

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0034157

Facility Name: Woodbridge Nursing Pavilion

Address: 2242 North Kedzie 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: 8/1/1988

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 01/01/07 to 12/31/07 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) _____
	(Type or Print Name) _____ (Date) _____
	(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: 01/01/07 Ending: 12/31/07

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>768</u>	<u>373</u>	<u>9,138</u>	<u>10,279</u>	8
9	SNF/PED					9
10	ICF	<u>58,160</u>	<u>2,648</u>	<u>496</u>	<u>61,304</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>58,928</u>	<u>3,021</u>	<u>9,634</u>	<u>71,583</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.34%

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)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 08/01/88

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ 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 9,138

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	309,030	32,459	12,096	353,585		353,585		353,585		1
2	Food Purchase		358,777		358,777	(74,679)	284,098	(151)	283,947		2
3	Housekeeping	67,929	12,550	270,624	351,103		351,103		351,103		3
4	Laundry		24,096	180,408	204,504		204,504	(5,555)	198,949		4
5	Heat and Other Utilities			191,173	191,173		191,173	1,785	192,958		5
6	Maintenance	112,912	35,206	65,550	213,668		213,668	23,071	236,739		6
7	Other (specify):*							1,191	1,191		7
8	TOTAL General Services	489,871	463,088	719,851	1,672,810	(74,679)	1,598,131	20,341	1,618,472		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	2,476,102	142,774	69,050	2,687,926		2,687,926	(909)	2,687,017		10
10a	Therapy										10a
11	Activities	133,943	4,939	4,357	143,239		143,239		143,239		11
12	Social Services	64,679		2,160	66,839		66,839		66,839		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,674,724	147,713	80,367	2,902,804		2,902,804	(909)	2,901,895		16
	C. General Administration										
17	Administrative	170,417			170,417		170,417	173,440	343,857		17
18	Directors Fees										18
19	Professional Services			981,941	981,941	(7,619)	974,322	(804,954)	169,369		19
20	Dues, Fees, Subscriptions & Promotions			78,488	78,488		78,488	(54,723)	23,765		20
21	Clerical & General Office Expenses	111,421	1,623	465,298	578,342		578,342	(282,548)	295,794		21
22	Employee Benefits & Payroll Taxes			566,022	566,022	74,679	640,701		640,701		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,466	1,466		1,466	486	1,952		24
25	Other Admin. Staff Transportation			5,844	5,844		5,844	1,775	7,619		25
26	Insurance-Prop.Liab.Malpractice			219,102	219,102		219,102	(30,020)	189,082		26
27	Other (specify):*							50,495	50,495		27
28	TOTAL General Administration	281,838	1,623	2,318,161	2,601,622	67,060	2,668,682	(946,048)	1,722,634		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,446,433	612,424	3,118,379	7,177,236	(7,619)	7,169,617	(926,616)	6,243,001		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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			61,229	61,229		61,229	286,723	347,952		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			110,504	110,504		110,504	534,788	645,292		32
33	Real Estate Taxes			247,209	247,209	7,619	254,828	6,309	261,137		33
34	Rent-Facility & Grounds			864,000	864,000		864,000	(864,000)			34
35	Rent-Equipment & Vehicles			10,102	10,102		10,102	13,582	23,684		35
36	Other (specify):*										36
37	TOTAL Ownership			1,293,044	1,293,044	7,619	1,300,663	(22,598)	1,278,065		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		320,632	872,271	1,192,903		1,192,903	(2,160)	1,190,743		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		320,632	993,816	1,314,448		1,314,448	(2,160)	1,312,288		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,446,433	933,056	5,405,239	9,784,728	(0)	9,784,728	(951,374)	8,833,354		45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

*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:

01/01/07

Ending:

12/31/07

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	BHF 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	(574)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	105,960	30		9
10	Interest and Other Investment Income	(33,441)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(151)	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	(4,665)	21		18
19	Entertainment				19
20	Contributions	(1,000)	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	(374,195)	21		24
25	Fund Raising, Advertising and Promotional	(52,264)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(84,426)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (444,756)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(506,618)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (506,618)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (951,374)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Sch. V Line
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
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92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101 Total	(84,426)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/07

Ending:

12/31/07

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													1
2	Food Purchase	(151)											(151)	2
3	Housekeeping													3
4	Laundry	(5,555)											(5,555)	4
5	Heat and Other Utilities			1,785									1,785	5
6	Maintenance	(3,161)		13,992	12,240								23,071	6
7	Other (specify):*					1,191							1,191	7
8	TOTAL General Services	(8,867)		15,777	12,240	1,191							20,341	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records						(909)						(909)	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						(909)						(909)	16
	C. General Administration													
17	Administrative				173,440								173,440	17
18	Directors Fees													18
19	Professional Services	(8,128)	900	(797,726)									(804,954)	19
20	Fees, Subscriptions & Promotions	(56,094)		1,371									(54,723)	20
21	Clerical & General Office Expenses	(387,345)	250	91,113	13,434								(282,548)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			486									486	24
25	Other Admin. Staff Transportation	(823)		2,598									1,775	25
26	Insurance-Prop.Liab.Malpractice	(33,686)		3,666									(30,020)	26
27	Other (specify):*			18,661		31,834							50,495	27
28	TOTAL General Administration	(486,075)	1,150	(679,831)	186,874	31,834							(946,048)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(494,942)	1,150	(664,054)	199,114	33,025	(909)						(926,616)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	105,960	176,083	4,680									286,723	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(33,441)	562,872	5,357									534,788	32
33	Real Estate Taxes			6,309									6,309	33
34	Rent-Facility & Grounds		(864,000)										(864,000)	34
35	Rent-Equipment & Vehicles			13,582									13,582	35
36	Other (specify):*	(21,293)	21,293											36
37	TOTAL Ownership	51,226	(103,752)	29,928									(22,598)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(1,040)					(1,120)						(2,160)	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	(1,040)					(1,120)						(2,160)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(444,756)	(102,602)	(634,126)	199,114	33,025	(2,029)						(951,374)	45

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/07

Ending:

12/31/07

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 864,000	Woodbridge Building LLC		\$	\$ (864,000)	1
2	V	32 Interest Income	54,877	Woodbridge Building LLC			(54,877)	2
3	V	32 Interest Expense- Lasalle Bank		Woodbridge Building LLC		617,749	617,749	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	30 Depreciation		Woodbridge Building LLC		176,083	176,083	6
7	V	36 Amortization of Mortgage Costs		Woodbridge Building LLC		21,293	21,293	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 918,877			\$ 816,275	\$ * (102,602)	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: 01/01/07Ending: 12/31/07

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%	\$ 1,785	\$ 1,785	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.		13,992	13,992	16
17	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.		5,054	5,054	17
18	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.		1,371	1,371	18
19	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.		91,113	91,113	19
20	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.		486	486	20
21	V	25 AUTO EXP.		DYNAMIC HEALTH CARE CONS.		2,598	2,598	21
22	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.		3,666	3,666	22
23	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.		18,661	18,661	23
24	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.		4,680	4,680	24
25	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.		5,357	5,357	25
26	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.		6,309	6,309	26
27	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.		13,582	13,582	27
28	V							28
29	V	19 Bookkeeping Services	802,780				(802,780)	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		\$ 802,780			\$ 168,654	\$ * (634,126)	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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 12,240	\$	12,240	15
16	V	10 DON SALARY - NON-OWNER		DYNAMIC HEALTH CARE CONS.					16
17	V	17 ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.		33,219		33,219	17
18	V	17 ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.		37,980		37,980	18
19	V	17 ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.					19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.		4,167		4,167	20
21	V	17 ADMIN. CMP. - S. KOPLIN		DYNAMIC HEALTH CARE CONS.		23,850		23,850	21
22	V	17 ADMIN. CMP. - D. MAGAFAS		DYNAMIC HEALTH CARE CONS.		22,295		22,295	22
23	V	17 ADMIN. CMP. - HOWARD ALTER		DYNAMIC HEALTH CARE CONS.					23
24	V	17 ADMIN. CMP. - NON-OWNER		DYNAMIC HEALTH CARE CONS.		20,651		20,651	24
25	V	17 ADMIN. CMP. - CFO NON OWNER		DYNAMIC HEALTH CARE CONS.		31,278		31,278	25
26	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.		13,434		13,434	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		\$			\$ 199,114	\$ *	199,114	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	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 1,191	\$ 1,191	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.		2,423	2,423	17
18	V	27 EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.		3,187	3,187	18
19	V	27 EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.				19
20	V	27 EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.		3,809	3,809	20
21	V	27 EMP. BEN.- S. KOPLIN		DYNAMIC HEALTH CARE CONS.		8,629	8,629	21
22	V	27 EMP. BEN.- D. MAGAFAS		DYNAMIC HEALTH CARE CONS.		1,858	1,858	22
23	V	27 EMP. BEN.- HOWARD ALTER		DYNAMIC HEALTH CARE CONS.				23
24	V	27 EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.		5,057	5,057	24
25	V	27 EMP. BEN.- CFO NON-OWNER		DYNAMIC HEALTH CARE CONS.		4,044	4,044	25
26	V	27 EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.		2,827	2,827	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		\$			\$ 33,025	\$ * 33,025	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	10 MEDICAL SUPPLIES	31,187	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	30,278	(909)	16
17	V	39 ANCILLARY EXPENSE	38,382	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	37,262	(1,120)	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		\$ 69,569			\$ 67,540	\$ * (2,029)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	7.38	14.76%	Dynamic Salary	\$ 33,219	17-7	1
2	Maury Aaron	Owner	Administrative	24.86%	See Attached	8.44	16.88%	Dynamic Salary	37,980	17-7	2
3	Diania Magafas	Owner	Administrative	0.59%	See Attached	10.55	21.10%	Dynamic Salary	22,295	17-7	3
4	Dennis Nehmer	Owner	Maintenance	0.59%	See Attached	8.44	21.10%	Dynamic Salary	12,240	6-7	4
5	Sue Koplín	Owner	Administrative	0.59%	See Attached	10.00	25.00%	Dynamic Salary	23,850	17-7	5
6	Sharon Aaron	Owner	Clerical	0.59%	See Attached	7.39	18.48%	Dynamic Salary	13,434	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 143,018		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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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	388,610	11	\$ 9,690	\$ 71,583	\$ 1,785	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	388,610	11	75,959	71,583	13,992	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	388,610	11	27,437	71,583	5,054	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	388,610	11	7,442	71,583	1,371	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	388,610	11	494,636	380,513	91,113	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	388,610	11	2,640	71,583	486	6
7	25	AUTO EXP.	PATIENT DAYS	388,610	11	14,104	71,583	2,598	7
8	26	INSURANCE	PATIENT DAYS	388,610	11	19,903	71,583	3,666	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	388,610	11	101,305	71,583	18,661	9
10	30	DEPRECIATION	PATIENT DAYS	388,610	11	25,409	71,583	4,680	10
11	32	INTEREST	PATIENT DAYS	388,610	11	29,080	71,583	5,357	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	388,610	11	34,252	71,583	6,309	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	388,610	11	73,733	71,583	13,582	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				\$ 915,590	\$ 380,513		\$ 168,654	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	8	58,010	58,010	8.44	12,240	1
2	10	DON SALARY - NON-OWNWER	WGHTD. AVG. HOURS	40	1	73,306	73,306	-		2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	180,000	180,000	7.38	33,219	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	180,000	180,000	8.44	37,980	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	95,250	95,250	-		5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	37,505	37,505	5.00	4,167	6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	30	3	71,549	71,549	10.00	23,850	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	50	8	105,666	105,666	10.55	22,295	8
9	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		9
10	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	8	97,823	97,823	9.50	20,651	10
11	17	ADMIN. CMP. - CFO NON OWN	WGHTD. AVG. HOURS	45	10	169,480	169,480	8.30	31,278	11
12	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	72,716	72,716	7.39	13,434	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					\$ 1,153,305	\$ 1,153,304		\$ 199,114	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	8	5,643	8.44	1,191	1
2	15	EMP. BEN - DON SALARY- NON	WGHTD. AVG. HOURS	40	1	19,251	-		2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	13,131	7.38	2,423	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	15,105	8.44	3,187	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	43,896	-		5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	34,284	5.00	3,809	6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	30	3	25,887	10.00	8,629	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	50	8	8,807	10.55	1,858	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,120	-		9
10	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	23,953	9.50	5,057	10
11	27	EMP. BEN.- CFO NON-OWNER	WGHTD. AVG. HOURS	45	10	21,910	8.30	4,044	11
12	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	15,300	7.39	2,827	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					\$ 228,287	\$	\$ 33,025	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/07

Ending: 12/31/07

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									1
2	10	MEDICAL SUPPLIES						30,278	2
3	39	ANCILLARY EXPENSE						37,262	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				\$	\$		\$ 67,540	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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	\$ 7,518,442		\$ 617,749	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	LaSalle Bank		X	Line of Credit				1,086,110		105,120	6									
7	MB Financial		X	Insurance Financing						4,054	7									
8	See Supplemental Schedule							11,754		6,687	8									
9	TOTAL Facility Related						\$ 7,880,000	\$ 8,616,307		\$ 733,610	9									
B. Non-Facility Related*																				
10	Interest Income									(33,442)	10									
11	Interest Income Bld. Co.									(54,877)	11									
12											12									
13	See Supplemental Schedule										13									
14	TOTAL Non-Facility Related						\$	\$		\$ (88,319)	14									
15	TOTALS (line 9+line14)						\$ 7,880,000	\$ 8,616,307		\$ 645,291	15									

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

* 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: 01/01/07 Ending: 12/31/07

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			\$	\$ 11,754			\$ 1,330	8						
9	Dynamic Allocation		X								\$ 5,357	9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital											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 2006 report.		\$ 242,000	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.)		\$ 248,518	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 6,518	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 247,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ 7,619	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 \$ 1,649 For 2004 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.		\$ 261,137	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	245,018	8
	2003	229,603	9
	2004	234,704	10
	2005	237,093	11
	2006	242,209	12
Accrual 2006 = 242000*1.026= \$248,518			
Line 2 Includes \$6,309 From Dynamic			
The Real Estate Tax Refund was not offset since it relates to a tax bill which was not used to set a rate.			
	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-35-217-015-0000</u>	<u>Long Term Care Property</u>	\$ <u>73,272.63</u>	\$ <u>73,272.63</u>
2. <u>13-35-217-016-0000</u>	<u>Long Term Care Property</u>	\$ <u>95,663.61</u>	\$ <u>95,663.61</u>
3. <u>13-35-217-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>73,272.63</u>	\$ <u>73,272.63</u>
4. <u>10-23-404-059-000</u>	<u>Dynamic Allocation</u>	\$ <u>33,229.65</u>	\$ <u>6,120.98</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>275,438.52</u>	\$ <u>248,329.85</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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		\$ _____	\$ _____

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:

01/01/07 Ending:

12/31/07

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

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	2,762	9
10	Various			1990	20,717		20	1,036	1,036	18,513	10
11	Various			1991	11,182		20	559	559	9,270	11
12	Various			1992	14,078		20	704	704	10,943	12
13	Various			1993	122,812		20	6,140	6,140	90,111	13
14	Various			1995	20,549		20	1,028	1,028	12,626	14
15	Various			1996	8,331		20	417	417	4,880	15
16	Various			1997	35,913		20	1,795	1,795	19,150	16
17	Various			1998	50,252		20	2,514	2,514	24,161	17
18	Various			1999	68,242		20	3,416	3,416	29,116	18
19	Various			2000	57,506		20	2,879	2,879	22,380	19
20	Various			2001	62,933		20	3,151	3,151	20,529	20
21	Various			2002	83,062		20	2,375	2,375	12,671	21
22	Various			2003	16,347		20	1,565	1,565	7,434	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:

01/01/07

Ending:

12/31/07

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		6,867,500	176,082		198,915	22,833	491,199	67
68		81,712	2,095		2,335	240	33,462	68
69			61,229			(61,229)		69
70		\$ 7,524,136	\$ 239,406		\$ 228,979	\$ (10,427)	\$ 809,207	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:

01/01/07

Ending:

12/31/07

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		\$ 7,524,136	\$ 239,406		\$ 228,979	\$ (10,427)	\$ 809,207	1
2	Cubicle Curtains And Drapery	2004	16,199		20	1,620	1,620	4,995	2
3	Doors, Painting, Border, Cove Base	2004	81,699		20	8,170	8,170	25,191	3
4	Replace Front Entrance Dynalock	2004	1,657		20	166	166	635	4
5	Delay Egress System - Security Doors	2004	3,662		20	366	366	1,312	5
6	Roof Repairs	2004	2,030		20	203	203	778	6
7	Elevator Repairs	2004	1,557		20	156	156	545	7
8	Econocare 2Nd Floor Remodeling	2004	5,478		20	548	548	1,689	8
9	Gre & Safety D. Of Smoke	2004	1,800		20	180	180	555	9
10	Paint	2004	1,019		20	102	102	399	10
11	Repair Front Door Dynalock	2004	573		20	57	57	220	11
12	B&G Bearing, Pump And Shaft	2004	562		20	56	56	183	12
13	Repair Hot Water Boiler System	2004	623		20	62	62	202	13
14	Smoke Detector	2005	1,812		20	259	259	776	14
15	Schwartz Bros	2005	1,000		20	100	100	283	15
16	Wallcovering And Cove Base	2005	2,509		20			2,509	16
17	Masonry Wall	2005	3,950		20	395	395	1,020	17
18	Flooring, Vct And Cove Base	2005	3,356		20	224	224	578	18
19	Ceiling Fans	2005	1,730		20	346	346	894	19
20	Custom Built-In Wardrobes	2005	47,143		20	4,714	4,714	12,179	20
21	Window Treatments/ Wall Coverings	2005	10,197		20	1,020	1,020	2,634	21
22	Wallcovering And Cove Base	2005	1,627		20			1,627	22
23	Wiring	2005	2,175		20	218	218	544	23
24	Wiring - Air Conditioners	2005	1,750		20	175	175	423	24
25	Bumper And Corner Guards	2005	924		20	185	185	493	25
26	Boiler Repair	2005	3,412		20	284	284	592	26
27	Boiler Repair Supplies	2005	967		20	81	81	175	27
28	Elevator Work	2005	29,888		20	1,494	1,494	2,989	28
29	Elevator Wall Panel	2006	12,329		20	1,233	1,233	2,363	29
30	Dining Room Wall Coverings	2006	37,725		20	3,144	3,144	37,725	30
31	Artwork	2006	2,203		20	220	220	404	31
32	Window Treatments	2006	6,453		20	645	645	1,183	32
33	Smoke Detectors	2006	1,398		20	200	200	333	33
34	TOTAL (lines 1 thru 33)		\$ 7,813,543	\$ 239,406		\$ 255,602	\$ 16,196	\$ 915,635	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,813,543	\$ 239,406		\$ 255,602	\$ 16,196	\$ 915,635	1
2	Furnace	2006	1,005		20	201	201	302	2
3	Air Conditioner/Furnace	2006	2,268		20	454	454	680	3
4	Walk-In Cooler Dryers	2006	2,450		20	490	490	694	4
5	Security System	2006	1,875		20	268	268	313	5
6	Wall Work For Dining Room	2006	2,396		20	1,597	1,597	2,396	6
7	Installation Of 2 Passenger Elevator	2007	148,000		20	6,167	6,167	6,167	7
8	Additional Work On 2 Pass. Elevator	2007	875		20	36	36	36	8
9	Addtl Work On 2 Pass. Elevator	2007	9,968		20	415	415	415	9
10	Electric Work On Elevator	2007	15,485		20	645	645	645	10
11	Addtl Elevator Work	2007	2,153		20	81	81	81	11
12	Addtl Elevator Work	2007	2,625		20	98	98	98	12
13	Required Coiler For A/C	2007	710		20	39	39	39	13
14	Rooftop Air Handler For Ac	2007	1,260		20	70	70	70	14
15	Abt Power Supply For Ac	2007	2,832		20	118	118	118	15
16	Cove Base For Resident Room	2007	503		20	38	38	38	16
17	Cubicle Curtain For Resident Room	2007	4,337		20	289	289	289	17
18	Four Security Cameras	2007	4,610		20	165	165	165	18
19	Western Security Systems	2007	2,505		20	60	60	60	19
20	Walk In Freezer	2007	7,845		20	261	261	261	20
21	Security System	2007	1,320		20	16	16	16	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)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,028,565	\$ 239,406		\$ 267,110	\$ 27,704	\$ 928,518	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:

01/01/07

Ending:

12/31/07

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	222		2005	1975	\$ 6,776,760	\$ 173,756	35	\$ 193,622	\$ 19,866	\$ 485,284	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof		2005	2005	74,030	1,898	20	4,318	2,420	4,826	9
10	Elevator (Electrical)		2005	2005	16,710	428	20	975	547	1,089	10
11											11
12											12
13											13
14											14
15											15
16											16
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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:

01/01/07

Ending:

12/31/07

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	
			6,867,500		176,082		198,915	22,833	491,199

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:

01/01/07

Ending:

12/31/07

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	\$ 81,712	\$ 2,095		\$ 2,335	\$ 240	\$ 33,462	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:

01/01/07

Ending:

12/31/07

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
			81,712		2,095	2,335	240	33,462

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: 01/01/07 Ending: 12/31/07

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	\$ 594,877	\$ 92	\$ 67,209	\$ 67,117	10	\$ 358,661	71
72	Current Year Purchases	18,487	524	1,591	1,067	10	1,591	72
73	Fully Depreciated Assets	206,777				10	206,777	73
74								74
75	TOTALS	\$ 820,141	\$ 616	\$ 68,800	\$ 68,184		\$ 567,029	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	\$	\$ 7,763	\$ 7,763	5	\$ 23,175	76
77		Dynamic Allocation	2007	31,763	1,969	4,278	2,309	5	21,066	77
78										78
79										79
80	TOTALS			\$ 83,402	\$ 1,969	\$ 12,041	\$ 10,072		\$ 44,241	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)	\$ 9,682,108	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 241,991	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 347,951	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 105,960	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,539,788	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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 4,988 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	Facility	1994 Dodge Ram Van	\$	\$ 5,114	17
18	Dynamic Allocation			13,582	18
19					19
20					20
21	TOTAL		\$	\$ 18,696	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	\$		\$ 366,144	\$		\$ 366,144	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,745			2,745	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			502,409			502,409	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescripts			973	255,490		256,463	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						65,142		65,142	13
14	TOTAL			\$		\$ 872,271	\$ 320,632		\$ 1,192,903	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: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 519,767	\$ 665,744	1
2	Cash-Patient Deposits	150,439	150,439	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,050,615	2,050,615	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	89,135	89,135	6
7	Other Prepaid Expenses	4,750	4,750	7
8	Accounts Receivable (owners or related parties)	505,625	515,625	8
9	Other(specify): <u>See Attached Schedule</u>	1,757	5,627	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,322,088	\$ 3,481,935	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	1,026,427	1,117,167	15
16	Equipment, at Historical Cost	834,233	834,233	16
17	Accumulated Depreciation (book methods)	(1,021,955)	(1,513,154)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,949	7,949	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,949)	(68,279)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	570	819,613	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 839,275	\$ 8,724,289	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,161,363	\$ 12,206,224	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 370,631	\$ 370,632	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	164,734	164,734	28
29	Short-Term Notes Payable	1,097,864	1,097,864	29
30	Accrued Salaries Payable	279,688	279,688	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,416	48,416	31
32	Accrued Real Estate Taxes(Sch.IX-B)	247,000	247,000	32
33	Accrued Interest Payable		53,001	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,483	10,483	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	258,900	258,900	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,477,716	\$ 2,530,718	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		7,518,442	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)	\$	\$ 7,518,442	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,477,716	\$ 10,049,160	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,683,647	\$ 2,157,064	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,161,363	\$ 12,206,224	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,708,348	1
2	Restatements (describe):		2
3	State Replacement Tax	(6,474)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,701,873	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,113,974	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	(1,132,200)	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)	\$ (18,226)	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)	\$ 1,683,647	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion# 0034157Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 10,135,237	1
2	Discounts and Allowances for all Levels	(3,016,629)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,118,608	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,935,050	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,935,050	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	382,066	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,270	19
20	Radiology and X-Ray	5,123	20
21	Other Medical Services	95,050	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 511,509	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	33,563	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,563	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	299,972	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 299,972	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,898,702	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,672,810	31
32	Health Care	2,902,804	32
33	General Administration	2,601,622	33
B. Capital Expense			
34	Ownership	1,293,044	34
C. Ancillary Expense			
35	Special Cost Centers	1,192,903	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)*	\$ 9,784,728	40
41	Income before Income Taxes (line 30 minus line 40)**	1,113,974	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,113,974	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:

01/01/07

Ending:

12/31/07

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	2,065	2,400	\$ 101,859	\$ 42.44	1
2	Assistant Director of Nursing	412	434	15,413	35.51	2
3	Registered Nurses	12,928	13,729	387,174	28.20	3
4	Licensed Practical Nurses	33,640	36,594	818,791	22.38	4
5	CNAs & Orderlies	98,127	106,719	1,119,785	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,950	2,189	27,298	12.47	9
10	Activity Assistants	11,892	13,353	106,645	7.99	10
11	Social Service Workers	3,175	390	64,679	165.84	11
12	Dietician					12
13	Food Service Supervisor	3,634	3,984	74,472	18.69	13
14	Head Cook	3,953	4,811	42,886	8.91	14
15	Cook Helpers/Assistants	19,572	21,434	191,672	8.94	15
16	Dishwashers					16
17	Maintenance Workers	7,933	9,077	112,912	12.44	17
18	Housekeepers	7,008	8,350	67,929	8.14	18
19	Laundry					19
20	Administrator	1,981	2,406	147,198	61.18	20
21	Assistant Administrator	365	365	23,219	63.61	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,519	8,523	111,421	13.07	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	2,347	2,576	33,080	12.84	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	218,501	237,334	\$ 3,446,433 *	\$ 14.52	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	376	\$ 12,096	01-03	35
36	Medical Director	72	4,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	179	7,504	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	91	4,357	11-03	44
45	Social Service Consultant	40	2,160	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	758	\$ 30,917		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	1,624	61,546	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,624	\$ 61,546		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

