FOR BHF USE

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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. (Number) Chicago (City) 60647 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) 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: 01/01/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	222	Skilled (SNF)	222	81,030	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	222	TOTALS	222	81,030	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,085	234	6,903	9,222	8
9	SNF/PED					9
10	ICF	57,558	2,579	2,040	62,177	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,643	2,813	8,943	71,399	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.11%

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 [X]

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

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 [X] Date 08/01/1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 222 and days of care provided 6,780

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	330,366	38,098	11,394	379,858		379,858		379,858			1
2	Food Purchase		425,896		425,896	(88,823)	337,073	(938)	336,135			2
3	Housekeeping	51,873	4,691	284,212	340,776		340,776		340,776			3
4	Laundry		2,521	192,473	194,994		194,994		194,994			4
5	Heat and Other Utilities			186,434	186,434		186,434	36	186,470			5
6	Maintenance	90,749	80,072	81,274	252,095		252,095	52,816	304,911			6
7	Other (specify):*							1,441	1,441			7
8	TOTAL General Services	472,988	551,278	755,787	1,780,053	(88,823)	1,691,230	53,355	1,744,585			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	3,091,987	207,729	21,273	3,320,989		3,320,989		3,320,989			10
10a	Therapy	188,689		60,855	249,544		249,544		249,544			10a
11	Activities	157,169	7,702	2,400	167,271		167,271		167,271			11
12	Social Services	168,325		6,830	175,155		175,155		175,155			12
13	CNA Training											13
14	Program Transportation			1,584	1,584		1,584		1,584			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,606,170	215,431	106,142	3,927,743		3,927,743		3,927,743			16
	C. General Administration											
17	Administrative	127,291			127,291		127,291	305,360	432,651			17
18	Directors Fees											18
19	Professional Services			996,530	996,530	(5,078)	991,452	(877,870)	113,582			19
20	Dues, Fees, Subscriptions & Promotions			123,748	123,748		123,748	(71,775)	51,973			20
21	Clerical & General Office Expenses	112,232	1,307	392,192	505,731		505,731	(232,337)	273,394			21
22	Employee Benefits & Payroll Taxes			831,139	831,139	88,823	919,962	(1,421)	918,541			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,759	5,759		5,759	1,379	7,138			24
25	Other Admin. Staff Transportation			13,917	13,917		13,917	2,030	15,947			25
26	Insurance-Prop.Liab.Malpractice			344,960	344,960		344,960	5,887	350,847			26
27	Other (specify):*							87,605	87,605			27
28	TOTAL General Administration	239,523	1,307	2,708,245	2,949,075	83,745	3,032,820	(781,142)	2,251,678			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,318,681	768,016	3,570,174	8,656,871	(5,078)	8,651,793	(727,787)	7,924,006			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion #0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			92,537	92,537		92,537	387,252	479,789			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,745	43,745		43,745	457,843	501,588			32
33	Real Estate Taxes					5,078	5,078	262,519	267,597			33
34	Rent-Facility & Grounds			1,357,509	1,357,509		1,357,509	(1,354,090)	3,419			34
35	Rent-Equipment & Vehicles			9,190	9,190		9,190	16,135	25,325			35
36	Other (specify):*							110,563	110,563			36
37	TOTAL Ownership			1,502,981	1,502,981	5,078	1,508,059	(119,778)	1,388,281			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	280,844	350,230	295	631,369		631,369	(36,806)	594,563			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,545	121,545		121,545		121,545			42
43	Other (specify):*	78,126			78,126		78,126	(78,126)				43
44	TOTAL Special Cost Centers	358,970	350,230	121,840	831,040		831,040	(114,932)	716,108			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,677,651	1,118,246	5,194,995	10,990,892		10,990,892	(962,498)	10,028,394			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(1,870)	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	83,766	30		9
10	Interest and Other Investment Income	(41,685)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(167)	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	(4,300)	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	(237,577)	21		24
25	Fund Raising, Advertising and Promotional	(63,128)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(40,055)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(191,714)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (496,731)		$	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)	(465,767)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (465,767)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (962,498)		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

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (11,242)	21	1
2	Penalties	(9,490)	21	2
3	COPE Dues	(5,636)	20	3
4	Building Company - Legal Fees	(2,808)	19	4
5	Building Company - Professional Fees	(3,910)	19	5
6	Building Company - Amortization	(11,106)	31	6
7	Building Company - Franchise Tax	(250)	36	7
8	Building Company - Additional R&M	10,353	06	8
9	Additional R&M	8,443	06	9
10	Prior Period - Office Expense	(44,309)	21	10
11	Prior Period - Other Employee Benefits	(1,421)	22	11
12	Prior Period - Maintenance	(594)	06	12
13	Prior Period - Pharmacy	(36,776)	39	13
14	Prior Period - Radiology	(30)	39	14
15	Prior Period - Food	(771)	02	15
16	Non-Allowable Legal	(3,669)	19	16
17	Marketing Travel	(372)	25	17
18	Marketing Salary	(78,126)	43	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**	(191,714)		49

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/11

Ending: 12/31/11

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Woodbridge Nursing Pavilion **#** 0034157 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(938)											(938)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,870)		1,906									36	5
6	Maintenance	18,202	10,093	11,769	12,752								52,816	6
7	Other (specify):*			179	1,262								1,441	7
8	**TOTAL General Services**	15,394	10,093	13,854	14,014								53,355	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative				305,360								305,360	17
18	Directors Fees													18
19	Professional Services	(10,387)	6,718	(874,201)									(877,870)	19
20	Fees, Subscriptions & Promotions	(73,064)		1,289									(71,775)	20
21	Clerical & General Office Expenses	(342,673)		95,181	15,155								(232,337)	21
22	Employee Benefits & Payroll Taxes	(1,421)											(1,421)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,379									1,379	24
25	Other Admin. Staff Transportation	(372)		2,402									2,030	25
26	Insurance-Prop.Liab.Malpractice		5,080	807									5,887	26
27	Other (specify):*			19,865	67,740								87,605	27
28	**TOTAL General Administration**	(427,917)	11,798	(753,278)	388,255								(781,142)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(412,523)	21,891	(739,424)	402,269								(727,787)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	83,766	299,653	3,833									387,252	30
31	Amortization of Pre-Op. & Org.	(11,106)	11,106											31
32	Interest	(41,685)	492,755	6,773									457,843	32
33	Real Estate Taxes		255,390	7,129									262,519	33
34	Rent-Facility & Grounds		(1,354,090)										(1,354,090)	34
35	Rent-Equipment & Vehicles			16,135									16,135	35
36	Other (specify):*	(250)	110,813										110,563	36
37	**TOTAL Ownership**	30,725	(184,373)	33,870									(119,778)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(36,806)											(36,806)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(78,126)											(78,126)	43
44	**TOTAL Special Cost Centers**	(114,932)											(114,932)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(496,731)	(162,482)	(705,554)	402,269								(962,498)	45

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,354,090	Woobridge Building LLC	100.00%	$	$ (1,354,090)	1
2	V	32	Interest	966	Woobridge Building LLC	100.00%	493,721	492,755	2
3	V	19	Professional Fees		Woobridge Building LLC	100.00%	3,910	3,910	3
4	V	19	Legal Fees		Woobridge Building LLC	100.00%	2,808	2,808	4
5	V	30	Depreciation		Woobridge Building LLC	100.00%	299,653	299,653	5
6	V	31	Amortization of Mortgage Costs		Woobridge Building LLC	100.00%	11,106	11,106	6
7	V	36	Mortgage Insurance		Woobridge Building LLC	100.00%	110,563	110,563	7
8	V	33	Real Estate Tax		Woobridge Building LLC	100.00%	255,390	255,390	8
9	V	06	Repairs and Maintenance		Woobridge Building LLC	100.00%	10,093	10,093	9
10	V	26	Insurance		Woobridge Building LLC	100.00%	5,080	5,080	10
11	V	36	Franchise Tax		Woobridge Building LLC	100.00%	250	250	11
12	V								12
13	V								13
14	Total			$ 1,355,056			$ 1,192,574	$ * (162,482)	14

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 1,906	$ 1,906	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	11,769	11,769	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	179	179	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	1,176	1,176	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	1,289	1,289	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	95,181	95,181	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	1,379	1,379	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	2,402	2,402	22
23	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	807	807	23
24	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	19,865	19,865	24
25	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	3,833	3,833	25
26	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	6,773	6,773	26
27	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	7,129	7,129	27
28	V	19	REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%	1,254	1,254	28
29	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	16,135	16,135	29
30	V								30
31	V								31
32	V	19	HOME OFFICE	876,631	DYNAMIC HEALTH CARE CONS.	100.00%		(876,631)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 876,631			$ 171,077	$ * (705,554)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 12,752	$ 12,752	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	36,162	36,162	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	40,984	40,984	17
18	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			18
19	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	76,001	76,001	19
20	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	18,526	18,526	20
21	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	31,261	31,261	21
22	V	17	ADMIN. CMP. - HOWARD ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	17	ADMIN. CMP. - NON-OWNER-V. DAVIS		DYNAMIC HEALTH CARE CONS.	100.00%	22,462	22,462	23
24	V	17	ADMIN. CMP. - NON-OWNER -VAR.		DYNAMIC HEALTH CARE CONS.	100.00%	40,824	40,824	24
25	V	17	ADMIN. CMP. - CFO NON OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	39,140	39,140	25
26	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	15,155	15,155	26
27	V	7	EMP. BEN.- D. NEHMER		DYNAMIC HEALTH CARE CONS.	100.00%	1,262	1,262	27
28	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	1,986	1,986	28
29	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	2,300	2,300	29
30	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			30
31	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	27,720	27,720	31
32	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	7,548	7,548	32
33	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	2,197	2,197	33
34	V	27	EMP. BEN.- HOWARD ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			34
35	V	27	EMP. BEN.-V. DAVIS		DYNAMIC HEALTH CARE CONS.	100.00%	5,446	5,446	35
36	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	12,875	12,875	36
37	V	27	EMP. BEN.- CFO NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	4,524	4,524	37
38	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,144	3,144	38
39	Total			$			$ 402,269	$ * 402,269	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	WOODBRIDGE 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	FREDA MAUER	4.505%	PARK RIDGE CARE CENTER, LTD.	PARK RIDGE				4
5	FRANCES MAUER	6.757%	STERLING PAVILION, LTD.	STERLING				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 ABRAHAM J. S	24.865%	WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				9
10	MIRIAM LATINIK	4.505%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (S	GALESBURG				10
11	SHARON S. AARON	0.586%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLF	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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Owner	Administrative	6.76%	See Attached	7.23	14.46%	Alloc. Salary	$ 36,162	17-7	1
2	Sharon Aaron	Owner	Clerical	0.59%	See Attached	7.24	18.10%	Alloc. Salary	15,155	21-7	2
3	Maury Aaron	Owner	Administrative	24.86%	See Attached	8.2	16.39%	Alloc. Salary	40,984	17-7	3
4	Diana Kufta	Owner	Administrative	0.59%	See Attached	10.25	20.49%	Alloc. Salary	31,261	17-7	4
5	Dennis Nehmer	Owner	Maintenance	0.59%	See Attached	8.2	20.50%	Alloc. Salary	12,752	6-7	5
6	Sue Koplin-Haramaras	Owner	Administrative	0.59%	See Attached	7.5	18.75%	Alloc. Salary	18,526	17-7	6
7											7
8	Where Applicable, The Amounts Reported On This Page Have Been Adjusted From The Actual Costs To Reflect Only Amounts Anticipated To Be Considered Allowable										8
9	By The IL. Department of HFS.										9
10											10
11											11
12											12
13								TOTAL	$ 154,840		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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	416,329	14	$ 11,113	$	71,399	$ 1,906	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	416,329	14	68,628	12,499	71,399	11,769	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	416,329	14	1,044		71,399	179	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	416,329	14	6,858		71,399	1,176	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	416,329	14	7,513		71,399	1,289	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	416,329	14	555,005	401,070	71,399	95,181	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	416,329	14	8,041		71,399	1,379	7
8	25	AUTO EXP.	PATIENT DAYS	416,329	14	14,007		71,399	2,402	8
9	26	INSURANCE	PATIENT DAYS	416,329	14	4,707		71,399	807	9
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	416,329	14	115,833		71,399	19,865	10
11	30	DEPRECIATION	PATIENT DAYS	416,329	14	22,348		71,399	3,833	11
12	32	INTEREST	PATIENT DAYS	416,329	14	39,492		71,399	6,773	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	416,329	14	41,569		71,399	7,129	13
14	33	REAL ESTATE TAX PROTEST	PATIENT DAYS	416,329	14	7,315		71,399	1,254	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	416,329	14	94,081		71,399	16,135	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 997,554	$ 413,569		$ 171,077	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	8	62,231	62,231	8.20	12,752	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	200,000	200,000	7.23	36,162	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	200,000	200,000	8.20	40,984	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	68,000	68,000			4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	121,602	121,602	25.00	76,001	5
6	17	ADMIN. CMP. - S. HARAMARAS	WGHTD. AVG. HOURS	40	4	74,106	74,106	7.50	18,526	6
7	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	152,525	152,525	10.25	31,261	7
8	17	ADMIN. CMP. - HOWARD ALTI	WGHTD. AVG. HOURS	50	1	12,000	12,000			8
9	17	ADMIN. CMP. - NON-OWNER-V	WGHTD. AVG. HOURS	40	8	74,874	74,874	12.00	22,462	9
10	17	ADMIN. CMP. - NON-OWNER -V	WGHTD. AVG. HOURS	45	8	198,817	198,817	9.24	40,824	10
11	17	ADMIN. CMP. - CFO NON OWN	WGHTD. AVG. HOURS	45	10	216,469	216,469	8.14	39,140	11
12	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	83,751	83,751	7.24	15,155	12
13	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	8	6,161		8.20	1,262	13
14	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	10,982		7.23	1,986	14
15	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	11,224		8.20	2,300	15
16	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	43,917				16
17	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	44,352		25.00	27,720	17
18	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	40	4	30,190		7.50	7,548	18
19	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,718		10.25	2,197	19
20	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	50	1	1,101				20
21	27	EMP. BEN.-V. DAVIS	WGHTD. AVG. HOURS	40	8	18,154		12.00	5,446	21
22	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	62,705		9.24	12,875	22
23	27	EMP. BEN.- CFO NON-OWNER	WGHTD. AVG. HOURS	45	10	25,019		8.14	4,524	23
24	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	17,376		7.24	3,144	24
25	TOTALS					$ 1,746,274	$ 1,464,375		$ 402,269	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage			$	$ 10,636,076			$ 493,721	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial		X	Line of Credit				2,801,646			40,007	6
7	Omnicare		X	Financing				158,803			3,738	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 13,596,525			$ 537,466	9
	B. Non-Facility Related*											
10	Interest Income		X								(41,685)	10
11	Bldg. Co. - Interest Income		X								(966)	11
12	Allocated from Dynamic	X									6,773	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (35,878)	14
15	TOTALS (line 9+line14)						$	$ 13,596,525			$ 501,588	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 110,563 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion **#** 0034157 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 240,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 252,519	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,519	3
4. Real Estate Tax accrual used for 2011 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.**		$ 5,078	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** $ 10,605 **For** Mult. **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.		$ 267,596	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	242,209	8
	2007	239,623	9
	2008	242,027	10
	2009	235,152	11
	2010	245,390	12

2011 Accrual = 245,390 x 1.02 = 250,000 (rounded)
Allocated from Dynamic = $7,129

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Woodbridge Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-35-217-015-0000	Long-Term Care Property	$ 74,299.17	$ 74,299.17
2.	13-35-217-016-0000	Long-Term Care Property	$ 96,791.24	$ 96,791.24
3.	13-35-217-017-0000	Long-Term Care Property	$ 74,299.17	$ 74,299.17
4.	10-23-404-059-0000	Allocated from Dynamic	$ 36,436.43	$ 1,818.89
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 281,826.01	$ 247,208.47

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2005	$ 750,000	1
2					2
3	TOTALS			$ 750,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	222		2005	1975	$ 6,776,760	$ 299,653	35	$ 193,622	$ (106,031)	$ 1,180,141	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	3,000		20			3,000	9
10	Various			1990	20,717		20			20,716	10
11	Various			1991	11,182		20	234	234	11,181	11
12	Various			1992	14,078		20	704	704	13,759	12
13	Various			1993	122,812		20	6,141	6,141	114,671	13
14	Various			1995	20,549		20	1,027	1,027	16,736	14
15	Various			1996	8,331		20	417	417	6,547	15
16	Various			1997	35,913		20	1,796	1,796	26,332	16
17	Various			1998	50,252		20	2,513	2,513	34,208	17
18	Various			1999	68,242		20	3,412	3,412	42,760	18
19	Various			2000	57,506		20	2,875	2,875	33,879	19
20	Various			2001	62,933		20	3,147	3,147	33,115	20
21	Various			2002	83,062		20	2,251	2,251	21,811	21
22	Various			2003	16,347		20	1,565	1,565	13,692	22
23	Various			2004	116,859		20	11,686	11,686	83,447	23
24	Various			2005	112,439		20	8,963	8,963	64,961	24
25	Various			2006	70,102		20	3,179	3,179	60,703	25
26	Various			2007	205,027		20	11,568	11,568	54,573	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,067,911			52,990	52,990	111,382	67
68	Related Party Allocations (Pages 12H & 12I)		76,076	1,951		2,174	223	39,849	68
69	Financial Statement Depreciation			92,537			(92,537)		69
70	TOTAL (lines 4 thru 69)		$ 9,000,097	$ 394,141		$ 310,262	$ (83,879)	$ 1,987,460	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 12A, Carried Forward		$ 9,000,097	$ 394,141		$ 310,262	$ (83,879)	$ 1,987,460	1
2	12 Boxes Cove Base W/Toe	2008	963		20	96	96	377	2
3	Parts For Generator	2008	2,949		20	295	295	1,155	3
4	Fire Alarm System	2008	57,766		20	5,777	5,777	20,700	4
5	Air Handler For A/C System	2008	2,850		20	285	285	1,021	5
6	Rebuild Generator	2008	13,725		20	1,373	1,373	4,804	6
7	7 Air Conditioners	2008	3,350		20	86	86	297	7
8	Boiler Repair	2008	2,342		20	234	234	781	8
9	Generator Repairs	2008	4,599		20	460	460	1,686	9
10	Hjf Assoc Building Repairs	2008	7,770		20	1,554	1,554	4,921	10
11	Generator Repairs	2008	3,525		20	705	705	2,174	11
12	Electrical Work	2009	9,950		20	255	255	712	12
13	10 Air Conditioners	2009	5,621		20	144	144	378	13
14	New Windows	2009	17,141		20	1,714	1,714	4,571	14
15	Plumbing Work	2009	40,057		20	1,027	1,027	2,696	15
16	Windows In Front	2009	51,424		20	1,319	1,319	3,461	16
17	Electrical Work	2009	23,100		20	592	592	1,505	17
18	Electrical Work	2009	35,340		20	906	906	2,228	18
19	Electrical Work	2009	7,630		20	196	196	465	19
20	Concrete & Beam Work	2009	17,500		20	449	449	1,066	20
21	Concrete And Beam Work	2009	17,500		20	449	449	1,066	21
22	Concrete And Beam Work	2009	2,955		20	76	76	180	22
23	Concrete And Beam Work	2009	17,500		20	449	449	1,066	23
24	Electrical Work	2009	8,320		20	213	213	507	24
25	Electrical Work	2009	17,360		20	445	445	909	25
26	Building Remodel	2009	176,726		20	4,531	4,531	9,252	26
27	Plumbing Work	2009	80,047		20	2,052	2,052	4,191	27
28	Ceramic Tile	2009	9,070		20	233	233	475	28
29	Security System	2009	8,125		20	208	208	425	29
30	Lighting/Corners/Windows/Cove/Curtain	2009	18,538		20	475	475	970	30
31	Faucet Handles, P-Trap, Supply Cover	2010	5,192		20	519	519	519	31
32	Roof Work	2011	7,800		20	390	390	390	32
33	Electrical Wiring	2011	38,821		20	1,941	1,941	1,941	33
34	TOTAL (lines 1 thru 33)		$ 9,715,653	$ 394,141		$ 339,710	$ (54,431)	$ 2,064,348	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: 01/01/11 Ending: 12/31/11

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 12B, Carried Forward		$ 9,715,653	$ 394,141		$ 339,710	$ (54,431)	$ 2,064,348	1
2	Bldg, Co. - Handrails	2011	9,416		20	471	471	471	2
3	Bldg. Co. - Ceiling Tiles	2011	6,254		20	313	313	313	3
4	Bldg. Co. - Ceiling Tiles And Doors For 1St Floor	2011	7,066		20	353	353	353	4
5	Bldg. Co, - Duct Work - Hvac	2011	3,380		20	169	169	169	5
6	Bldg. Co. - Ceiling Tile	2011	4,375		20	219	219	219	6
7	Bldg. Co. - Wallpaper & Corner Guards	2011	13,125		20	656	656	656	7
8	Bldg. Co. - Pumps And Piping	2011	6,010		20	301	301	301	8
9	Bldg. Co. - Drain System And New Valves	2011	4,475		20	224	224	224	9
10	Bldg. Co. - Fire Alarm And Sprinkler System	2011	3,625		20	181	181	181	10
11	Bldg. Co. - Corner Guards And End Caps	2011	4,341		20	217	217	217	11
12	Bldg. Co. - Hvac System	2011	4,018		20	201	201	201	12
13	Bldg. Co. - Pump And Piping For Heating And Chilling System	2011	6,180		20	309	309	309	13
14	Bldg. Co. - New Lamps And Light Accessories	2011	4,969		20	248	248	248	14
15	Bldg, Co. - Window Treatments	2011	4,329		20	216	216	216	15
16	Bldg. Co. - 28 Through The Wall Air Conditioners	2011	10,722		20	536	536	536	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)		$ 9,807,938	$ 394,141		$ 344,324	$ (49,817)	$ 2,068,962	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: 01/01/11 Ending: 12/31/11

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		$ 9,807,938	$ 394,141		$ 344,324	$ (49,817)	$ 2,068,962	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)		$ 9,807,938	$ 394,141		$ 344,324	$ (49,817)	$ 2,068,962	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: 01/01/11 Ending: 12/31/11

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 12D, Carried Forward		$ 9,807,938	$ 394,141		$ 344,324	$ (49,817)	$ 2,068,962	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)		$ 9,807,938	$ 394,141		$ 344,324	$ (49,817)	$ 2,068,962	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: 01/01/11 Ending: 12/31/11

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								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	19,634	9
10	Elevator (Electrical)	2005	16,710		20	836	836	4,433	10
11	Heating System Boiler Repair	2010	4,385		20	219	219	438	11
12	Materials for Therapy Room	2010	5,309		20	265	265	530	12
13	Air Handler Unit in Basement	2010	10,188		20	509	509	1,018	13
14	Air Conditioning Work	2010	7,685		20	384	384	768	14
15	Sprinkler System Repair	2010	4,795		20	240	240	480	15
16	Exhaust Fan/Dampers/Duct - Elevator Room	2010	3,855		20	193	193	386	16
17	Fix Closets In Patient Rooms	2010	4,140		20	207	207	414	17
18	Materials For Therapy Room	2010	3,560		20	178	178	356	18
19	Plumbing	2010	6,497		20	325	325	650	19
20	Custom Cabinets For Therapy Room	2010	14,843		20	742	742	1,484	20
21	Wall Covering For Therapy Room	2010	3,280		20	164	164	328	21
22	Flooring For Therapy Room	2010	18,260		20	913	913	1,826	22
23	Fire Alarm System	2010	4,785		20	239	239	478	23
24	Fan Coil Units For Lobby	2010	3,400		20	170	170	340	24
25	Metal Door And Frame	2010	1,911		20	96	96	192	25
26	Window Treatment & Cubicle Curtains - Therapy Room	2010	68,886		20	3,444	3,444	6,888	26
27	Laundry Room Work	2010	3,200		20	160	160	320	27
28	Installation Of Ramp	2010	313,956		20	15,698	15,698	31,396	28
29	Lighting For Therapy Room Corridor	2010	64,109		20	3,205	3,205	6,410	29
30	Drywall And Piping	2010	5,372		20	269	269	538	30
31	Carpeting & Wallcovering For Lobby	2010	2,830		20	142	142	284	31
32	Piping Repairs	2010	4,910		20	246	246	492	32
33	Conduit For Fire Alarm System	2010	7,030		20	352	352	704	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: 01/01/11 Ending: 12/31/11

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	302	2
3	10 Air Conditioner Sleeve Units	2010	5,621		20	281	281	562	3
4	2 new Boilers For Hot Water System	2010	59,941		20	2,997	2,997	5,994	4
5	Therapy Room/Lobby/Bathroom/Fire Doors/Wallpaper	2010	26,569		20	1,328	1,328	2,657	5
6	Wiring, Cameras, Alarms	2010	5,305		20	265	265	531	6
7	Electrical Work In Laundry Room	2010	10,360		20	518	518	1,036	7
8	Electrical For Lobby	2010	11,550		20	578	578	1,155	8
9	Air Exchanger in Basement	2010	8,200		20	410	410	820	9
10	Engineering Costs For Renovation	2010	37,935		20	1,897	1,897	3,794	10
11	Wallcovering	2010	10,605		20	530	530	1,061	11
12	Flooring	2010	12,772		20	639	639	1,277	12
13	Lighting Fixtures	2010	14,557		20	728	728	1,456	13
14	Flooring	2010	3,578		20	179	179	358	14
15	Kitchen Shelving	2011	3,253		20	163	163	163	15
16	Nurses Station	2011	7,266		20	363	363	363	16
17	Vinyl Flooring	2011	6,692		20	335	335	335	17
18	Vinyl Flooring	2011	24,304		20	1,215	1,215	1,215	18
19	Wallpaper and Handrails	2011	16,500		20	825	825	825	19
20	Drop Ceiling	2011	5,525		20	276	276	276	20
21	Window Treatment and Curtains	2011	12,162		20	608	608	608	21
22	Flooring - Hardware, Vinyl, Wall Guards	2011	6,581		20	329	329	329	22
23	Painting - Room Buildout	2011	27,911		20	1,396	1,396	1,396	23
24	Schwarts Bros -Corner Gaurds, Blinds, Vinyle Base Boards	2011	6,735		20	337	337	337	24
25	Blinds, Bumpers, & Baseboards	2011	4,551		20	228	228	228	25
26	Vinyl Flooring	2011	25,882		20	1,294	1,294	1,294	26
27	Ramp Replacement	2011	3,310		20	166	166	166	27
28	Vinyl Flooring	2011	2,554		20	128	128	128	28
29	Landscaping - Irrigation System	2011	3,625		20	181	181	181	29
30	Landscaping - Install Sod	2011	3,450		20	173	173	173	30
31	Security Alarm System	2011	7,965		20	398	398	398	31
32	Schwarts Bros -Doors, Windows, and Drywall	2011	23,579		20	1,179	1,179	1,179	32
33	Handrails	2011	8,132						33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 1,067,911	$		$ 52,990	$ 52,990	$ 111,382	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: 01/01/11 Ending: 12/31/11

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	1993	76,076	1,951	35	2,174	223	39,849	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Continued								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)		$ 76,076	$ 1,951		$ 2,174	$ 223	$ 39,849	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: 01/01/11 Ending: 12/31/11

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	$ 908,375	$	$ 120,464	$ 120,464	10	$ 554,532	71
72	Current Year Purchases	33,475		2,127	2,127	10	2,127	72
73	Fully Depreciated Assets	387,244		29	29	10	387,075	73
74								74
75	TOTALS	$ 1,329,094	$	$ 122,620	$ 122,620		$ 943,734	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	$	$ 6,325	$ 6,325	5	$ 48,476	76
77		Allocated from Dynamic	2011	39,476	1,882	6,519	4,637	5	18,631	77
78										78
79										79
80	TOTALS			$ 91,115	$ 1,882	$ 12,844	$ 10,962		$ 67,107	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,978,147	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 396,023	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 479,789	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 83,766	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,079,803	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.

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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? ☐ YES ☐ NO
   If NO, see instructions.

		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				3,419			5
6								6
7	TOTAL				$ 3,419 **			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: ____ *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 6,220 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1994 Dodge Ram Van	$ 247.50	$ 2,970	17
18	Alllocated from Dynamic			16,135	18
19					19
20					20
21	TOTAL		$ 247.50	$ 19,105	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2		3	4	5	6	7	8	
	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	$ 81,131		$	$		$ 81,131	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			265			265	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	199,713					199,713	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				307,031		307,031	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						43,199		43,199	13
14	TOTAL			$ 280,844		$ 265	$ 350,230		$ 631,339	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

STATE OF ILLINOIS

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (18,528)	$ 217,662	1
2	Cash-Patient Deposits	156,163	156,163	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,639,649	3,639,649	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	144,994	190,664	6
7	Other Prepaid Expenses	3,804	3,804	7
8	Accounts Receivable (owners or related parties)	600,923	1,057,999	8
9	Other(specify): See Attached Schedule	5,706	851,249	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,532,711	$ 6,117,190	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	1,738,308	2,859,292	15
16	Equipment, at Historical Cost	1,392,270	1,401,460	16
17	Accumulated Depreciation (book methods)	(1,754,716)	(3,169,103)	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	235,737	521,722	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,611,599	$ 9,140,131	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,144,310	$ 15,257,321	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 698,777	$ 698,774	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	176,250	176,250	28
29	Short-Term Notes Payable	2,960,449	3,180,182	29
30	Accrued Salaries Payable	392,758	392,758	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,370	4,370	31
32	Accrued Real Estate Taxes(Sch.IX-B)		250,000	32
33	Accrued Interest Payable	5,906	46,678	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	19,504	19,504	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	388,640	423,069	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,646,654	$ 5,191,585	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,416,343	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)**	$	$ 10,416,343	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,646,654	$ 15,607,928	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,497,656	$ (350,607)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,144,310	$ 15,257,321	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,494,633	1
2	Restatements (describe):		2
3	**CIP Capitalization/Depreciation Adjustment**	(3,469)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,491,164	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	805,692	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,799,200)	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)**	$ (993,508)	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)**	$ 1,497,656	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,231,893	1
2	Discounts and Allowances for all Levels	(2,144,317)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,087,576	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,926,673	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,926,673	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	402,040	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,269	19
20	Radiology and X-Ray	4,883	20
21	Other Medical Services	68,676	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 507,868	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	41,685	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41,685	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	232,782	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 232,782	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,796,584	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,780,053	31
32	Health Care	3,927,743	32
33	General Administration	2,949,075	33
	B. Capital Expense		
34	Ownership	1,502,981	34
	C. Ancillary Expense		
35	Special Cost Centers	709,495	35
36	Provider Participation Fee	121,545	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,990,892	40
41	**Income before Income Taxes (line 30 minus line 40)****	805,692	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 805,692	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,190	2,450	$ 116,472	$ 47.54	1
2	Assistant Director of Nursing	1,179	1,202	45,632	37.96	2
3	Registered Nurses	16,979	17,735	575,021	32.42	3
4	Licensed Practical Nurses	36,330	38,859	1,032,501	26.57	4
5	CNAs & Orderlies	104,882	114,743	1,287,624	11.22	5
6	CNA Trainees					6
7	Licensed Therapist	6,325	6,465	280,844	43.44	7
8	Rehab/Therapy Aides	12,724	13,893	188,689	13.58	8
9	Activity Director	2,020	2,080	33,446	16.08	9
10	Activity Assistants	12,895	13,667	123,723	9.05	10
11	Social Service Workers	8,745	9,317	168,325	18.07	11
12	Dietician					12
13	Food Service Supervisor	2,425	2,671	55,964	20.95	13
14	Head Cook	6,982	7,685	87,870	11.43	14
15	Cook Helpers/Assistants	18,504	19,569	186,532	9.53	15
16	Dishwashers					16
17	Maintenance Workers	6,065	6,576	90,749	13.80	17
18	Housekeepers		5,678	51,873	9.14	18
19	Laundry					19
20	Administrator	2,031	2,143	106,119	49.52	20
21	Assistant Administrator	309	309	21,172	68.52	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,174	8,581	112,232	13.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,995	2,235	34,737	15.54	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,024	2,240	78,126	34.88	33
34	TOTAL (lines 1 - 33)	251,777	278,099	$ 4,677,651 *	$ 16.82	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	332	$ 11,394	01-03	35
36	Medical Director	248	13,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	163	6,848	10-03	38
39	Pharmacist Consultant	306	12,843	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	1,126	60,855	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,400	11-03	44
45	Social Service Consultant	118	6,830	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,333	$ 114,370		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	48	1,582	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	48	$ 1,582		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jay Gonzalez	Administrator	0.00%	$ 22,884
Jeremy Boches	Administrator	0.00%	83,236
Steve Goldstein	Asst. Admin.	0.00%	21,172
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,292

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Casamba	Data Processing	$ 3,600
eHealth Solutions	Data Processing	3,725
Health Data Systems	Data Processing	5,670
Dynamic HC Consultants	Data Processing/Bookkeeping	876,631
Frost, Ruttenberg & Rothblatt	Accounting	19,615
Personnel Planners	Unemployment Consult.	1,782
See Attached	Legal Fees	84,197
Cerner Corporation	Software	868
Singer Networks	Software	442
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 996,530

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,685
Unemployment Compensation Insurance	38,388
FICA Taxes	357,500
Employee Health Insurance	263,098
Employee Meals	88,823
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	18,598
Chicago Head Tax	6,450
TOTAL (agree to Schedule V, line 22, col.8)	$ 918,542

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	22,587
Health Care Worker Background Check	
(Indicate # of checks performed 672)	6,715
Patient Background Checks	
Advertising and Promotion	63,128
Dues & Subscriptions	17,199
Licenses and Permits	4,183
Allocated from Dynamic	1,289
Less: Public Relations Expense	( )
Non-allowable advertising	(63,128)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 51,973

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,759
Allocated from Dynamic	1,379
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,138

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Woodbridge Nursing Pavilion **#** 0034157 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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. **ICLTC $8,676**

(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. $ **71,399** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **121,545**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **88,823** 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 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.