

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 N. Kedzie Ave. Chicago 60647
Number City Zip Code

County: Cook

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

HFS ID Number:

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

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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) _____
(Title) _____

Paid
Preparer

(Signed) _____
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

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>81,252</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>81,252</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,818</u>	<u>182</u>	<u>7,685</u>	<u>11,685</u>	8
9	SNF/PED					9
10	ICF	<u>59,206</u>	<u>1,457</u>	<u>767</u>	<u>61,430</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>63,024</u>	<u>1,639</u>	<u>8,452</u>	<u>73,115</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.99%

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 08/01/1988 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 7,685

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: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number **Woodbridge Nursing Pavilion** # **0034157** Report Period Beginning: **01/01/12** Ending: **12/31/12**
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	337,961	36,456	11,448	385,865		385,865		385,865			1
2	Food Purchase		411,644		411,644	(84,528)	327,116	(92)	327,024			2
3	Housekeeping		621	282,000	282,621		282,621		282,621			3
4	Laundry		11,938	192,000	203,938		203,938		203,938			4
5	Heat and Other Utilities			176,251	176,251		176,251	(609)	175,642			5
6	Maintenance	116,612	92,960	93,148	302,720		302,720	82,471	385,191			6
7	Other (specify):*							1,678	1,678			7
8	TOTAL General Services	454,573	553,619	754,847	1,763,039	(84,528)	1,678,511	83,448	1,761,959			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,186,181	244,821	21,077	3,452,079		3,452,079	(6,165)	3,445,914			10
10a	Therapy	111,309			111,309		111,309		111,309			10a
11	Activities	133,817	6,344	2,200	142,361		142,361		142,361			11
12	Social Services	232,496		3,968	236,464		236,464		236,464			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,663,803	251,165	51,245	3,966,213		3,966,213	(6,165)	3,960,048			16
	C. General Administration											
17	Administrative	119,553			119,553		119,553	307,664	427,217			17
18	Directors Fees											18
19	Professional Services			1,024,551	1,024,551	(15,105)	1,009,446	(889,325)	120,121			19
20	Dues, Fees, Subscriptions & Promotions			117,604	117,604		117,604	(76,593)	41,011			20
21	Clerical & General Office Expenses	70,184	1,197	951,423	1,022,804		1,022,804	(784,818)	237,986			21
22	Employee Benefits & Payroll Taxes			810,346	810,346	84,528	894,874		894,874			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,413	6,413		6,413	4,812	11,225			24
25	Other Admin. Staff Transportation			20,420	20,420		20,420	130	20,550			25
26	Insurance-Prop.Liab.Malpractice			251,113	251,113		251,113	10,496	261,609			26
27	Other (specify):*							81,693	81,693			27
28	TOTAL General Administration	189,737	1,197	3,181,870	3,372,804	69,423	3,442,227	(1,345,941)	2,096,286			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,308,113	805,981	3,987,962	9,102,056	(15,105)	9,086,951	(1,268,658)	7,818,293			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			88,650	88,650		88,650	403,424	492,074			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,027	71,027		71,027	440,047	511,074			32
33	Real Estate Taxes					15,105	15,105	251,101	266,206			33
34	Rent-Facility & Grounds			1,357,593	1,357,593		1,357,593	(1,354,090)	3,503			34
35	Rent-Equipment & Vehicles			6,090	6,090		6,090	17,230	23,320			35
36	Other (specify):*							52,586	52,586			36
37	TOTAL Ownership			1,523,360	1,523,360	15,105	1,538,465	(189,702)	1,348,763			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	577,867	318,299	983	897,149		897,149	(614)	896,535			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			518,699	518,699		518,699		518,699			42
43	Other (specify):*	82,058		332	82,390		82,390	(82,390)				43
44	TOTAL Special Cost Centers	659,925	318,299	520,014	1,498,238		1,498,238	(83,004)	1,415,234			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,968,038	1,124,280	6,031,336	12,123,654		12,123,654	(1,541,364)	10,582,290			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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(2,690)	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	77,917	30		9
10	Interest and Other Investment Income	(49,091)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(92)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,500)	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	(529,000)	21		24
25	Fund Raising, Advertising and Promotional	(59,405)	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	(490,734)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,055,595)		\$	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 Amount	2 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)	(485,769)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (485,769)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,541,364)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

ID#

0034157

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (8,738)	21	1
2	Cope Dues	(11,543)	20	2
3	Building Co. - Legal Fees	(269)	19	3
4	Building Co. - Accounting Fees	(17,140)	19	4
5	Building Co. - Amortization	(11,106)	31	5
6	Building Co. - State Replacement Tax	(506)	21	6
7	Building Co. - Franchise Tax	(250)	20	7
8	Marketing Travel Expense	(96)	43	8
9	Marketing Benefits	(236)	43	9
10	Non Allowable Legal Fees	(9,727)	19	10
11	Additional R&M	16,685	06	11
12	Building Co. - Additional R&M	17,636	06	12
13	Marketing Salary	(82,058)	43	13
14	PPA - Repair and Maintenance	(3,211)	06	14
15	PPA - Medical Supplies	(6,165)	10	15
16	PPA - Professional Fees	(1,583)	19	16
17	PPA - Background Checks, Want Ads, Licenses	(4,442)	20	17
18	PPA - Office Expenses	(367,985)	21	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
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	(490,734)		49

ID#0034157

Report Period Beginning:01/01/12

Ending:12/31/12

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

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	
30	Depreciation	77,917	320,253	5,254									403,424	30
31	Amortization of Pre-Op. & Org.	(11,106)	11,106											31
32	Interest	(49,091)	482,973	6,165									440,047	32
33	Real Estate Taxes		244,369	6,732									251,101	33
34	Rent-Facility & Grounds		(1,354,090)										(1,354,090)	34
35	Rent-Equipment & Vehicles			17,230									17,230	35
36	Other (specify):*		52,586										52,586	36
37	TOTAL Ownership	17,720	(242,803)	35,381									(189,702)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(614)						(614)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(82,390)											(82,390)	43
44	TOTAL Special Cost Centers	(82,390)					(614)						(83,004)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,055,595)	(193,070)	(691,150)	336,275	62,790	(614)						(1,541,364)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,354,090	Woodbridge Building LLC	100.00%	\$	\$ (1,354,090)	1
2	V	32	Interest Income	850	Woodbridge Building LLC	100.00%		(850)	2
3	V	19	Legal & Accounting Fees		Woodbridge Building LLC	100.00%	17,409	17,409	3
4	V	30	Depreciation		Woodbridge Building LLC	100.00%	320,253	320,253	4
5	V	31	Amortization of Mortgage Cts		Woodbridge Building LLC	100.00%	11,106	11,106	5
6	V	33	Real Estate Tax		Woodbridge Building LLC	100.00%	244,369	244,369	6
7	V	20	Franchise Tax		Woodbridge Building LLC	100.00%	250	250	7
8	V	21	State Replacement Tax		Woodbridge Building LLC	100.00%	506	506	8
9	V	06	Repairs and Maintenance		Woodbridge Building LLC	100.00%	21,072	21,072	9
10	V	32	Interest Expense - Heartland		Woodbridge Building LLC	100.00%	483,823	483,823	10
11	V	36	Mortgage Insurance		Woodbridge Building LLC	100.00%	52,586	52,586	11
12	V	26	Insurance		Woodbridge Building LLC	100.00%	10,496	10,496	12
13	V								13
14	Total			\$ 1,354,940			\$ 1,161,870	\$ * (193,070)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 2,081	\$ 2,081	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	17,873	17,873	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	383	383	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	2,539	2,539	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	1,297	1,297	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	104,710	104,710	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	4,812	4,812	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	130	130	22
23	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	20,198	20,198	23
24	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	5,254	5,254	24
25	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	6,165	6,165	25
26	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	6,732	6,732	26
27	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	16,627	16,627	27
28	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	603	603	28
29	V								29
30	V								30
31	V								31
32	V	19	HOME OFFICE	880,554	DYNAMIC HEALTH CARE CONS.	100.00%		(880,554)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 880,554			\$ 189,404	\$ * (691,150)	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%	\$ 12,416	\$ 12,416	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	37,214	37,214	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	42,275	42,275	17
18	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			18
19	V	17	ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	63,804	63,804	20
21	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	18,467	18,467	21
22	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	32,169	32,169	22
23	V	17	ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	17	ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	41,195	41,195	24
25	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	39,042	39,042	25
26	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	33,498	33,498	26
27	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	15,899	15,899	27
28	V	21	CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	296	296	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			\$			\$ 336,275	\$ * 336,275	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 1,295	\$ 1,295	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	2,018	2,018	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	2,917	2,917	17
18	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			18
19	V	27	EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	23,643	23,643	20
21	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	5,944	5,944	21
22	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	2,256	2,256	22
23	V	27	EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	27	EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	7,077	7,077	24
25	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	10,464	10,464	25
26	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	4,195	4,195	26
27	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	2,955	2,955	27
28	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	26	26	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			\$			\$ 62,790	\$ * 62,790	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	39	DME and Medical Supplies	3,339	Integra Healthcare Equipment	100.00%	2,725	\$ (614)	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			\$ 3,339			\$ 2,725	\$ * (614)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM J. STERN	17.153%	BRIDGEVIEW HEALTH CARE CENTER, LTD.	BRIDGEVIEW	WOODBIDGE BUILING LLC		BUILDING CO.	1
2	DENNIS NEHMER	0.586%	GROSSE POINTE MANOR, L.L.C.	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULT	2
3	DIANIA KUFTA	0.586%	OTTAWA PAVILION, LTD.	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	ESTATE OF LEO MAUER	4.505%	PARK RIDGE CARE CENTER, LTD.	PARK RIDGE	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME	4
5	FRANCES MAUER	6.757%	STERLING PAVILION, LTD.	STERLING	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	5
6	FRED L. AARON	22.703%	WARREN PARK HEALTH AND LIVING CENTER,LLC	CHICAGO				6
7	JOSEPH MAUER	4.505%	WATERFRONT TERRACE, INC.	CHICAGO				7
8	MARSHALL A. MAUER	6.757%	WILLOW CREST NURSING PAVILION, LTD.	SANDWICH				8
9	MAURICE I. AARON C/O DYNAMIC HEALTH	24.865%	WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				9
10	MIRIAM LATINIK	4.505%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (I GALESBURG					10
11	SHARON S. AARON	0.586%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLI GENESEO					11
12	SUE KOPLIN	0.586%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC (SLF PONTIAC					12
13	SUSAN L. STERN	4.505%						13
14	SUSIE & HOWIE ALTER	1.171%						14
15	SYLVIA AARON	0.234%						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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

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

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	7.44	14.88%	Alloc. Salary	\$ 37,214	17-7	1
2	Sharon Aaron	Owner	Clerical	0.59%	See Attached	7.45	18.62%	Alloc. Salary	15,899	21-7	2
3	Maury Aaron	Owner	Administrative	24.86%	See Attached	8.45	16.90%	Alloc. Salary	42,275	17-7	3
4	Diania Kufra	Owner	Administrative	0.59%	See Attached	10.57	21.14%	Alloc. Salary	32,169	17-7	4
5	Dennis Nehmer	Owner	Maintenance	0.59%	See Attached	8.45	21.13%	Alloc. Salary	12,416	6-7	5
6	Sue Koplin-Haramaras	Owner	Administrative	0.59%	See Attached	7.5	18.75%	Alloc. Salary	18,467	17-7	6
7	Esther Maryles	Relative	Clerical	0%	See Attached	0.54	1.93%	Alloc. Salary	296	21-7	7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 158,736		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: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	PATIENT DAYS	413,728	13	\$ 11,773	\$	73,115	\$ 2,081	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	413,728	13	101,134	34,519	73,115	17,873	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	413,728	13	2,165		73,115	383	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	413,728	13	14,369		73,115	2,539	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	413,728	13	7,338		73,115	1,297	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	413,728	13	592,509	421,664	73,115	104,710	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,728	13	27,227		73,115	4,812	7
8	25	AUTO EXP.	PATIENT DAYS	413,728	13	736		73,115	130	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	413,728	13	114,290		73,115	20,198	9
10	30	DEPRECIATION	PATIENT DAYS	413,728	13	29,732		73,115	5,254	10
11	32	INTEREST	PATIENT DAYS	413,728	13	34,887		73,115	6,165	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,728	13	38,096		73,115	6,732	12
13	35	AUTO RENTAL	PATIENT DAYS	413,728	13	94,085		73,115	16,627	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	3,415		73,115	603	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,071,756	\$ 456,183		\$ 189,404	25

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

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	8	58,740	58,740	8.45	12,416	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	200,000	200,000	7.44	37,214	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	200,000	200,000	8.45	42,275	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	47,000	47,000	-		4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	52,765	52,765	-		5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	102,086	102,086	25.00	63,804	6
7	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	4	73,867	73,867	7.50	18,467	7
8	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	152,170	152,170	10.57	32,169	8
9	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		9
10	17	ADMIN. CMP. - V. DAVIS (NON-	WGHTD. AVG. HOURS	40	8	117,701	117,701	14.00	41,195	10
11	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	184,393	184,393	9.53	39,042	11
12	17	ADMIN. CMP. - CFO (NON-OW	WGHTD. AVG. HOURS	45	10	180,028	180,028	8.37	33,498	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	85,386	85,386	7.45	15,899	13
14	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	12	15,265	15,265	0.54	296	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,481,401	\$ 1,481,401		\$ 336,275	25

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

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	8	6,127		8.45	1,295	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	10,847		7.44	2,018	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	13,801		8.45	2,917	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	36,183				4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	4,278				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,829		25.00	23,643	6
7	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	4	23,776		7.50	5,944	7
8	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,672		10.57	2,256	8
9	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,076				9
10	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	8	20,219		14.00	7,077	10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	49,423		9.53	10,464	11
12	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	45	10	22,545		8.37	4,195	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	15,870		7.45	2,955	13
14	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	12	1,340		0.54	26	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 253,986	\$		\$ 62,790	25

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

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 Integra Healthcare Equipment, LLC
Street Address 747 Church Road
City / State / Zip Code Elmhurst, IL
Phone Number (630) 834-3700
Fax Number (630) 834-1500

	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	39	DME and Medical Supplies	Direct Allocation						2,725	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					\$	\$		\$ 2,725	25

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

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

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

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	HUD		X	Mortgage			\$	10,416,343			\$	483,823	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	MB Finanical		X	Line of Credit				1,616,249				63,087	6
7	Insurance Financing		X	Insurance								613	7
8	See Supplemental Schedule							102,632				7,327	8
9	TOTAL Facility Related						\$	12,135,224			\$	554,850	9
	B. Non-Facility Related*												
10	Interest Income		X									(49,091)	10
11	Inrst Inc - Bldg Co. Rpl Rsr		X									(550)	11
12	Inrst Inc - Bldg Co. Rps		X									(300)	12
13	See Supplemental Schedule											6,165	13
14	TOTAL Non-Facility Related						\$				\$	(43,776)	14
15	TOTALS (line 9+line14)						\$	12,135,224			\$	511,074	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 52,586 Line # 36

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$		\$			\$	1						
2													2						
3													3						
4													4						
5													5						
6													6						
7	TOTAL Long-Term												7						
	Working Capital																		
8	Omincare		X	Vendor Financing			\$		\$ 102,632			\$ 7,327	8						
9													9						
10													10						
11													11						
12													12						
13													13						
14	TOTAL Working Capital								102,632			7,327	14						
	B. Non-Facility Related*																		
15	Allocated from Dynamic		X				\$		\$			\$ 6,165	15						
16													16						
17													17						
18													18						
19													19						
20	TOTAL Non-Facility Related											6,165	20						

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	250,000	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.)		\$	251,101	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	1,101	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	250,000	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		\$	15,105	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	266,206	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	239,623	8	
		2008	242,027	9	
		2009	235,152	10	
		2010	245,390	11	
		2011	244,369	12	
2012 Accrual = \$244,369 x 1.025 = \$250,000 (Rounded)					
Allocated from Dynamic - \$6,586					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Woodbridge Nursing Pavilion</u>	COUNTY	<u>Cook</u>
---------------	------------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<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>73,990.15</u>	\$ <u>73,990.15</u>
2. <u>13-35-217-016-0000</u>	<u>Long Term Care Property</u>	\$ <u>96,388.65</u>	\$ <u>96,388.65</u>
3. <u>13-35-217-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>73,990.15</u>	\$ <u>73,990.15</u>
4. <u>10-23-404-059-0000</u>	<u>Allocated from Dynamic</u>	\$ <u>37,266.21</u>	\$ <u>6,585.77</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>281,635.16</u>	\$ <u>250,954.72</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 and 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

TELEPHONE () FAX #: ()

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</u> <u>Applicable to</u> <u>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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,560

B. General Construction Type: Exterior BrickFrameNumber 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	Facility		2005	\$ 750,000	1
2					2
3	TOTALS			\$ 750,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	222		2005	1975	\$ 6,776,760	\$ 320,253	35	\$ 193,622	\$ (126,631)	\$ 1,373,763
5										
6										
7										
8										
	Improvement Type**									
9	Various		1989	3,000		20				3,000
10	Various		1990	20,717		20				20,716
11	Various		1991	11,182		20				11,181
12	Various		1992	14,078		20	316	316		14,075
13	Various		1993	122,812		20	5,770	5,770		120,441
14	Various		1995	20,549		20	1,027	1,027		17,763
15	Various		1996	8,331		20	417	417		6,963
16	Various		1997	35,913		20	1,796	1,796		28,127
17	Various		1998	50,252		20	2,513	2,513		36,721
18	Various		1999	68,242		20	3,412	3,412		46,172
19	Various		2000	57,506		20	2,875	2,875		36,754
20	Various		2001	62,933		20	3,147	3,147		36,261
21	Various		2002	83,062		20	2,160	2,160		23,971
22	Various		2003	16,347		20	1,565	1,565		15,257
23	Various		2004	116,859		20	11,686	11,686		95,133
24	Various		2005	112,439		20	8,705	8,705		73,665
25	Various		2006	70,102		20	2,566	2,566		63,269
26	Various		2007	205,027		20	11,568	11,568		66,140
27	Various		2008	99,839		20	10,864	10,864		48,780
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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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)		1,067,911			52,990	52,990	164,375	67
68	Related Party Allocations (Pages 12H & 12I)		78,394	2,010		2,240	230	43,303	68
69	Financial Statement Depreciation			88,650			(88,650)		69
70	TOTAL (lines 4 thru 69)		\$ 9,102,254	\$ 410,913		\$ 319,238	\$ (91,675)	\$ 2,345,830	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:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 9,102,254	\$ 410,913		\$ 319,238	\$ (91,675)	\$ 2,345,830	1
2	Electrical Work	2009	9,950		20	255	255	967	2
3	10 Air Conditioners	2009	5,621		20	144	144	522	3
4	New Windows	2009	17,141		20	1,714	1,714	6,285	4
5	Plumbing Work	2009	40,057		20	1,027	1,027	3,723	5
6	Windows In Front	2009	51,424		20	1,319	1,319	4,780	6
7	Electrical Work	2009	23,100		20	592	592	2,098	7
8	Electrical Work	2009	35,340		20	906	906	3,134	8
9	Electrical Work	2009	7,630		20	196	196	660	9
10	Concrete & Beam Work	2009	17,500		20	449	449	1,514	10
11	Concrete And Beam Work	2009	17,500		20	449	449	1,514	11
12	Concrete And Beam Work	2009	2,955		20	76	76	256	12
13	Concrete And Beam Work	2009	17,500		20	449	449	1,514	13
14	Electrical Work	2009	8,320		20	213	213	720	14
15	Electrical Work	2009	17,360		20	445	445	1,354	15
16	Building Remodel	2009	176,726		20	4,531	4,531	13,783	16
17	Plumbing Work	2009	80,047		20	2,052	2,052	6,243	17
18	Ceramic Tile	2009	9,070		20	233	233	707	18
19	Security System	2009	8,125		20	208	208	634	19
20	Lighting/Corners/Windows/Cove/Curtain	2009	18,538		20	475	475	1,446	20
21	Faucet Handles, P-Trap, Supply Cover	2010	5,192		20	260	260	779	21
22	Roof Work	2011	7,800		20	200	200	392	22
23	Electrical Wiring	2011	38,821		20	995	995	1,037	23
24	Handrails And Bumpers- 1St Floor-Corridors	2011	9,416		20	471	471	471	24
25	Screens And Paint With Doors And Frames- Lobby/Basement	2011	6,254		20	313	313	313	25
26	Ceiling Tiles And Doors For 1St Floor And Basement Rooms	2011	7,066		20	353	353	353	26
27	Bldg. Co. - Duct Work - Hvac- For Dining Room	2011	3,380		20	169	169	169	27
28	Ceiling Tile- First Floor And Basement Rooms	2011	4,375		20	219	219	219	28
29	Wallpaper & Corner Guards In Basement And 1St Fl. Offices	2011	13,125		20	656	656	656	29
30	Bldg. Co. - Pumps And Piping	2011	6,010		20	301	301	301	30
31	Bldg. Co. - Drain System And New Valves	2011	4,475		20	224	224	224	31
32	Bldg. Co. - Fire Alarm And Sprinkler System	2011	3,625		20	181	181	181	32
33	Corner Guards And End Caps For 1St Floor Hallways/Rooms	2011	4,341		20	217	217	217	33
34	TOTAL (lines 1 thru 33)		\$ 9,780,038	\$ 410,913		\$ 339,530	\$ (71,383)	\$ 2,402,996	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:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,780,038	\$ 410,913		\$ 339,530	\$ (71,383)	\$ 2,402,996	1
2	Bldg. Co. - Hvac System	2011	4,018		20	201	201	201	2
3	Bldg. Co. - Pump And Piping For Heating And Chilling System	2011	6,180		20	309	309	309	3
4	New Lamps And Light Accessories In Lobby/Res Rooms	2011	4,969		20	248	248	248	4
5	Window Treatments W Frame In Res Rms, Lobby/1St Fl Corridor	2011	4,329		20	216	216	216	5
6	Bldg. Co. - 28 Through The Wall Air Conditioners	2011	10,722		20	536	536	536	6
7	Elevator Work	2012	13,960		20	465	465	465	7
8	Wire And Generator	2012	3,175		20	37	37	37	8
9	En Ergy Supply Fan Cool Air	2012	3,459		20	120	120	120	9
10	Elevator Work	2012	3,129		20	13	13	13	10
11	Camera Monitor	2012	4,090		20	95	95	95	11
12	Bldg. Co. - Power For Ejector & Circulating Pumps	2012	3,950		20	379	379	379	12
13	Bldg. Co. -Water Coil For Roof	2012	4,301		20	413	413	413	13
14	Bldg. Co. - Fire Dampers & Insulation	2012	3,142		20	301	301	301	14
15	Bldg. Co. - Sprinkler System, Sprinkler Head Piping	2012	2,850		20	273	273	273	15
16	Bldg. Co. - Boiler Pump, New Boiler	2012	5,698		20	546	546	546	16
17	Bldg. Co. - Fire Alarm Door Release	2012	3,837		20	367	367	367	17
18	Doors For Resident Rooms And Floors And Lobby	2012	3,560		20	427	427	427	18
19	Ceramic Tiling In Basement Bathrooms	2012	6,767		20	649	649	649	19
20	Ceramic Tiling In 1St Floor Bathroom/Shower Room	2012	6,917		20	663	663	663	20
21	Bldg. Co. - Shower Tub & Base Installation, Valve & Wiring,	2012	16,021		20	1,536	1,536	1,536	21
22	Lighting For First Floor Resident Rooms	2012	11,470		20	1,099	1,099	1,099	22
23	Bldg. Co. - Service Sink Installation	2012	2,513		20	241	241	241	23
24	Bldg. Co. - Condenser Installation	2012	4,675		20	448	448	448	24
25	Bldg. Co. - Electrical Work For Air Handler, Laundry Room, Resi	2012	11,666		20	1,118	1,118	1,118	25
26	Bldg. Co. - Install Condensate Pump	2012	3,165		20	303	303	303	26
27	Doors For Resident Rooms And Floors And Lobby	2012	4,956		20	475	475	475	27
28	Bldg. Co.-Camera & Pacing System, Monitors, Lights, Alarms	2012	7,875		20	1,575	1,575	1,575	28
29	Bldg. Co -Exit Signs, Camera Outlets, Automatic Door Control	2012	7,410		20	1,482	1,482	1,482	29
30	Bldg. Co.-Heat Curtain Installation	2012	3,365		20	673	673	673	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,952,207	\$ 410,913		\$ 354,739	\$ (56,174)	\$ 2,418,205	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 and Improvement Costs-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		\$ 9,952,207	\$ 410,913		\$ 354,739	\$ (56,174)	\$ 2,418,205	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)		\$ 9,952,207	\$ 410,913		\$ 354,739	\$ (56,174)	\$ 2,418,205	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 and Improvement Costs-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	Totals from Page 12D, Carried Forward		\$ 9,952,207	\$ 410,913		\$ 354,739	\$ (56,174)	\$ 2,418,205	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)		\$ 9,952,207	\$ 410,913		\$ 354,739	\$ (56,174)	\$ 2,418,205	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:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 Building Company Information								1
2 Buildings:								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Roof	2005	74,030		20	3,702	3,702	23,336	9
10 Elevator (Electrical)	2005	16,710		20	836	836	5,269	10
11 Heating System Boiler Repair	2010	4,385		20	219	219	657	11
12 Materials for Therapy Room	2010	5,309		20	265	265	795	12
13 Air Handler Unit in Basement	2010	10,188		20	509	509	1,527	13
14 Air Conditioning Work	2010	7,685		20	384	384	1,152	14
15 Sprinkler System Repair	2010	4,795		20	240	240	720	15
16 Exhaust Fan/Dampers/Duct - Elevator Room	2010	3,855		20	193	193	579	16
17 Fix Closets In Patient Rooms	2010	4,140		20	207	207	621	17
18 Materials For Therapy Room	2010	3,560		20	178	178	534	18
19 Plumbing	2010	6,497		20	325	325	975	19
20 Custom Cabinets For Therapy Room	2010	14,843		20	742	742	2,226	20
21 Wall Covering For Therapy Room	2010	3,280		20	164	164	492	21
22 Flooring For Therapy Room	2010	18,260		20	913	913	2,739	22
23 Fire Alarm System	2010	4,785		20	239	239	717	23
24 Fan Coil Units For Lobby	2010	3,400		20	170	170	510	24
25 Metal Door And Frame	2010	1,911		20	96	96	288	25
26 Window Treatment & Cubicle Curtains - Therapy Room	2010	68,886		20	3,444	3,444	10,332	26
27 Laundry Room Work	2010	3,200		20	160	160	480	27
28 Installation Of Ramp	2010	313,956		20	15,698	15,698	47,094	28
29 Lighting For Therapy Room Corridor	2010	64,109		20	3,205	3,205	9,615	29
30 Drywall And Piping	2010	5,372		20	269	269	807	30
31 Carpeting & Wallcovering For Lobby	2010	2,830		20	142	142	426	31
32 Piping Repairs	2010	4,910		20	246	246	738	32
33 Conduit For Fire Alarm System	2010	7,030		20	352	352	1,056	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:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 Continued		\$	\$		\$	\$	\$	1
2	Air Handler/Damper	2010	3,015		20	151	151	453	2
3	10 Air Conditioner Sleeve Units	2010	5,621		20	281	281	843	3
4	2 new Boilers For Hot Water System	2010	59,941		20	2,997	2,997	8,991	4
5	Therapy Room/Lobby/Bathroom/Fire Doors/Wallpaper	2010	26,569		20	1,328	1,328	3,985	5
6	Wiring, Cameras, Alarms	2010	5,305		20	265	265	796	6
7	Electrical Work In Laundry Room	2010	10,360		20	518	518	1,554	7
8	Electrical For Lobby	2010	11,550		20	578	578	1,733	8
9	Air Exchanger in Basement	2010	8,200		20	410	410	1,230	9
10	Engineering Costs For Renovation	2010	37,935		20	1,897	1,897	5,691	10
11	Wallcovering	2010	10,605		20	530	530	1,591	11
12	Flooring	2010	12,772		20	639	639	1,916	12
13	Lighting Fixtures	2010	14,557		20	728	728	2,184	13
14	Flooring- Lobby/Therapy Room	2010	3,578		20	179	179	537	14
15	Shelving in Kitchen	2011	3,253		20	163	163	326	15
16	Nurses Station on First Floor	2011	7,266		20	363	363	726	16
17	Vinyl Flooring- First Floor Corridor and Dining Room	2011	6,692		20	335	335	670	17
18	Vinyl Flooring- First Floor Corridor and Dining Room	2011	24,304		20	1,215	1,215	2,430	18
19	Wallpaper and Handrails: 1st Fl. and Basement Rms/corridors	2011	16,500		20	825	825	1,650	19
20	Drop Ceiling: First Floor and Basement Rooms and Corridor	2011	5,525		20	276	276	552	20
21	Window Treatment/Curtains- Res Rooms/Basement Dining	2011	12,162		20	608	608	1,216	21
22	Flooring:Hardware,Vinyl,Wall Guards-Basement Therapy/Dine Rm	2011	6,581		20	329	329	658	22
23	Painting/Room Buildout- Therapy Room & Basement Dining Rm	2011	27,911		20	1,396	1,396	2,792	23
24	Corner Gaurds, Blinds, Vinyl Base Boards:1st Fl Res Rooms	2011	6,735		20	337	337	674	24
25	Blinds, Bumpers, & Baseboards-1st Floor Resident Rooms	2011	4,551		20	228	228	456	25
26	Vinyl Flooring- Basement Dining Room/Corridor	2011	25,882		20	1,294	1,294	2,588	26
27	Ramp Replacement	2011	3,310		20	166	166	332	27
28	Vinyl Flooring- Lower Level Bathroom and in Elevators	2011	2,554		20	128	128	256	28
29	Landscaping - Irrigation System	2011	3,625		20	181	181	362	29
30	Landscaping - Install Sod	2011	3,450		20	173	173	346	30
31	Security Alarm System	2011	7,965		20	398	398	796	31
32	Doors, Windows, and Drywall: Basement Dining & Hallway	2011	23,579		20	1,179	1,179	2,358	32
33	Handrails in First floor- Hallways	2011	8,132						33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 1,067,911	\$		\$ 52,990	\$ 52,990	\$ 164,375	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 and Improvement Costs-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 HC Consultants	1993	78,394	2,010	35	2,240	230	43,303	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.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	\$ 78,394	\$ 2,010		\$ 2,240	\$ 230	\$ 43,303	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$878,298	\$	\$115,758	\$115,758	10	\$609,417	71
72	Current Year Purchases	86,481	569	11,778	11,209	10	11,778	72
73	Fully Depreciated Assets	451,988		50	50	10	451,814	73
74								74
75	TOTALS	\$1,416,767	\$569	\$127,587	\$127,018		\$1,073,009	75

D. Vehicle Costs. (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	\$	\$3,163	\$3,163	5	\$51,639	76
77		Allocated from Dynamic	2012	44,343	2,676	6,587	3,911	5	12,511	77
78										78
79										79
80	TOTALS			\$95,982	\$2,676	\$9,750	\$7,074		\$64,150	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$12,214,956	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$414,158	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$492,075	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$77,917	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,555,364	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	\$	\$	86
87	Land - Section 754 Step-Up - 2005	71,004			87
88					88
89					89
90					90
91	TOTALS	\$712,577	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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				3,503			5
6								6
7	TOTAL				\$ 3,503			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: \$ 6,693
- 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	Allocated from Dynamic		\$	\$ 16,627	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 16,627	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		Facility			
		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)	\$			

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.)

12345678										
	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 - 01	hrs	\$ 130,354		\$	\$		\$ 130,354	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	160,224		1,590			161,814	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	287,289					287,289	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			(607)	234,742		234,135	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						83,557		83,557	13
14	TOTAL			\$ 577,867		\$ 983	\$ 318,299		\$ 897,149	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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 163,692	\$ 278,148	1
2	Cash-Patient Deposits	111,566	111,566	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,858,438	1,858,438	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	183,165	229,144	6
7	Other Prepaid Expenses	1,875	1,875	7
8	Accounts Receivable (owners or related parties)	925,923	1,282,999	8
9	Other(specify): See Attached Schedule	184,560	958,752	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,429,219	\$ 4,720,922	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	1,770,220	2,991,023	15
16	Equipment, at Historical Cost	1,426,772	1,514,530	16
17	Accumulated Depreciation (book methods)	(1,843,366)	(3,560,627)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,949	7,949	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,949)	(7,949)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	172,959	447,838	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,526,585	\$ 8,919,524	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,955,804	\$ 13,640,446	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 574,868	\$ 574,867	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	137,987	137,987	28
29	Short-Term Notes Payable	1,718,881	1,948,937	29
30	Accrued Salaries Payable	439,651	439,651	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,911	3,911	31
32	Accrued Real Estate Taxes(Sch.IX-B)		250,000	32
33	Accrued Interest Payable	3,485	43,414	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	22,355	22,355	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	208,277	208,277	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,109,415	\$ 3,629,399	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,186,287	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 10,186,287	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,109,415	\$ 13,815,686	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,846,389	\$ (175,240)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,955,804	\$ 13,640,446	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,497,657	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,497,654	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,147,935	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	(799,200)	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)	\$ 348,735	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)	\$ 1,846,389	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,535,967	1
2	Discounts and Allowances for all Levels	(2,606,514)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,929,453	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,340,680	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,340,680	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	357,487	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,878	19
20	Radiology and X-Ray	41,791	20
21	Other Medical Services	89,209	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 518,365	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	49,091	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49,091	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	434,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 434,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,271,589	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,763,039	31
32	Health Care	3,966,213	32
33	General Administration	3,372,804	33
	B. Capital Expense		
34	Ownership	1,523,360	34
	C. Ancillary Expense		
35	Special Cost Centers	979,539	35
36	Provider Participation Fee	518,699	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,123,654	40
41	Income before Income Taxes (line 30 minus line 40)**	1,147,935	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,147,935	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,488,068	44
45	Private Pay - Net Inpatient Revenue	250,702	45
46	Medicare - Net Inpatient Revenue	1,092,744	46
47	Other-(specify) Hospice	97,939	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,929,453	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,929	2,067	\$ 97,320	\$ 47.08	1
2	Assistant Director of Nursing	1,897	1,955	74,598	38.16	2
3	Registered Nurses	16,990	17,757	590,921	33.28	3
4	Licensed Practical Nurses	37,437	39,917	1,093,566	27.40	4
5	CNAs & Orderlies	106,349	114,434	1,273,210	11.13	5
6	CNA Trainees					6
7	Licensed Therapist	9,060	9,655	577,867	59.85	7
8	Rehab/Therapy Aides	20,095	21,413	111,309	5.20	8
9	Activity Director	1,104	1,403	16,181	11.53	9
10	Activity Assistants	12,531	13,220	117,636	8.90	10
11	Social Service Workers	11,647	12,939	232,496	17.97	11
12	Dietician					12
13	Food Service Supervisor	2,675	2,879	62,871	21.84	13
14	Head Cook	7,705	8,388	101,237	12.07	14
15	Cook Helpers/Assistants	16,574	18,218	173,853	9.54	15
16	Dishwashers					16
17	Maintenance Workers	6,387	6,911	116,612	16.87	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,821	1,854	100,449	54.18	20
21	Assistant Administrator	272	272	19,104	70.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,788	5,235	70,184	13.41	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	3,642	4,114	56,566	13.75	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,024	2,232	82,058	36.76	33
34	TOTAL (lines 1 - 33)	264,927	284,863	\$ 4,968,038 *	\$ 17.44	34

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	396	\$ 11,448	01-03	35
36	Medical Director	240	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	80	7,014	10-03	38
39	Pharmacist Consultant	96	14,063	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	418			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,200	11-03	44
45	Social Service Consultant	67	3,968	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,345	\$ 62,693		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

(If total legal fees exceed \$5,000, attach copy of invoices.)

****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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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

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 - \$21,978

(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.

\$9,541

Line10-2

(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?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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.

\$518,699

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.

\$84,528

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% Ln 14

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?

N/A

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 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.

SEE ACCOUNTANTS' COMPILATION REPORT