

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>222</u>	Skilled (SNF)	<u>222</u>	<u>81,030</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>222</u>	TOTALS	<u>222</u>	<u>81,030</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>5,012</u>	<u>272</u>	<u>6,305</u>	<u>11,589</u>	8
9	SNF/PED					9
10	ICF	<u>58,299</u>	<u>3,132</u>	<u>708</u>	<u>62,139</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>63,311</u>	<u>3,404</u>	<u>7,013</u>	<u>73,728</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.99%

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 08/01/1988

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 222 and days of care provided 6,305

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	325,180	49,299	10,800	385,279		385,279		385,279		1
2	Food Purchase		377,721		377,721	(76,942)	300,779	(174)	300,605		2
3	Housekeeping	44,859	15,181	281,575	341,615		341,615		341,615		3
4	Laundry		15,962	187,709	203,671		203,671		203,671		4
5	Heat and Other Utilities			175,410	175,410		175,410	1,497	176,907		5
6	Maintenance	93,738	47,988	94,752	236,478		236,478	22,672	259,150		6
7	Other (specify):*							1,319	1,319		7
8	TOTAL General Services	463,777	506,151	750,246	1,720,174	(76,942)	1,643,232	25,314	1,668,546		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	2,856,326	233,903	28,457	3,118,686		3,118,686	(8,889)	3,109,797		10
10a	Therapy	165,176		95,324	260,500		260,500		260,500		10a
11	Activities	149,227	4,871	4,792	158,890		158,890		158,890		11
12	Social Services	120,960		3,230	124,190		124,190		124,190		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,291,689	238,774	136,603	3,667,066		3,667,066	(8,889)	3,658,177		16
	C. General Administration										
17	Administrative	160,752			160,752		160,752	279,436	440,188		17
18	Directors Fees										18
19	Professional Services			906,003	906,003	(2,198)	903,805	(818,651)	85,154		19
20	Dues, Fees, Subscriptions & Promotions			124,270	124,270		124,270	(59,848)	64,422		20
21	Clerical & General Office Expenses	125,764	1,942	559,628	687,334		687,334	(400,054)	287,280		21
22	Employee Benefits & Payroll Taxes			754,850	754,850	76,942	831,792	(53,236)	778,556		22
23	Inservice Training & Education			152	152		152		152		23
24	Travel and Seminar			2,427	2,427		2,427	504	2,931		24
25	Other Admin. Staff Transportation			5,280	5,280		5,280	760	6,040		25
26	Insurance-Prop.Liab.Malpractice			249,044	249,044		249,044	1,305	250,349		26
27	Other (specify):*							80,525	80,525		27
28	TOTAL General Administration	286,516	1,942	2,601,654	2,890,112	74,744	2,964,856	(969,259)	1,995,597		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,041,982	746,867	3,488,503	8,277,352	(2,198)	8,275,154	(952,834)	7,322,320		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			305,022	305,022		305,022	70,192	375,214			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,987	63,987		63,987	238,691	302,678			32
33	Real Estate Taxes			244,027	244,027	2,198	246,225	7,493	253,718			33
34	Rent-Facility & Grounds			864,231	864,231		864,231	(864,000)	231			34
35	Rent-Equipment & Vehicles			12,094	12,094		12,094	13,964	26,058			35
36	Other (specify):*											36
37	TOTAL Ownership			1,489,361	1,489,361	2,198	1,491,559	(533,660)	957,899			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	451,146	271,247		722,393		722,393	(3,201)	719,192			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	451,146	271,247	121,545	843,938		843,938	(3,201)	840,737			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,493,128	1,018,114	5,099,409	10,610,651		10,610,651	(1,489,695)	9,120,956			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	(999)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(112,761)	30		9
10	Interest and Other Investment Income	(42,180)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(174)	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	(15,275)	21		18
19	Entertainment				19
20	Contributions	(200)	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	(487,068)	21		24
25	Fund Raising, Advertising and Promotional	(51,149)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,440)	20		28
29	Other-Attach Schedule	(134,567)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (846,813)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(642,882)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (642,882)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,489,695)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Discounts Earned	\$ (188)	21	1
2	Bank Charges	(17,370)	21	2
3	COPE Dues	(7,030)	20	3
4	Building Company Franchise Tax	(275)	21	4
5	Building Company Amortization	(21,292)	31	5
6	Building Company Accounting Fees	(950)	19	6
7	Building Company Licenses & Fees	(1,000)	20	7
8	Building Company Replacement Taxes	(5,584)	21	8
9	Prior Period - R&M	(9,821)	06	9
10	Prior Period - Professional Fees	(2,829)	19	10
11	Prior Period - Laboratory	(47)	39	11
12	Prior Period - Employee Benefits	(53,236)	22	12
13	Prior Period - Seminars	(110)	24	13
14	Prior Period - Nursing Supplies	(1,638)	10	14
15	Additional R&M	6,359	06	15
16	Non-Allowable Seminar	(475)	24	16
17	Non-Allowable Travel	(261)	25	17
18	Non-Allowable Legal	(559)	19	18
19	Prior Period- Radiology	(248)	39	19
20	Van Insurance Recovery	(1,563)	26	20
21	Non-Care Depreciation	(16,450)	30	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(134,567)		49

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Woodbridge Nursing Pavilion# 0034157

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(174)											(174)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(999)		2,496									1,497	5
6	Maintenance	(3,462)		12,719	13,415								22,672	6
7	Other (specify):*					1,319							1,319	7
8	TOTAL General Services	(4,635)		15,215	13,415	1,319							25,314	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,638)					(7,251)						(8,889)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(1,638)					(7,251)						(8,889)	16
	C. General Administration													
17	Administrative				279,436								279,436	17
18	Directors Fees													18
19	Professional Services	(4,338)	950	(815,263)									(818,651)	19
20	Fees, Subscriptions & Promotions	(61,819)	1,000	971									(59,848)	20
21	Clerical & General Office Expenses	(525,760)	5,859	103,244	16,603								(400,054)	21
22	Employee Benefits & Payroll Taxes	(53,236)											(53,236)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(585)		1,089									504	24
25	Other Admin. Staff Transportation	(261)		1,021									760	25
26	Insurance-Prop.Liab.Malpractice	(1,563)		2,868									1,305	26
27	Other (specify):*			20,049		60,476							80,525	27
28	TOTAL General Administration	(647,562)	7,809	(686,021)	296,039	60,476							(969,259)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(653,835)	7,809	(670,806)	309,454	61,795	(7,251)						(952,834)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Woodbridge Nursing Pavilion# 0034157

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(129,211)	192,532	6,871									70,192	30
31	Amortization of Pre-Op. & Org.	(21,292)	21,292											31
32	Interest	(42,180)	274,687	6,184									238,691	32
33	Real Estate Taxes			7,493									7,493	33
34	Rent-Facility & Grounds		(864,000)										(864,000)	34
35	Rent-Equipment & Vehicles			13,964									13,964	35
36	Other (specify):*													36
37	TOTAL Ownership	(192,683)	(375,489)	34,512									(533,660)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(295)					(2,906)						(3,201)	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	(295)					(2,906)						(3,201)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(846,813)	(367,680)	(636,294)	309,454	61,795	(10,157)						(1,489,695)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 864,000	Woodbridge Building LLC	100.00%	\$	(864,000)	1
2	V	32 Interest Expense		Woodbridge Building LLC	100.00%	274,687	274,687	2
3	V	21 Franchise Tax		Woodbridge Building LLC	100.00%	275	275	3
4	V	30 Depreciation		Woodbridge Building LLC	100.00%	192,532	192,532	4
5	V	31 Amortization of Mort. Costs		Woodbridge Building LLC	100.00%	21,292	21,292	5
6	V	19 Accounting Fees		Woodbridge Building LLC	100.00%	950	950	6
7	V	20 Licenses & Fees		Woodbridge Building LLC	100.00%	1,000	1,000	7
8	V	21 State Replacement Taxes		Woodbridge Building LLC	100.00%	5,584	5,584	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 864,000			\$ 496,320	\$ * (367,680)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 2,496	\$ 2,496
16	V	6 REPAIRS & MAINT.				12,719	12,719
17	V	19 PROFESSIONAL FEES				1,817	1,817
18	V	20 DUES AND SUBSCRIPTIONS				971	971
19	V	21 CLERICAL & GENERAL				103,244	103,244
20	V	24 SEMINARS AND TRAVEL				1,089	1,089
21	V	25 AUTO EXP.				1,021	1,021
22	V	26 INSURANCE				2,868	2,868
23	V	27 EMP.BEN. - GEN. ADMIN.				20,049	20,049
24	V	30 DEPRECIATION				6,871	6,871
25	V	32 INTEREST				6,184	6,184
26	V	33 REAL ESTATE TAXES				7,493	7,493
27	V	35 EQUIPMENT RENTAL				13,964	13,964
28	V						
29	V	19 BOOKKEEPING	817,080				(817,080)
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 817,080			\$ 180,786	\$ * (636,294)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 13,415	\$	13,415	15
16	V	17 ADMIN. CMP. - M. MAUER				36,599		36,599	16
17	V	17 ADMIN. CMP. - M. AARON				41,503		41,503	17
18	V	17 ADMIN. CMP. - F. AARON							18
19	V	17 ADMIN. CMP. - S. GOLDSTEIN				59,089		59,089	19
20	V	17 ADMIN. CMP. - J. AARON							20
21	V	17 ADMIN. CMP. - S. KOPLIN				24,399		24,399	21
22	V	17 ADMIN. CMP. - D. MAGAFAS				34,138		34,138	22
23	V	17 ADMIN. CMP. - HOWARD ALTER							23
24	V	17 ADMIN. CMP. - NON-OWNER-V. DAVIS							24
25	V	17 ADMIN. CMP. - NON-OWNER -VAR.				46,069		46,069	25
26	V	17 ADMIN. CMP. - CFO NON OWNER				37,639		37,639	26
27	V	21 CLERICAL CMP. - S. AARON				16,603		16,603	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		\$			\$ 309,454	\$ *	309,454	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%	\$ 1,319	\$ 1,319
16	V	27 EMP. BEN.- M. MAUER				2,627	2,627
17	V	27 EMP. BEN.- M. AARON				3,426	3,426
18	V	27 EMP. BEN.- F. AARON					
19	V	27 EMP. BEN.- S. GOLDSTEIN				23,580	23,580
20	V	27 EMP. BEN.- J. AARON					
21	V	27 EMP. BEN.- S. KOPLIN				8,513	8,513
22	V	27 EMP. BEN.- D. MAGAFAS				2,212	2,212
23	V	27 EMP. BEN.- HOWARD ALTER					
24	V	27 EMP. BEN.-V. DAVIS					
25	V	27 EMP. BEN.- NON-OWNER				13,000	13,000
26	V	27 EMP. BEN.- CFO NON-OWNER				4,164	4,164
27	V	27 EMP. BEN. - S. AARON				2,954	2,954
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 61,795	\$ * 61,795

* 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	10 MEDICAL SUPPLIES	67,172	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	59,921	(7,251)	16
17	V	39 ANCILLARY EXPENSE	26,920	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	24,014	(2,906)	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		\$ 94,092			\$ 83,935	\$ * (10,157)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

Facility Name & ID Number

Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	6.76%	See Attached	7.51	15.01%	Alloc. Salary	\$ 36,599	17-7	1
2	Maury Aaron	Owner	Administrative	24.86%	See Attached	8.51	17.03%	Alloc. Salary	41,503	17-7	2
3	Diania Magafas	Owner	Administrative	0.59%	See Attached	10.64	21.28%	Alloc. Salary	34,138	17-7	3
4	Dennis Nehmer	Owner	Maintenance	0.59%	See Attached	8.51	21.28%	Alloc. Salary	13,415	6-7	4
5	Sue Koplín	Owner	Administrative	0.59%	See Attached	10.00	25.00%	Alloc. Salary	24,399	17-7	5
6	Sharon Aaron	Owner	Clerical	0.59%	See Attached	7.52	18.77%	Alloc. Salary	16,603	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 166,657		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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	393,498	11	\$ 13,322	\$ 73,728	\$ 2,496	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	393,498	11	67,883	73,728	12,719	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	393,498	11	9,699	73,728	1,817	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	393,498	11	5,183	73,728	971	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	393,498	11	551,031	404,350	103,244	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	393,498	11	5,810	73,728	1,089	6
7	25	AUTO EXP.	PATIENT DAYS	393,498	11	5,452	73,728	1,021	7
8	26	INSURANCE	PATIENT DAYS	393,498	11	15,305	73,728	2,868	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	393,498	11	107,005	73,728	20,049	9
10	30	DEPRECIATION	PATIENT DAYS	393,498	11	36,672	73,728	6,871	10
11	32	INTEREST	PATIENT DAYS	393,498	11	33,003	73,728	6,184	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	393,498	11	39,991	73,728	7,493	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	393,498	11	74,530	73,728	13,964	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					\$ 964,886	\$ 404,350	\$ 180,786	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	63,031	9	13,415	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	195,000	8	36,599	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	195,000	9	41,503	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	106,000			4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	94,542	25	59,089	5
6	17	ADMIN. CMP. - J. AARON	WGHTD. AVG. HOURS	40	1	2,657			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	30	3	73,196	10	24,399	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	50	8	160,425	11	34,138	8
9	17	ADMIN. CMP. - HOWARD ALTI	WGHTD. AVG. HOURS	40	1	12,000			9
10	17	ADMIN. CMP. - NON-OWNER-V	WGHTD. AVG. HOURS	40	1	74,152			10
11	17	ADMIN. CMP. - NON-OWNER -	WGHTD. AVG. HOURS	45	8	216,303	10	46,069	11
12	17	ADMIN. CMP. - CFO NON OWN	WGHTD. AVG. HOURS	45	10	200,543	8	37,639	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	88,338	8	16,603	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					\$ 1,481,187	\$ 1,481,188	\$ 309,454	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	6,197	9	1,319	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	13,995	8	2,627	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	16,097	9	3,426	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	43,678			4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,728	25	23,580	5
6	27	EMP. BEN.- J. AARON	WGHTD. AVG. HOURS	40	1				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	30	3	25,540	10	8,513	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	50	8	10,394	11	2,212	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,079			9
10	27	EMP. BEN.-V. DAVIS	WGHTD. AVG. HOURS	40	1	17,756			10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	61,038	10	13,000	11
12	27	EMP. BEN.- CFO NON-OWNER	WGHTD. AVG. HOURS	45	10	22,185	8	4,164	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	15,719	8	2,954	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					\$ 271,406	\$	\$ 61,795	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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						59,921	2
3	39	ANCILLARY EXPENSE						24,014	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					\$	\$	\$ 83,935	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

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Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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: 01/01/09 Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending:

12/31/09

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	Bank of America		X	Mortgage			\$ 7,880,000	\$ 7,158,442			\$ 274,687	1										
2												2										
3												3										
4												4										
5	See Supplemental Schedule											5										
	Working Capital																					
6	Bank of America		X	Line of Credit				1,100,000			61,014	6										
7	MB Financial		X	Insurance Financing							2,973	7										
8	See Supplemental Schedule										6,184	8										
9	TOTAL Facility Related						\$ 7,880,000	\$ 8,258,442			\$ 344,858	9										
	B. Non-Facility Related*																					
10	Interest Income		X								(42,180)	10										
11												11										
12												12										
13	See Supplemental Schedule											13										
14	TOTAL Non-Facility Related						\$	\$			\$ (42,180)	14										
15	TOTALS (line 9+line14)						\$ 7,880,000	\$ 8,258,442			\$ 302,678	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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:

01/01/09

Ending:

12/31/09

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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term																		
	Working Capital																		
8	Allocated From Dynamic																		
9							\$	\$			\$	6,184							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related																		

* 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:

01/01/09 Ending:

12/31/09

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2005</u>	<u>\$ 750,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 750,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1989	3,000		20	88	88	3,000	9
10	Various		1990	20,717		20	1,036	1,036	20,584	10
11	Various		1991	11,182		20	559	559	10,388	11
12	Various		1992	14,078		20	704	704	12,351	12
13	Various		1993	122,812		20	6,140	6,140	102,391	13
14	Various		1995	20,549		20	1,028	1,028	14,681	14
15	Various		1996	8,331		20	417	417	5,714	15
16	Various		1997	35,913		20	1,795	1,795	22,740	16
17	Various		1998	50,252		20	2,514	2,514	29,185	17
18	Various		1999	68,242		20	3,416	3,416	35,935	18
19	Various		2000	57,506		20	2,879	2,879	28,126	19
20	Various		2001	62,933		20	3,151	3,151	26,820	20
21	Various		2002	83,062		20	2,260	2,260	17,310	21
22	Various		2003	16,347		20	1,565	1,565	10,563	22
23	Various		2004	116,859		20	11,686	11,686	60,075	23
24	Various		2005	112,440		20	9,495	9,495	46,828	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	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	Related Building Company (Pages 12F & 12G)	6,867,500	176,082		198,160	22,078	887,519	67
68	Related Party Allocations (Pages 12H & 12I)	83,115	2,131		2,375	244	38,786	68
69	Financial Statement Depreciation		142,800			(142,800)		69
70	TOTAL (lines 4 thru 69)	\$ 7,754,838	\$ 321,013		\$ 249,268	\$ (71,745)	\$ 1,372,996	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:

01/01/09

Ending:

12/31/09

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		\$ 7,754,838	\$ 321,013		\$ 249,268	\$ (71,745)	\$ 1,372,996	1
2	Elevator Wall Panel	2006	12,329		20	1,233	1,233	4,829	2
3	Dining Room Wall Coverings	2006	37,725		20			37,725	3
4	Artwork	2006	2,203		20	220	220	844	4
5	Window Treatments	2006	6,453		20	645	645	2,474	5
6	Smoke Detectors	2006	1,398		20	200	200	732	6
7	Furnace	2006	1,005		20	201	201	704	7
8	Air Conditioner/Furnace	2006	2,268		20	454	454	1,588	8
9	Walk-In Cooler Dryers	2006	2,450		20	490	490	1,674	9
10	Security System	2006	1,875		20	268	268	848	10
11	Wall Work For Dining Room	2006	2,396		20			2,396	11
12	Installation Of 2 Passanger Elevator	2007	148,000		20	7,400	7,400	20,967	12
13	Additional Work On 2 Pass. Elevator	2007	875		20	44	44	124	13
14	Addtl Work On 2 Pass. Elevator	2007	9,968		20	498	498	1,412	14
15	Electric Work On Elevator	2007	15,485		20	774	774	2,194	15
16	Addtl Elevator Work	2007	2,153		20	108	108	296	16
17	Addtl Elevator Work	2007	2,625		20	131	131	361	17
18	Required Coiler For A/C	2007	710		20	59	59	158	18
19	Rooftop Air Handler For Ac	2007	1,260		20	105	105	280	19
20	Abt Power Supply For Ac	2007	2,832		20	236	236	590	20
21	Cove Base For Resident Room	2007	503		20	50	50	138	21
22	Cubicle Curtain For Resident Room	2007	4,337		20	434	434	1,156	22
23	Four Security Cameras	2007	4,610		20	659	659	1,482	23
24	Western Security Systems	2007	2,505		20	358	358	775	24
25	Walk In Freezer	2007	7,845		20	523	523	1,112	25
26	Security System	2007	1,320		20	189	189	393	26
27	12 Boxes Cove Base W/Toe	2008	963		20	96	96	184	27
28	Parts For Generator	2008	2,949		20	295	295	565	28
29	Fire Alarm System	2008	57,766		20	5,777	5,777	9,146	29
30	Air Handler For A/C System	2008	2,850		20	285	285	451	30
31	Rebuild Generator	2008	13,725		20	1,373	1,373	2,059	31
32	7 Air Conditioners	2008	3,350		20	86	86	125	32
33	Boiler Repair	2008	2,342		20	234	234	312	33
34	TOTAL (lines 1 thru 33)		\$ 8,113,913	\$ 321,013		\$ 272,693	\$ (48,320)	\$ 1,471,090	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,113,913	\$ 321,013		\$ 272,693	\$ (48,320)	\$ 1,471,090	1
2	2008	4,599		20	460	460	767	2
3	2008	7,770		20	1,554	1,554	1,813	3
4	2008	3,525		20	705	705	764	4
5	2009	9,950		20	202	202	202	5
6	2009	5,621		20	90	90	90	6
7	2009	17,141		20	1,143	1,143	1,143	7
8	2009	40,057		20	642	642	642	8
9	2009	51,424		20	824	824	824	9
10	2009	23,100		20	321	321	321	10
11	2009	35,340		20	415	415	415	11
12	2009	80,047		20	924	924	924	12
13	2009	7,630		20	73	73	73	13
14	2009	17,500		20	168	168	168	14
15	2009	17,500		20	168	168	168	15
16	2009	2,955		20	28	28	28	16
17	2009	17,500		20	168	168	168	17
18	2009	9,070		20	24	24	24	18
19	2009	8,125		20	88	88	88	19
20	2009	8,320		20	80	80	80	20
21	2009	17,360		20	19	19	19	21
22	2009	176,726		20	189	189	189	22
23	2009	18,538		20	20	20	20	23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 8,693,711	\$ 321,013		\$ 280,998	\$ (40,015)	\$ 1,480,020	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,693,711	\$ 321,013		\$ 280,998	\$ (40,015)	\$ 1,480,020	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,693,711	\$ 321,013		\$ 280,998	\$ (40,015)	\$ 1,480,020	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,693,711	\$ 321,013		\$ 280,998	\$ (40,015)	\$ 1,480,020	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,693,711	\$ 321,013		\$ 280,998	\$ (40,015)	\$ 1,480,020	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	Building Company Information								1
2	Buildings:								2
3	222 Beds	1975	6,776,760	173,756	35	193,622	19,866	872,528	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Roof	2005	74,030	1,898	20	3,702	1,804	12,230	9
10	Elevator (Electrical)	2005	16,710	428	20	836	408	2,761	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

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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 6,867,500	\$ 176,082		\$ 198,160	\$ 22,078	\$ 887,519	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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Dynamic	1993	83,115	2,131	35	2,375	244	38,786	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 83,115	\$ 2,131		\$ 2,375	\$ 244	\$ 38,786	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:

01/01/09

Ending:

12/31/09

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	\$ 583,335	\$ 106,754	\$ 64,621	\$ (42,133)	10	\$ 430,555	71
72	Current Year Purchases	283,922	42,700	17,091	(25,609)	10	17,091	72
73	Fully Depreciated Assets	249,787		108	108	10	249,603	73
74								74
75	TOTALS	\$ 1,117,044	\$ 149,454	\$ 81,820	\$ (67,634)		\$ 697,249	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2005 FORD E350 BUS	2005	\$ 51,639	\$ 12,768	\$ 6,325	\$ (6,443)	5	\$ 35,826	76
77		Allocated From Dynamic	2009	37,097	4,740	6,071	1,331	5	7,758	77
78										78
79										79
80	TOTALS			\$ 88,736	\$ 17,508	\$ 12,396	\$ (5,112)		\$ 43,584	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)	\$ 10,649,491	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 487,975	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 375,214	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (112,761)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,220,853	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	Building- Section 754 Step-up - 2005	\$ 641,573	\$ 16,450	\$ 78,843	86
87	Land- Section 754 Step-up - 2005	71,004			87
88					88
89					89
90					90
91	TOTALS	\$ 712,577	\$ 16,450	\$ 78,843	91

G. Construction-in-Progress

	Description	Cost	
92	Architecture	\$ 10,291	92
93			93
94			94
95		\$ 10,291	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	Storage Unit				231			5
6								6
7	TOTAL				\$ 231			7

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,797 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 Ran Van	\$ 459.08	\$ 5,509	17
18	Allocated From Dynamic			13,752	18
19					19
20					20
21	TOTAL		\$ 459.08	\$ 19,261	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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		Contract	Total
		1	2		
		Drop-outs	Completed		
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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 178,735		\$	\$					\$ 178,735				1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 01	hrs	272,411											272,411	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescrpts							217,957					217,957	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): <u>See Supplemental</u>									53,290					53,290	13
14	TOTAL			\$ 451,146		\$	\$			\$ 271,247		\$		\$ 722,393		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**

0034157

Report Period Beginning: **01/01/09**

Ending: **12/31/09**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09**

(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	\$ 96,259	\$ 159,930	1
2	Cash-Patient Deposits	164,889	164,889	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,998,306	1,998,306	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	105,156	105,156	6
7	Other Prepaid Expenses	3,232	3,232	7
8	Accounts Receivable (owners or related parties)	706,000	1,070,000	8
9	Other(specify): <u>See Attached Schedule</u>	91,183	91,183	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,165,025	\$ 3,592,696	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	1,691,687	1,782,427	15
16	Equipment, at Historical Cost	1,146,427	1,146,427	16
17	Accumulated Depreciation (book methods)	(1,405,802)	(2,249,166)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,949	7,949	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,949)	(7,949)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	141,088	817,110	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,573,400	\$ 9,023,558	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,738,425	\$ 12,616,254	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 665,035	\$ 923,843	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	188,233	188,233	28
29	Short-Term Notes Payable	1,100,000	1,100,000	29
30	Accrued Salaries Payable	396,736	396,736	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,826	3,826	31
32	Accrued Real Estate Taxes(Sch.IX-B)	247,000	247,000	32
33	Accrued Interest Payable	2,037	(221,835)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	16,807	16,807	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	123,203	123,203	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,742,877	\$ 2,777,813	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		7,158,442	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)	\$	\$ 7,158,442	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,742,877	\$ 9,936,255	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,995,548	\$ 2,679,999	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,738,425	\$ 12,616,254	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,770,850	1
2	Restatements (describe):		2
3	CIP Capitalization/Depreciation Adjustments	(17,101)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,753,749	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,262,999	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	(1,021,200)	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)	\$ 241,799	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)	\$ 1,995,548	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion

0034157

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	\$ 10,742,261	1
2	Discounts and Allowances for all Levels	(2,458,487)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,283,774	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,613,090	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,613,090	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	324,122	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,410	19
20	Radiology and X-Ray	5,314	20
21	Other Medical Services	83,740	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 435,586	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	42,180	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 42,180	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	499,020	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 499,020	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,873,650	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,720,174	31
32	Health Care	3,667,066	32
33	General Administration	2,890,112	33
B. Capital Expense			
34	Ownership	1,489,361	34
C. Ancillary Expense			
35	Special Cost Centers	722,393	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)*	\$ 10,610,651	40
41	Income before Income Taxes (line 30 minus line 40)**	1,262,999	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,262,999	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:

01/01/09

Ending:

12/31/09

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	2,021	2,508	\$ 113,823	\$ 45.38	1
2	Assistant Director of Nursing	45	50	1,081	21.62	2
3	Registered Nurses	16,081	16,490	504,873	30.62	3
4	Licensed Practical Nurses	34,712	37,822	932,601	24.66	4
5	CNAs & Orderlies	107,007	117,201	1,272,891	10.86	5
6	CNA Trainees					6
7	Licensed Therapist	10,627	10,892	451,146	41.42	7
8	Rehab/Therapy Aides	11,341	12,465	165,176	13.25	8
9	Activity Director	1,866	2,186	28,068	12.84	9
10	Activity Assistants	12,683	14,056	121,159	8.62	10
11	Social Service Workers	5,681	6,108	120,960	19.80	11
12	Dietician					12
13	Food Service Supervisor	3,729	4,368	88,766	20.32	13
14	Head Cook	3,820	4,458	42,866	9.62	14
15	Cook Helpers/Assistants	18,942	20,812	193,548	9.30	15
16	Dishwashers					16
17	Maintenance Workers	6,136	7,092	93,738	13.22	17
18	Housekeepers	4,965	5,390	44,859	8.32	18
19	Laundry					19
20	Administrator	1,939	2,481	141,700	57.11	20
21	Assistant Administrator	285	285	19,052	66.85	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,781	7,923	125,764	15.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,791	2,087	31,057	14.88	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	250,452	274,674	\$ 4,493,128 *	\$ 16.36	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	338	\$ 10,800	01-03	35
36	Medical Director	72	4,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	181	7,599	10-03	38
39	Pharmacist Consultant	243	10,206	10-03	39
40	Physical Therapy Consultant	1,267	64,634	10a-03	40
41	Occupational Therapy Consultant	602	30,690	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	4,792	11-03	44
45	Social Service Consultant	60	3,230	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,859	\$ 136,751		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	299	10,652	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	299	\$ 10,652		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jay Gonzalez	Administrator	0.00%	\$ 141,700	Workers' Compensation Insurance	\$ 74,886	IDPH License Fee	\$	
Steve Goldstein	Asst. Admin.	0.00%	19,052	Unemployment Compensation Insurance	27,025	Advertising: Employee Recruitment	26,793	
				FICA Taxes	336,311	Health Care Worker Background Check (Indicate # of checks performed <u>2004</u>)	20,038	
				Employee Health Insurance	239,740	Patient Background Checks		
				Employee Meals	76,942	Advertising & Promotions	53,590	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	13,271	
				Chicago Head Tax	7,218	Licenses & Permits	3,348	
				Other Employee Benefits	16,434	Allocation From Dynamic	971	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 160,752	TOTAL (agree to Schedule V, line 22, col.8)		\$ 64,422		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising (51,149)	
			\$				Yellow page advertising (2,440)	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services							Description	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount	
Frost, Ruttenberg & Rothblatt	Accounting		\$ 12,933			\$	Out-of-State Travel \$	
See Attached	Legal		53,868					
Health Data Systems	Data Processing		12,927					
Casamba	Data Processing		2,100				In-State Travel	
Dynamic HC Consultants	Bookkeeping		817,080					
Geodetic	Surveyor		400					
Personnel Planners	Unemployment Consult		1,668				Seminar Expense 1,842	
Prior Period Professional Serv.	Adjusted on Page 5A		2,829				Allocated From Dynamic 1,089	
Skidelsky & Associates	Legal- RE Tax Appeal		2,080					
Finkel, Martwick & Colson	Legal- RE Tax Appeal		118				Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 906,003	TOTAL			\$ 2,931	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2006					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion# 0034157Report Period Beginning: 01/01/09Ending: 12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$8,767
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,183 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 121,545
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 76,942 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.