

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

I. IDPH Facility ID Number: 0034157

Facility Name: Woodbridge Nursing Pavilion

Address: 2242 North Kedzie Ave Chicago 60647
 Number City Zip Code

County: Cook

Telephone Number: (773) 486-7700 **Fax #** (773) 486-7937

HFS ID Number: 363585796001

Date of Initial License for Current Owners: 08/01/88

Type of Ownership:

<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 _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

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>	

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion# 0034157 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,379</u>	<u>150</u>	<u>6,755</u>	<u>8,284</u>	8
9	SNF/PED					9
10	ICF	<u>58,815</u>	<u>3,282</u>	<u>2,500</u>	<u>64,597</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>60,194</u>	<u>3,432</u>	<u>9,255</u>	<u>72,881</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.94%

D. How many bed-hold days during this year were paid by the Department?

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)

NoneF. 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 _____ 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 6,601Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	290,975	32,626	12,096	335,697		335,697	(370)	335,327			1
2	Food Purchase		328,657		328,657	(67,324)	261,333	(154)	261,178			2
3	Housekeeping	162,550	57,477	128,689	348,716		348,716		348,716			3
4	Laundry	47,847	30,856	85,438	164,141		164,141		164,141			4
5	Heat and Other Utilities			197,267	197,267		197,267	1,888	199,155			5
6	Maintenance	88,304	29,964	63,071	181,339		181,339	19,094	200,433			6
7	Other (specify):*							1,096	1,096			7
8	TOTAL General Services	589,676	479,580	486,561	1,555,817	(67,324)	1,488,493	21,554	1,510,046			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,451,339	140,330	20,673	2,612,342		2,612,342	(4,666)	2,607,676			10
10a	Therapy			583	583		583		583			10a
11	Activities	125,410	6,720	4,584	136,714		136,714		136,714			11
12	Social Services	63,902		2,836	66,738		66,738		66,738			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,640,651	147,050	32,276	2,819,977		2,819,977	(4,666)	2,815,311			16
	C. General Administration											
17	Administrative	151,051			151,051		151,051	157,911	308,962			17
18	Directors Fees											18
19	Professional Services			822,033	822,033	(2,750)	819,283	(732,445)	86,838			19
20	Dues, Fees, Subscriptions & Promotions			66,729	66,729		66,729	(46,584)	20,145			20
21	Clerical & General Office Expenses	110,866	1,795	733,430	846,091		846,091	(601,543)	244,548			21
22	Employee Benefits & Payroll Taxes			563,305	563,305	67,324	630,629		630,629			22
23	Inservice Training & Education											23
24	Travel and Seminar			330	330		330	149	479			24
25	Other Admin. Staff Transportation			6,304	6,304		6,304	933	7,237			25
26	Insurance-Prop.Liab.Malpractice			219,904	219,904		219,904	7,151	227,055			26
27	Other (specify):*							44,585	44,585			27
28	TOTAL General Administration	261,917	1,795	2,412,035	2,675,747	64,574	2,740,321	(1,169,843)	1,570,478			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,492,244	628,425	2,930,872	7,051,541	(2,750)	7,048,791	(1,152,955)	5,895,836			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.

Facility Name & ID Number Woodbridge Nursing Pavilion #0034157 Report Period Beginning: 01/01/06 Ending: 12/31/06

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			111,802	111,802		111,802	259,167	370,969			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,608	83,608		83,608	556,717	640,325			32
33	Real Estate Taxes			239,093	239,093	2,750	241,843	5,796	247,639			33
34	Rent-Facility & Grounds			864,000	864,000		864,000	(864,000)				34
35	Rent-Equipment & Vehicles			10,795	10,795		10,795	10,264	21,059			35
36	Other (specify):*											36
37	TOTAL Ownership			1,309,298	1,309,298	2,750	1,312,048	(32,056)	1,279,992			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		283,488	526,556	810,044		810,044	(3,284)	806,760			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		283,488	648,101	931,589		931,589	(3,284)	928,305			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,492,244	911,913	4,888,271	9,292,428		9,292,428	(1,188,296)	8,104,132			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: 01/01/06

Ending: 12/31/06

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	67,978	30		9
10	Interest and Other Investment Income	(26,362)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	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				18
19	Entertainment				19
20	Contributions	(1,799)	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	(675,591)	21		24
25	Fund Raising, Advertising and Promotional	(40,336)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,607)	20		28
29	Other-Attach Schedule	(52,597)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (730,469)		\$	30

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)	(457,827)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (457,827)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,188,296)		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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
1		1
2		2
3		3
4		4
5		5
6		6
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97		97
98		98
99		99
100		100
101 Total	(52,597)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	(370)											(370)	1
2	Food Purchase	(154)											(154)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,888									1,888	5
6	Maintenance	(1,245)		9,178	11,161								19,094	6
7	Other (specify):*					1,096							1,096	7
8	TOTAL General Services	(1,769)		11,066	11,161	1,096							21,554	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,016)					(3,650)						(4,666)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(1,016)					(3,650)						(4,666)	16
	C. General Administration													
17	Administrative				157,911								157,911	17
18	Directors Fees													18
19	Professional Services	(1,433)	900	(731,912)									(732,445)	19
20	Fees, Subscriptions & Promotions	(47,782)		1,198									(46,584)	20
21	Clerical & General Office Expenses	(697,505)	910	82,335	12,717								(601,543)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(170)		319									149	24
25	Other Admin. Staff Transportation	(900)		1,833									933	25
26	Insurance-Prop.Liab.Malpractice			7,151									7,151	26
27	Other (specify):*			15,374		29,211							44,585	27
28	TOTAL General Administration	(747,790)	1,810	(623,702)	170,628	29,211							(1,169,843)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(750,575)	1,810	(612,636)	181,789	30,307	(3,650)						(1,152,955)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Woodbridge Nursing Pavilion# 0034157

Report Period Beginning:

01/01/06 Ending:12/31/06

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	67,978	175,666	15,523									259,167	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(26,362)	578,535	4,544									556,717	32
33	Real Estate Taxes			5,796									5,796	33
34	Rent-Facility & Grounds		(864,000)										(864,000)	34
35	Rent-Equipment & Vehicles	(216)		10,480									10,264	35
36	Other (specify):*	(21,293)	21,293											36
37	TOTAL Ownership	20,107	(88,506)	36,343									(32,056)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,284)						(3,284)	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						(3,284)						(3,284)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(730,469)	(86,696)	(576,293)	181,789	30,307	(6,934)						(1,188,296)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Woodbridge Building LLC		Bldg. Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 864,000	WoodBridge Building LLC		\$	\$ (864,000)	1
2	V	32 Interest Income	39,496	WoodBridge Building LLC			(39,496)	2
3	V	32 Interest Expense- LaSalle Bank		WoodBridge Building LLC		618,031	618,031	3
4	V	21 Franchise Tax		WoodBridge Building LLC		250	250	4
5	V	19 Accounting Fees		WoodBridge Building LLC		900	900	5
6	V	21 Replacement Tax		WoodBridge Building LLC		660	660	6
7	V	30 Depreciation Expense		WoodBridge Building LLC		175,666	175,666	7
8	V	36 Amort. Of Mortgage Costs		WoodBridge Building LLC		21,293	21,293	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 903,496			\$ 816,800	\$ * (86,696)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion# 0034157Report Period Beginning: 01/01/06Ending: 12/31/06

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%	\$ 1,888	1,888	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.		9,178	9,178	16
17	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.		1,818	1,818	17
18	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.		1,198	1,198	18
19	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.		82,335	82,335	19
20	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.		319	319	20
21	V	25 AUTO EXP.		DYNAMIC HEALTH CARE CONS.		1,833	1,833	21
22	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.		7,151	7,151	22
23	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.		15,374	15,374	23
24	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.		15,523	15,523	24
25	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.		4,544	4,544	25
26	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.		5,796	5,796	26
27	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.		10,480	10,480	27
28	V							28
29	V							29
30	V	19 Bookkeeping Services	733,730				(733,730)	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		\$ 733,730			\$ 157,437	\$ * (576,293)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion# 0034157Report Period Beginning: 01/01/06Ending: 12/31/06

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%	\$ 11,161	11,161	15
16	V	10 DON SALARY - NON-OWNER		DYNAMIC HEALTH CARE CONS.				16
17	V	17 ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.		30,357	30,357	17
18	V	17 ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.		34,540	34,540	18
19	V	17 ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.				19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.		3,022	3,022	20
21	V	17 ADMIN. CMP. - S. KOPLIN		DYNAMIC HEALTH CARE CONS.		19,892	19,892	21
22	V	17 ADMIN. CMP. - D. MAGAFAS		DYNAMIC HEALTH CARE CONS.		21,449	21,449	22
23	V	17 ADMIN. CMP. - S. LEVY		DYNAMIC HEALTH CARE CONS.		29,014	29,014	23
24	V	17 ADMIN. CMP. - HOWARD ALTER		DYNAMIC HEALTH CARE CONS.				24
25	V	17 ADMIN. CMP. - NON-OWNER		DYNAMIC HEALTH CARE CONS.		19,637	19,637	25
26	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.		12,717	12,717	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		\$			\$ 181,789	\$ * 181,789	39

* 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	7	EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 1,096	1,096	15
16	V	15	EMP. BEN - DON SALARY- NON OWNER		DYNAMIC HEALTH CARE CONS.				16
17	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.		2,169	2,169	17
18	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.		3,427	3,427	18
19	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.				19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.		3,503	3,503	20
21	V	27	EMP. BEN.- S. KOPLIN		DYNAMIC HEALTH CARE CONS.		6,300	6,300	21
22	V	27	EMP. BEN.- D. MAGAFAS		DYNAMIC HEALTH CARE CONS.		3,780	3,780	22
23	V	27	EMP. BEN.- S. LEVY		DYNAMIC HEALTH CARE CONS.		2,978	2,978	23
24	V	27	EMP. BEN.- HOWARD ALTER		DYNAMIC HEALTH CARE CONS.				24
25	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.		4,463	4,463	25
26	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.		2,591	2,591	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		\$				\$ 30,307	\$ * 30,307	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10 MEDICAL SUPPLIES	32,502	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	28,852	\$	(3,650)	15
16	V	39 ANCILLARY EXPENSE	29,232	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	25,948		(3,284)	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		\$ 61,734			\$ 54,800	\$ *	(6,934)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		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		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			\$			\$		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		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			\$			\$		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.

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			\$			\$		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.

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			\$			\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Marshall Mauer	Owner	Administrative	6.75%	See Attached	7.14	14.29%	Dynamic Salary	\$ 30,357	17-7	1
2	Maury Aaron	Owner	Administrative	24.86%	See Attached	8.13	16.25%	Dynamic Salary	34,540	17-7	2
3	Diania Magafas	Owner	Administrative	0.59%	See Attached	9.14	20.32%	Dynamic Salary	21,449	17-7	3
4	Dennis Nehmer	Owner	Maintenance	0.59%	See Attached	8.13	20.33%	Dynamic Salary	11,161	6-7	4
5	Sue Koplin	Owner	Administrative	0.59%	See Attached	11.20	28.00%	Dynamic Salary	19,892	17-7	5
6	Sharon Aaron	Owner	Clerical	0.59%	See Attached	7.14	17.85%	Dynamic Salary	12,717	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 130,116		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: 01/01/06

Ending: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	408,951	12	\$ 10,593	\$ 72,881	\$ 1,888	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	408,951	12	51,500	72,881	9,178	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	408,951	12	10,199	72,881	1,818	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	408,951	12	6,724	72,881	1,198	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	408,951	12	461,999	356,210	82,335	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	408,951	12	1,791	72,881	319	6
7	25	AUTO EXP.	PATIENT DAYS	408,951	12	10,284	72,881	1,833	7
8	26	INSURANCE	PATIENT DAYS	408,951	12	40,124	72,881	7,151	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	408,951	12	86,265	72,881	15,374	9
10	30	DEPRECIATION	PATIENT DAYS	408,951	12	87,103	72,881	15,523	10
11	32	INTEREST	PATIENT DAYS	408,951	12	25,499	72,881	4,544	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	408,951	12	32,525	72,881	5,796	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	408,951	12	58,806	72,881	10,480	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					\$ 883,412	\$ 356,210	\$ 157,437	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	54,933	54,933	8	11,161	1
2	10	DON SALARY - NON-OWNWER	WGHTD. AVG. HOURS	40	1	74,145	74,145			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	170,000	170,000	7	30,357	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	170,000	170,000	8	34,540	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	47	6	57,500	57,500			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	27,199	27,199	5	3,022	6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	71,067	71,067	11	19,892	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	105,603	105,603	9	21,449	8
9	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	162,480	162,480	8	29,014	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	9	96,679	96,679	9	19,637	11
12	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	71,245	71,245	7	12,717	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					\$ 1,072,851	\$ 1,072,853		\$ 181,789	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,392	8	1,096	1
2	15	EMP. BEN - DON SALARY- NON	WGHTD. AVG. HOURS	40	1	15,214			2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	12,149	7	2,169	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	16,867	8	3,427	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	47	6	40,734			5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	31,524	5	3,503	6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	22,507	11	6,300	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	18,613	9	3,780	8
9	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	16,678	8	2,978	9
10	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,101			10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	21,972	9	4,463	11
12	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	14,514	7	2,591	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					\$ 217,265	\$	\$ 30,307	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization LINCOLN MEDICAL SUPPLIES, INC.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION					28,852	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					25,948	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				\$	\$		\$ 54,800	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	LaSalle Bank		X	Building			\$ 7,880,000	\$ 7,698,442		\$ 618,031	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	LaSalle Bank		X	Line of Credit				1,586,110		76,176	6									
7	MB Financial		X	Insurance Financing						5,076	7									
8	See Supplemental Schedule							29,386		6,900	8									
9	TOTAL Facility Related						\$ 7,880,000	\$ 9,313,938		\$ 706,183	9									
B. Non-Facility Related*																				
10	Interest Income		X							(26,362)	10									
11	Interest Income- Bld. Co.		X							(39,496)	11									
12											12									
13	See Supplemental Schedule										13									
14	TOTAL Non-Facility Related						\$	\$		\$ (65,858)	14									
15	TOTALS (line 9+line14)						\$ 7,880,000	\$ 9,313,938		\$ 640,325	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:

01/01/06

Ending:

12/31/06

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						
		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	Interest		X	Van Loan			\$	\$ 29,386			\$ 2,356	8						
9	Dynamic Allocation		X								4,544	9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital							29,386			6,900	14						
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.)

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2005 report.		\$ 240,000	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.)		\$ 242,889	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ 2,889	3																																	
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 242,000	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.)		\$ 2,750	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.		\$ 247,639	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td><u>242,302</u></td><td><u>8</u></td></tr> <tr><td>2002</td><td><u>245,018</u></td><td><u>9</u></td></tr> <tr><td>2003</td><td><u>229,603</u></td><td><u>10</u></td></tr> <tr><td>2004</td><td><u>234,704</u></td><td><u>11</u></td></tr> <tr><td>2005</td><td><u>237,093</u></td><td><u>12</u></td></tr> </table>	2001	<u>242,302</u>	<u>8</u>	2002	<u>245,018</u>	<u>9</u>	2003	<u>229,603</u>	<u>10</u>	2004	<u>234,704</u>	<u>11</u>	2005	<u>237,093</u>	<u>12</u>	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2001	<u>242,302</u>	<u>8</u>																																		
2002	<u>245,018</u>	<u>9</u>																																		
2003	<u>229,603</u>	<u>10</u>																																		
2004	<u>234,704</u>	<u>11</u>																																		
2005	<u>237,093</u>	<u>12</u>																																		
FOR BHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
Accrual 2006 = 240000*1.01= \$242889																																				
Line 2 Includes \$5796 From Dynamic																																				

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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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>71,384.97</u>	\$ <u>71,384.97</u>
2. <u>13-35-217-016-0000</u>	<u>Long Term Care Property</u>	\$ <u>94,323.36</u>	\$ <u>94,323.36</u>
3. <u>13-35-217-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>71,384.97</u>	\$ <u>71,384.97</u>
4. <u>10-23-404-059-000</u>	<u>Dynamic Allocation</u>	\$ <u>5,563.28</u>	\$ <u>5,563.28</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>242,656.58</u>	\$ <u>242,656.58</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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

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.

2000 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		\$ <u>_____</u>	\$ <u>_____</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? 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:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,560 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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, CNA 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			<u>2005</u>	<u>\$ 750,000</u>	1
2					2
3	TOTALS			\$ 750,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF 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	2,612	9
10	Various			1990	20,717		20	1,036	1,036	17,477	10
11	Various			1991	11,182		20	559	559	8,711	11
12	Various			1992	14,078		20	704	704	10,241	12
13	Various			1993	122,812		20	6,140	6,140	83,970	13
14	Various			1995	20,549		20	1,028	1,028	11,598	14
15	Various			1996	8,331		20	417	417	4,465	15
16	Various			1997	35,913		20	1,795	1,795	17,355	16
17	Various			1998	50,252		20	2,514	2,514	21,648	17
18	Various			1999	68,242		20	3,416	3,416	25,707	18
19	Various			2000	57,506		20	2,879	2,879	19,506	19
20	Various			2001	62,933		20	3,151	3,151	17,385	20
21	Various			2002	83,062		20	2,375	2,375	10,296	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

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending:

12/31/06

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
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67		6,870,488	175,666		200,658	24,992	835,373	67
68		79,056	2,027		2,259	232	30,116	68
69			111,802			(111,802)		69
70		\$ 7,508,121	\$ 289,495		\$ 229,081	\$ (60,414)	\$ 1,116,460	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:

01/01/06

Ending:

12/31/06

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		\$ 7,508,121	\$ 289,495		\$ 229,081	\$ (60,414)	\$ 1,116,460	1
2	Elevator Repair	2003	2,696		20	270	270	1,079	2
3	2 Door Exit Alarms	2003	1,150		20	115	115	450	3
4	Evaporator Coil - Walk-In Cooler	2003	1,350		20	135	135	518	4
5	Heating Coil - Dining Room Air Handler	2003	3,000		20	300	300	1,150	5
6	Draperies, Curtains	2003	2,714		20	271	271	1,018	6
7	Carpeting, Cove Base, Built-In Wardrobe	2003	4,037		20	404	404	1,413	7
8	Light Fixtures	2003	863		20	43	43	147	8
9	Elevator Repairs	2003	537		20	27	27	94	9
10	Cubicle Curtains And Drapery	2004	16,199		20	1,620	1,620	3,375	10
11	Doors, Painting, Border, Cove Base	2004	81,699		20	8,170	8,170	17,021	11
12	Replace Front Entrance Dynalock	2004	1,657		20	166	166	469	12
13	Delay Egress System - Security Doors	2004	3,662		20	366	366	946	13
14	Roof Repairs	2004	2,030		20	203	203	575	14
15	Elevator Repairs	2004	1,557		20	156	156	389	15
16	Econocare 2Nd Floor Remodeling	2004	5,478		20	548	548	1,141	16
17	Gre & Safety D. Of Smoke	2004	1,800		20	180	180	375	17
18	Paint	2004	1,019		20	102	102	297	18
19	Repair Front Door Dynalock	2004	573		20	57	57	162	19
20	B&G Bearing, Pump And Shaft	2004	562		20	56	56	126	20
21	Repair Hot Water Boiler System	2004	623		20	62	62	140	21
22	Smoke Detector	2005	1,812		20	259	259	518	22
23	Schwartz Bros	2005	1,000		20	100	100	183	23
24	Wallcovering And Cove Base	2005	2,509		20	627	627	2,509	24
25	Masonry Wall	2005	3,950		20	395	395	625	25
26	Flooring, Vct And Cove Base	2005	3,356		20	224	224	354	26
27	Ceiling Fans	2005	1,730		20	346	346	548	27
28	Custom Built-In Wardrobes	2005	47,143		20	4,714	4,714	7,464	28
29	Window Treatments/ Wall Coverings	2005	10,197		20	1,020	1,020	1,614	29
30	Wallcovering And Cove Base	2005	1,627		20	407	407	1,627	30
31	Wiring	2005	2,175		20	218	218	326	31
32	Wiring - Air Conditioners	2005	1,750		20	175	175	248	32
33	Bumper And Corner Guards	2005	924		20	185	185	308	33
34	TOTAL (lines 1 thru 33)		\$ 7,719,500	\$ 289,495		\$ 251,002	\$ (38,493)	\$ 1,163,669	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:

01/01/06

Ending:

12/31/06

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		\$ 7,719,500	\$ 289,495		\$ 251,002	\$ (38,493)	\$ 1,163,669	1
2	Boiler Repair	2005	3,412		20	284	284	308	2
3	Boiler Repair Supplies	2005	967		20	81	81	94	3
4	Elevator Wall Panel	2006	12,329		20	1,130	1,130	1,130	4
5	Dining Room Wall Coverings	2006	37,725		20	34,581	34,581	34,581	5
6	Artwork	2006	2,203		20	184	184	184	6
7	Window Treatments	2006	6,453		20	538	538	538	7
8	Smoke Detectors	2006	1,398		20	133	133	133	8
9	Furnace	2006	1,005		20	101	101	101	9
10	Air Conditioner/Furnace	2006	2,268		20	227	227	227	10
11	Walk-In Cooler Dryers	2006	2,450		20	204	204	204	11
12	Security System	2006	1,875		20	45	45	45	12
13	Elevator Work	2006	29,888		20	1,494	1,494	1,494	13
14	Wall Work For Dining Room	2006	2,396		20	799	799	799	14
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	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:

01/01/06

Ending:

12/31/06

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	
1		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	1
2								2
3								3
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	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:

01/01/06

Ending:

12/31/06

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	
1		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	1
2								2
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33								33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507		1
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4									4
5									5
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507		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:

01/01/06

Ending:

12/31/06

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		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	1
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507		1
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507		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:

01/01/06

Ending:

12/31/06

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	
1		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	1
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33								33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	34

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Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
1		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	1
2								2
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34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	34

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Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
1		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	1
2								2
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33								33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	34

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

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0034157

Report Period Beginning:

01/01/06

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12/31/06

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	
1		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	1
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	34

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0034157

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	34

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Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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33								33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	34

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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	
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33								33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	34

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**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:

01/01/06

Ending:

12/31/06

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	
1		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	1
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	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:

01/01/06

Ending:

12/31/06

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	
1		\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,823,869	\$ 289,495		\$ 290,803	\$ 1,308	\$ 1,203,507	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

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	
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Bed* FOR OHF USE ONLY	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	Building	2005	1975	\$ 6,776,760	\$ 173,756	35	\$ 193,622	\$ 19,866	\$ 816,274	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Roof		2005	74,030		20	4,318	4,318	11,721	9
10	Elevator		2005	2,988		20	1,743	1,743	4,732	10
11	Elevator (Electrical)		2005	16,710		20	975	975	2,646	11
12	Depreciation				1,910			(1,910)		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

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:

01/01/06

Ending:

12/31/06

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)	\$ 6,870,488	\$ 175,666		\$ 200,658	\$ 24,992	\$ 835,373	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:

01/01/06

Ending:

12/31/06

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	Dynamic		1993	1993	\$ 79,056	\$ 2,027		\$ 2,259	\$ 232	\$ 30,116	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

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:

01/01/06

Ending:

12/31/06

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
			79,056		2,259	232	30,116	

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: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 514,166	\$ 124	\$ 56,317	\$ 56,193	10	\$ 290,862	71
72	Current Year Purchases	89,227	10,205	9,703	(502)	10	9,703	72
73	Fully Depreciated Assets	196,232		127	127	10	196,232	73
74								74
75	TOTALS	\$ 799,625	\$ 10,329	\$ 66,147	\$ 55,818		\$ 496,797	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		2005 FORD E350 BUS	2005	\$ 51,639	\$	\$ 9,880	\$ 9,880	5	\$ 15,413	76
77		Dynamic Allocation	Various	30,730	3,167	4,139	972	5	16,242	77
78										78
79										79
80	TOTALS			\$ 82,369	\$ 3,167	\$ 14,019	\$ 10,852		\$ 31,655	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)	\$ 9,455,863	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 302,991	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 370,969	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,978	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,731,959	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 5,059 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	<u>Facility</u>	<u>1994 Dodge Ram Van</u>	\$ _____	\$ <u>5,520</u>	17
18	<u>Dynamic Allocation</u>			<u>10,480</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>16,000</u>	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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA 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 CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs 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 CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 181,077	\$		\$ 181,077	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,984			6,984	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			338,495			338,495	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				224,059		224,059	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						59,429		59,429	13
14	TOTAL			\$		\$ 526,556	\$ 283,488		\$ 810,044	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 CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion# 0034157Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 147,361	\$ 286,849	1
2	Cash-Patient Deposits	121,706	121,706	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,257,423	2,257,423	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	116,213	116,213	6
7	Other Prepaid Expenses	4,221	4,221	7
8	Accounts Receivable (owners or related parties)	756,511	766,511	8
9	Other(specify): <u>See Attached Schedule</u>	275,097	280,154	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,678,532	\$ 3,833,077	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		750,000	13
14	Buildings, at Historical Cost		6,776,760	14
15	Leasehold Improvements, at Historical Cost	821,400	912,140	15
16	Equipment, at Historical Cost	816,267	816,267	16
17	Accumulated Depreciation (book methods)	(960,726)	(1,275,842)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,949	7,949	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,949)	(46,986)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	44,970	864,013	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 721,911	\$ 8,804,301	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,400,443	\$ 12,637,378	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 323,752	\$ 323,752	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	147,515	147,515	28
29	Short-Term Notes Payable	1,615,496	1,615,496	29
30	Accrued Salaries Payable	277,026	277,026	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,903	4,903	31
32	Accrued Real Estate Taxes(Sch.IX-B)	242,000	242,000	32
33	Accrued Interest Payable	8,277	63,660	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,126	10,126	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	63,000	63,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,692,095	\$ 2,747,478	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		7,698,442	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 7,698,442	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,692,095	\$ 10,445,920	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,708,348	\$ 2,191,458	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,400,443	\$ 12,637,378	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,618,549	1
2	Restatements (describe):		2
3	State Replacement Tax	(16,629)	3
4	Rounding	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,601,921	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,416,227	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	(1,309,800)	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)	\$ 106,427	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)	\$ 1,708,348	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion# 0034157Report Period Beginning: 01/01/06Ending: 12/31/06**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	\$ 9,703,925	1
2	Discounts and Allowances for all Levels	(1,909,577)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,794,348	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,704,890	6
7	Oxygen	3,708	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,708,598	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA 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	336,118	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,167	19
20	Radiology and X-Ray	5,648	20
21	Other Medical Services	167,155	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 554,088	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	26,362	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,362	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	625,259	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 625,259	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,708,655	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,555,817	31
32	Health Care	2,819,977	32
33	General Administration	2,675,747	33
B. Capital Expense			
34	Ownership	1,309,298	34
C. Ancillary Expense			
35	Special Cost Centers	810,044	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)*	\$ 9,292,428	40
41	Income before Income Taxes (line 30 minus line 40)**	1,416,227	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,416,227	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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:

01/01/06

Ending:

12/31/06

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	2,165	2,440	\$ 101,130	\$ 41.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,631	16,282	455,911	28.00	3
4	Licensed Practical Nurses	31,681	33,388	756,897	22.67	4
5	CNAs & Orderlies	103,768	111,061	1,107,113	9.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,753	2,018	23,490	11.64	9
10	Activity Assistants	11,817	12,819	101,920	7.95	10
11	Social Service Workers	3,460	3,844	63,902	16.62	11
12	Dietician					12
13	Food Service Supervisor	1,933	2,294	45,587	19.87	13
14	Head Cook	5,272	5,720	62,111	10.86	14
15	Cook Helpers/Assistants	19,508	21,380	183,277	8.57	15
16	Dishwashers					16
17	Maintenance Workers	6,262	7,071	88,304	12.49	17
18	Housekeepers	17,887	19,926	162,550	8.16	18
19	Laundry	4,983	6,073	47,847	7.88	19
20	Administrator	1,853	2,190	131,999	60.27	20
21	Assistant Administrator	365	365	19,052	52.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,964	8,498	110,866	13.05	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	2,061	2,301	30,288	13.16	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	238,363	257,670	\$ 3,492,244 *	\$ 13.55	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	384	\$ 12,096	01-03	35
36	Medical Director	54	3,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	15	640	10-03	38
39	Pharmacist Consultant	164	6,881	10-03	39
40	Physical Therapy Consultant	10	518	10a-03	40
41	Occupational Therapy Consultant	1	52	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	13	10a-03	43
44	Activity Consultant	96	4,584	11-03	44
45	Social Service Consultant	57	2,836	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	782	\$ 31,220		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses	411	13,152	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	411	\$ 13,152		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
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

