ADMIN. CMP. - S. BOGEN					
23	V	17 ADMIN. CMP. - S. LEVY				22,456	22,456
24	V	17 ADMIN. CMP. - HOWARD ALTER					
25	V	17 ADMIN. CMP. - NON-OWNER				30,030	30,030
26	V	21 CLERICAL CMP. - S. AARON				10,919	10,919
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 266,410	\$ * 266,410

* 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	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 998	\$ 998
16	V	27 EMP. BEN.- M. MAUER				2,066	2,066
17	V	27 EMP. BEN.- M. AARON				3,189	3,189
18	V	27 EMP. BEN.- F. AARON					
19	V	27 EMP. BEN.- S. GOLDSTEIN				6,540	6,540
20	V	27 EMP. BEN.- S. KOPLIN				6,806	6,806
21	V	27 EMP. BEN.- D. MAGAFAS					
22	V	27 EMP. BEN.- S. BOGEN					
23	V	27 EMP. BEN.- S. LEVY				3,248	3,248
24	V	27 EMP. BEN.- HOWARD ALTER					
25	V	27 EMP. BEN.- NON-OWNER				4,561	4,561
26	V	27 EMP. BEN. - S. AARON				2,151	2,151
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 29,559	\$ * 29,559

* 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	\$ 30,169	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	\$ 30,169	\$
16	V	19 PROFESSIONAL FEES		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%		
17	V	22 EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%		
18	V	39 ANCILLARY SERVICES	129,701	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	129,701	
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 159,870			\$ 159,870	\$ *

* 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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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		\$			\$	\$ *	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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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		\$			\$	\$ *	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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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		\$			\$	\$ *	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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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		\$			\$	\$ *	39

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	Administrative	24.86%	See Attached	7.82	15.64%	Dynamic Sal	\$ 95,823	17-7	1
2	Marshall Mauer	Owner	Administrative	6.75%	See Attached	6.97	13.94%	Dynamic Sal	65,106	17-7	2
3	Sue Koplin	Owner	Administrative	0.59%	See Attached	10.41	26.04%	Dynamic Sal	17,990	17-7	3
4	Dennis Nehmer	Owner	Maintenance	0.59%	See Attached	7.82	20.00%	Dynamic Sal	11,711	6-7	4
5	Sharon Aaron	Relative	Administrative		See Attached	6.97	18.00%	Dynamic Sal	10,919	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 201,549		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$			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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 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

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 MEDICAL SUPPLIES	DIRECT ALLOCATION						27,700	1
2	39 ANCILLARY EXPENSE	DIRECT ALLOCATION						15,256	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				\$	\$		\$ 42,956	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 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

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	5 UTILITIES	PATIENT DAYS	423,801	12	\$ 10,611	\$	72,933	\$ 1,826	1
2	6 REPAIRS & MAINT.	PATIENT DAYS	423,801	12	8,462		72,933	1,456	2
3	7 EMP.BEN. - GEN. SERVICES	PATIENT DAYS	423,801	12			72,933		3
4	19 PROFESSIONAL FEES	PATIENT DAYS	423,801	12	28,879		72,933	4,970	4
5	20 DUES AND SUBSCRIPTIONS	PATIENT DAYS	423,801	12	9,628		72,933	1,657	5
6	21 CLERICAL & GENERAL	PATIENT DAYS	423,801	12	388,179	279,093	72,933	66,803	6
7	24 SEMINARS AND TRAVEL	PATIENT DAYS	423,801	12	5,844		72,933	1,006	7
8	26 INSURANCE	PATIENT DAYS	423,801	12	31,856		72,933	5,482	8
9	27 EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	423,801	12	66,362		72,933	11,420	9
10	30 DEPRECIATION	PATIENT DAYS	423,801	12	35,898		72,933	6,178	10
11	32 INTEREST	PATIENT DAYS	423,801	12	33,975		72,933	5,847	11
12	33 REAL ESTATE TAXES	PATIENT DAYS	423,801	12	25,761		72,933	4,433	12
13	35 EQUIPMENT RENTAL	PATIENT DAYS	423,801	12	70,935		72,933	12,207	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				\$ 716,390	\$ 279,093		\$ 123,285	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 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

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	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	59,901	59,901	8	11,711	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	373,726	373,726	7	65,106	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	490,141	490,141	8	95,823	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	191,118	191,118			4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	3	49,500	49,500	10	12,375	5
6	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	69,097	69,097	10	17,990	6
7	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	77,417	77,417			7
8	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	11	2	40,545	40,545			8
9	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	128,818	128,818	8	22,456	9
10	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			10
11	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	11	153,735	153,735	9	30,030	11
12	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	62,676	62,676	7	10,919	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,708,674	\$ 1,708,675		\$ 266,410	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 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

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	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,106	8	998	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,858	7	2,066	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	16,312	8	3,189	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	6	32,071			4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	3	26,160	10	6,540	5
6	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	26,142	10	6,806	6
7	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	6,801			7
8	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	11	2	3,320			8
9	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	18,630	8	3,248	9
10	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	4,292			10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	11	23,348	9	4,561	11
12	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	12,346	7	2,151	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					\$ 186,386	\$	\$ 29,559	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 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

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	10A THERAPY	DIRECT ALLOCATION						30,169	1
2	19 PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	22 EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39 ANCILLARY SERVICES	DIRECT ALLOCATION						129,701	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				\$	\$		\$ 159,870	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$			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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$			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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$			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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$			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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
	Working Capital																			
6	LaSalle Bank		X	Line Of Credit							10,299	6								
7	AI Credit Corporation			Insurance Financing							5,391	7								
8	See Supplemental Schedule						889,110				44,146	8								
9	TOTAL Facility Related					\$	\$ 889,110			\$	59,836	9								
	B. Non-Facility Related*																			
10												10								
11	Interest Income										(47,062)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related					\$	\$			\$	(47,062)	14								
15	TOTALS (line 9+line14)					\$	\$ 889,110			\$	12,774	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

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

** 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 Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
A. Directly Facility Related																				
Long-Term																				
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
6											6									
7	TOTAL Long-Term										7									
Working Capital																				
8	Allocated From Dynamic					\$	\$			\$	5,847									
9	LaSalle Bank		X	Note Payable			889,110				38,299									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital						889,110				44,146									
B. Non-Facility Related*																				
15						\$	\$			\$	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

** 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 **Woodbridge Nursing Pavilion**# **0034157** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2002 report.			\$	247,000	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.)			\$	249,451	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	2,451	3
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	250,000	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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	7,552	5
6.	Subtract a refund of real estate taxes. 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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	260,003	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1998	251,196	8	FOR OHF USE ONLY	
		1999	249,510	9	13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
		2000	236,160	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2001	242,302	11	15	LESS REFUND FROM LINE 6 \$ 15
		2002	245,018	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>Accrual 2002 X 1.02</u>						
245,018 x 1.02 =250.000 (Rounded)						
Allocated From Dynamic 4,433						

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Woodbridge Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>13-35-217-015-0000</u>	<u>Long Term Care Property</u>	\$ <u>73,788.20</u>	\$ <u>73,788.20</u>
2. <u>13-35-217-016-0000</u>	<u>Long Term Care Property</u>	\$ <u>97,441.94</u>	\$ <u>97,441.94</u>
3. <u>13-35-217-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>73,788.20</u>	\$ <u>73,788.20</u>
4. <u>10-23-404-059-0000</u>	<u>Dynamic Allocation</u>	\$ <u>26,274.55</u>	\$ <u>4,521.66</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>271,292.89</u>	\$ <u>249,540.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Woodbridge Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157 Report Period Beginning:

01/01/03 Ending:

12/31/03

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1989		3,000		20	150	150	2,162	9
10	Various		1990		20,717		20	1,036	1,036	14,370	10
11	Various		1991		11,182		20	559	559	7,033	11
12	Various		1992		14,078		20	704	(704)	8,129	12
13	Various		1993		122,812		20	6,140	6,140	65,547	13
14	Various		1995		20,549		20	1,028	1,028	8,516	14
15	Various		1996		8,331		20	417	417	3,214	15
16	Various		1997		35,913		20	1,795	1,795	11,967	16
17	Various		1998		50,252		20	2,514	2,514	14,109	17
18	Various		1999		68,242		20	3,416	3,416	15,466	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		76,340	1,967		2,181	214	22,538	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			14,148			(14,148)		68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 431,416	\$ 16,115		\$ 19,940	\$ 2,417	\$ 173,051	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

Page 12B

12/31/03

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 431,416	\$ 16,115		\$ 19,940	\$ 3,825	\$ 173,051	1
2	Carpeting	2000	7,671		20	384	384	1,535	2
3	Carpeting	2000	2,790		20	140	140	559	3
4	Cove Base	2000	358		20	18	18	72	4
5	Fixtures	2000	793		20	40	40	159	5
6	Rails & Cove Base	2000	6,000		20	300	300	1,200	6
7	Duct Detectors	2000	986		20	49	49	193	7
8	Fire Alarm Repairs	2000	1,361		20	68	68	266	8
9	Duct Detectors	2000	489		20	24	24	95	9
10	Fire Alarm Repairs	2000	362		20	18	18	71	10
11	Handrails & Bumpers	2000	1,670		20	84	84	335	11
12	Handrails & Bumpers	2000	461		20	23	23	92	12
13	Cubicle Curtains	2000	516		20	26	26	104	13
14	Cubicle Track	2000	125		20	6	6	25	14
15	Cubicle Track	2000	175		20	9	9	36	15
16	Repair Walls	2000	1,611		20	81	81	323	16
17	New Coil	2000	1,320		20	66	66	259	17
18	Install Coil	2000	710		20	36	36	140	18
19	Elevator Carpet	2000	1,230		20	62	62	242	19
20	Install Test Header	2000	2,146		20	107	107	411	20
21	Carpet & Cove Base	2000	2,624		20	131	131	513	21
22	Window Treatments	2000	1,377		20	69	69	270	22
23	Vertical Blinds	2000	543		20	27	27	108	23
24	Fire Alarm Repair	2000	815		20	41	41	147	24
25	Install Dynalock	2000	1,453		20	73	73	230	25
26	Electrical Feed	2000	700		20	35	35	111	26
27	Wallpaper	2000	1,472		20	74	74	295	27
28	Paint/Borders	2000	2,885		20	144	144	577	28
29	Paint/Wallpaper	2000	780		20	39	39	150	29
30	Wallpaper	2000	483		20	24	24	92	30
31	Artwork	2000	1,813		20	91	91	348	31
32	Hvac Repair	2000	893		20	45	45	149	32
33	Phone System	2000	10,894		20	545	545	1,770	33
34	TOTAL (lines 1 thru 33)		\$ 488,922	\$ 16,115		\$ 22,819	\$ 6,704	\$ 183,928	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 488,922	\$ 16,115		\$ 22,819	\$ 6,704	\$ 183,928	1
2	Water Cooler	2001	531		20	27	27	78	2
3	Roof Repair	2001	1,190		20	60	60	169	3
4	Water Proofing	2001	750		20	38	38	107	4
5	Electric Improv	2001	1,270		20	64	64	164	5
6	Split Heating System	2001	6,360		20	318	318	822	6
7	Furnace	2001	32,000		20	1,600	1,600	4,133	7
8	Chiller Repair	2001	1,180		20	59	59	152	8
9	Tile Floor	2001	1,300		20	65	65	168	9
10	Fire Alarm Wiring	2001	775		20	39	39	98	10
11	Sign	2001	716		20	36	36	90	11
12	Air Cond Coils	2001	2,210		20	111	111	277	12
13	Boiler Tubing	2001	2,851		20	143	143	345	13
14	Tuck Pointing	2001	750		20	38	38	91	14
15	Concrete Paving/Stal	2001	4,754		20	238	238	554	15
16	Fire Alarm Wiring	2001	775		20	39	39	98	16
17	Boiler Tubing	2001	4,916		20	246	246	513	17
18	Electrical Work	2001	605		20	3	3	56	18
19	Compressor	2002	517		20	52	52	86	19
20	Drapery	2002	2,667		20	68	68	114	20
21	Wardrobe Room	2002	18,175		20	466	466	738	21
22	Cooler Unit	2002	900		20	23	23	38	22
23	Air Coil	2002	2,300		20	59	59	93	23
24	Sprinkler Heads	2002	2,455		20	63	63	84	24
25	Motor	2002	1,421		20	36	36	46	25
26	Work Station	2002	11,900		20	305	305	356	26
27	Duct Deflectors	2002	5,986		20	153	153	217	27
28	Therapy Room Improvement	2002	15,746		20	404	404	437	28
29	Tiling/Flooring	2002	18,311		20	470	470	509	29
30	Faucets & Sinks	2002	132		20	3	3	4	30
31	Blinds	2002	262		20	7	7	7	31
32	Fire Alarms	2002	877		20	125	125	240	32
33	Ac Repairs	2002	550		20	55	55	83	33
34	TOTAL (lines 1 thru 33)		\$ 634,054	\$ 16,115		\$ 28,232	\$ 12,117	\$ 194,895	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

Page 12D

12/31/03

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 634,054	\$ 16,115		\$ 28,232	\$ 12,117	\$ 194,895		1
2	Eyewash Machine	863		20	86	86	115		2
3	Elevator Repair	2,696		20	270	270	270		3
4	2 Door Exit Alarms	1,150		20	105	105	105		4
5	Evaporator Coil - Walk-In Cooler	1,350		20	113	113	113		5
6	Heating Coil - Dining Room Air Handler	3,000		20	250	250	250		6
7	Draperies, Curtains	2,714		20	204	204	204		7
8	Carpeting, Cove Base, Built-In Wardrobe	4,037		20	202	202	202		8
9	Light Fixtures	863		20	18	18	18		9
10	Elevator Repair	537		20	13	13	13		10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

Page 12G

12/31/03

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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14									14
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17									17
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

12/31/03

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12J, Carried Forward	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		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
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16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 651,264	\$ 16,115		\$ 29,493	\$ 13,378	\$ 196,185		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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
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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

*Total beds on this schedule must agree with page 2.

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

See Page 12A-BLDG, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Bed(s)*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocation From Dynamic	1993		\$ 76,340	\$ 1,967	35	\$ 2,181	\$ 214	\$ 22,538	4
5										5
6										6
7										7
8										8
Improvement Type**										
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 76,340	\$ 1,967		\$ 2,181	\$ 214	\$ 22,538		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 369,568	\$ 1,681	\$ 35,768	\$ 34,087	10	\$ 183,114	71
72	Current Year Purchases	23,860	54,215	4,407	(49,808)	10	4,407	72
73	Fully Depreciated Assets	146,299				10	146,298	73
74								74
75	TOTALS	\$ 539,727	\$ 55,896	\$ 40,175	\$ (15,721)		\$ 333,819	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	DODGE TRUCK	1993	\$ 24,451	\$ 1,675	\$	(1,675)	5	\$ 24,451	76
77		Allocated From Dynamic		9,688	1,640	2,773	1,133	5	2,773	77
78										78
79										79
80	TOTALS			\$ 34,139	\$ 3,315	\$ 2,773	\$ (542)		\$ 27,224	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,225,130	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,326	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,441	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,885)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 557,228	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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	TOTAL		222		\$ 1,092,930			7

10. Effective dates of current rental agreement:

Beginning 07/01/95
Ending 06/30/15

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2004</u>	\$ <u>1,092,930</u>
13.	<u>/2005</u>	\$ <u>1,092,930</u>
14.	<u>/2006</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: _____ *

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: \$ 17,364 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 4,235		\$ 52,672						\$ 56,907	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,902						6,902	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs			85,333						85,333	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39 - 02	# of prescripts						80,404			80,404	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify): See Supplemental								44,607			44,607	13	
14	TOTAL			\$ 4,235		\$ 144,907		\$ 125,011				\$ 274,153	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 74,083	\$ 74,169	1
2 Cash-Patient Deposits	131,436	131,436	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,222,394	1,222,394	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	83,382	83,382	6
7 Other Prepaid Expenses	1,014	1,014	7
8 Accounts Receivable (owners or related parties)	815,250	825,250	8
9 Other(specify): See Attached Schedule	477	477	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,328,036	\$ 2,338,122	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cost	515,331	515,331	15
16 Equipment, at Historical Cost	552,156	552,156	16
17 Accumulated Depreciation (book methods)	(583,627)	(583,627)	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 Attached Schedule	570	713,147	23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 484,430	\$ 1,197,007	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,812,466	\$ 3,535,129	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 320,444	\$ 320,490	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	140,959	140,959	28
29 Short-Term Notes Payable	889,110	889,110	29
30 Accrued Salaries Payable	337,392	337,392	30
31 Accrued Taxes Payable (excluding real estate taxes)	4,656	4,656	31
32 Accrued Real Estate Taxes(Sch.IX-B)	250,000	250,000	32
33 Accrued Interest Payable	4,180	4,180	33
34 Deferred Compensation			34
35 Federal and State Income Taxes	7,589	7,589	35
Other Current Liabilities(specify):			
36 See Attached Schedule			36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,954,330	\$ 1,954,376	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 See Attached Schedule			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,954,330	\$ 1,954,376	46
47 TOTAL EQUITY(page 18, line 24)	\$ 858,136	\$ 1,580,753	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,812,466	\$ 3,535,129	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 970,859	1
2	Restatements (describe):		2
3	State Replacement Tax	(717)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 970,142	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	420,794	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(532,800)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (112,006)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 858,136	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/03

Ending:

12/31/03

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,903,638	1
2	Discounts and Allowances for all Levels	(780,675)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,122,963	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	719,300	6
7	Oxygen	14,413	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 733,713	8
C. Other Operating Revenue			
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 Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	122,468	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,399	19
20	Radiology and X-Ray	3,245	20
21	Other Medical Services	72,311	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 212,423	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	47,062	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 47,062	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	925	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 925	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,117,086	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,331,084	31
32	Health Care	2,768,691	32
33	General Administration	1,731,577	33
B. Capital Expense			
34	Ownership	1,469,242	34
C. Ancillary Expense			
35	Special Cost Centers	274,153	35
36	Provider Participation Fee	121,545	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,696,292	40
41	Income before Income Taxes (line 30 minus line 40)**	420,794	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 420,794	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/03

Ending:

12/31/03

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,074	2,225	\$ 86,224	\$ 38.75	1
2	Assistant Director of Nursing	1,852	2,066	61,504	29.77	2
3	Registered Nurses	23,891	25,105	628,890	25.05	3
4	Licensed Practical Nurses	25,149	26,855	544,185	20.26	4
5	Nurse Aides & Orderlies	103,836	110,005	990,383	9.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	183	183	4,235	23.14	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,877	2,039	21,866	10.72	9
10	Activity Assistants	15,278	16,215	114,162	7.04	10
11	Social Service Workers	3,778	3,976	62,148	15.63	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,126	42,041	19.77	13
14	Head Cook	6,280	6,806	64,503	9.48	14
15	Cook Helpers/Assistants	17,564	18,296	138,718	7.58	15
16	Dishwashers					16
17	Maintenance Workers	6,163	6,600	79,224	12.00	17
18	Housekeepers	25,982	27,488	204,797	7.45	18
19	Laundry	12,395	13,234	103,135	7.79	19
20	Administrator	1,997	2,126	104,483	49.15	20
21	Assistant Administrator	1,043	1,243	15,354	12.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,443	7,920	98,086	12.38	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	2,019	2,227	24,900	11.18	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	260,793	276,735	\$ 3,388,838 *	\$ 12.25	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	425	\$ 7,200	01-03	35
36	Medical Director	68	3,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	309	9,894	10-03	38
39	Pharmacist Consultant	170	6,800	10-03	39
40	Physical Therapy Consultant	384	13,680	10a-03	40
41	Occupational Therapy Consultant	483	17,159	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	230	12,610	10a-03	43
44	Activity Consultant	99	4,485	11-03	44
45	Social Service Consultant	25	1,238	12-03	45
46	Other(specify)				46
47	UR Review	24	1,200	10-03	47
48					48
49	TOTAL (lines 35 - 48)	2,217	\$ 77,666		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	83	\$ 2,892	10-03	50
51	Licensed Practical Nurses	167	5,870	10-03	51
52	Nurse Aides	31	622	10-03	52
53	TOTAL (lines 50 - 52)	281	\$ 9,384		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Juvenal Gonzales	Administrator	0	\$ 104,483	Workers' Compensation Insurance	\$ 118,222	IDPH License Fee	\$ 4,311	
Steven Goldstein	Asst. Administrator	0	3,500	Unemployment Compensation Insurance	29,463	Advertising: Employee Recruitment	4,311	
Iris Ehrlicher	Asst. Administrator	0	11,854	FICA Taxes	251,890	Health Care Worker Background Check (Indicate # of checks performed <u>3</u>)	32	
				Employee Health Insurance	74,274	ICLTC	12,021	
				Employee Meals	63,364	ICLTC COPE	(3,193)	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising and Promotion	39,740	
				City Tax	7,944	Subscriptions	179	
				Health Insurance-Non Union	42,531	Licenses and Permits	2,590	
				Other Employee Benefits	20,126	See Supplemental Schedule	12,157	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(37,658)	
						Yellow page advertising	(2,082)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 119,837	TOTAL (agree to Schedule V, line 22, col.8)	\$ 607,814	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,097	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Dynamic Healthcare			\$ 205,200				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 205,200					
C. Professional Services								
Vendor/Payee	Type		Amount					
Frost,Ruttenberg&Rothblatt	Accounting		\$ 16,311					
Sachnoff & Weaver, Ltd.	Legal		10,783					
Chicago Legal Clinic	Legal		275					
Personnel Planners	Unemployment Conslt.		4,001					
Dynamic Healthcare Conslt.	Bookkeeping Service		344,800					
Econocare Inc.	Purchasing Conslt.		3,996					
Health Data System	Data Processing		6,073					
Prior Period Adjustment	Legal		1,343				Seminar Expense	1,136
Finkel,Martwick & Colson, PC	Legal		7,552				Allocated From Dynamic	1,006
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 395,134	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	\$ 2,142

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

