FOR BHF USE

LL1

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.

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

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 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(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: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1 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	81,252	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	81,252	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	3,818	182	7,685	11,685	8
9	SNF/PED					9
10	ICF	59,206	1,457	767	61,430	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,024	1,639	8,452	73,115	14

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

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 7,685

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	337,961	36,456	11,448	385,865		385,865		385,865			1
2	Food Purchase		411,644		411,644	(84,528)	327,116	(92)	327,024			2
3	Housekeeping		621	282,000	282,621		282,621		282,621			3
4	Laundry		11,938	192,000	203,938		203,938		203,938			4
5	Heat and Other Utilities			176,251	176,251		176,251	(609)	175,642			5
6	Maintenance	116,612	92,960	93,148	302,720		302,720	82,471	385,191			6
7	Other (specify):*							1,678	1,678			7
8	**TOTAL General Services**	454,573	553,619	754,847	1,763,039	(84,528)	1,678,511	83,448	1,761,959			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,186,181	244,821	21,077	3,452,079		3,452,079	(6,165)	3,445,914			10
10a	Therapy	111,309			111,309		111,309		111,309			10a
11	Activities	133,817	6,344	2,200	142,361		142,361		142,361			11
12	Social Services	232,496		3,968	236,464		236,464		236,464			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,663,803	251,165	51,245	3,966,213		3,966,213	(6,165)	3,960,048			16
	C. General Administration											
17	Administrative	119,553			119,553		119,553	307,664	427,217			17
18	Directors Fees											18
19	Professional Services			1,024,551	1,024,551	(15,105)	1,009,446	(889,325)	120,121			19
20	Dues, Fees, Subscriptions & Promotions			117,604	117,604		117,604	(76,593)	41,011			20
21	Clerical & General Office Expenses	70,184	1,197	951,423	1,022,804		1,022,804	(784,818)	237,986			21
22	Employee Benefits & Payroll Taxes			810,346	810,346	84,528	894,874		894,874			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,413	6,413		6,413	4,812	11,225			24
25	Other Admin. Staff Transportation			20,420	20,420		20,420	130	20,550			25
26	Insurance-Prop.Liab.Malpractice			251,113	251,113		251,113	10,496	261,609			26
27	Other (specify):*							81,693	81,693			27
28	**TOTAL General Administration**	189,737	1,197	3,181,870	3,372,804	69,423	3,442,227	(1,345,941)	2,096,286			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,308,113	805,981	3,987,962	9,102,056	(15,105)	9,086,951	(1,268,658)	7,818,293			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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			88,650	88,650		88,650	403,424	492,074			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,027	71,027		71,027	440,047	511,074			32
33	Real Estate Taxes					15,105	15,105	251,101	266,206			33
34	Rent-Facility & Grounds			1,357,593	1,357,593		1,357,593	(1,354,090)	3,503			34
35	Rent-Equipment & Vehicles			6,090	6,090		6,090	17,230	23,320			35
36	Other (specify):*							52,586	52,586			36
37	**TOTAL Ownership**			1,523,360	1,523,360	15,105	1,538,465	(189,702)	1,348,763			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	577,867	318,299	983	897,149		897,149	(614)	896,535			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			518,699	518,699		518,699		518,699			42
43	Other (specify):*	82,058		332	82,390		82,390	(82,390)				43
44	**TOTAL Special Cost Centers**	659,925	318,299	520,014	1,498,238		1,498,238	(83,004)	1,415,234			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,968,038	1,124,280	6,031,336	12,123,654		12,123,654	(1,541,364)	10,582,290			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,690)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	77,917	30		9
10	Interest and Other Investment Income	(49,091)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(92)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(529,000)	21		24
25	Fund Raising, Advertising and Promotional	(59,405)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(490,734)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,055,595)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(485,769)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (485,769)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,541,364)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (8,738)	21	1
2	Cope Dues	(11,543)	20	2
3	Building Co. - Legal Fees	(269)	19	3
4	Building Co. - Accounting Fees	(17,140)	19	4
5	Building Co. - Amortization	(11,106)	31	5
6	Building Co. - State Replacement Tax	(506)	21	6
7	Building Co. - Franchise Tax	(250)	20	7
8	Marketing Travel Expense	(96)	43	8
9	Marketing Benefits	(236)	43	9
10	Non Allowable Legal Fees	(9,727)	19	10
11	Additional R&M	16,685	06	11
12	Building Co. - Additional R&M	17,636	06	12
13	Marketing Salary	(82,058)	43	13
14	PPA - Repair and Maintenance	(3,211)	06	14
15	PPA - Medical Supplies	(6,165)	10	15
16	PPA - Professional Fees	(1,583)	19	16
17	PPA - Background Checks, Want Ads, Licenses	(4,442)	20	17
18	PPA - Office Expenses	(367,985)	21	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(490,734)		49

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/12

Ending: 12/31/12

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

STATE OF ILLINOIS **Summary A**

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(92)											(92)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,690)		2,081									(609)	5
6	Maintenance	31,110	21,072	17,873	12,416								82,471	6
7	Other (specify):*			383		1,295							1,678	7
8	**TOTAL General Services**	28,328	21,072	20,337	12,416	1,295							83,448	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(6,165)											(6,165)	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**	(6,165)											(6,165)	16
	C. General Administration													
17	Administrative				307,664								307,664	17
18	Directors Fees													18
19	Professional Services	(28,719)	17,409	(878,015)									(889,325)	19
20	Fees, Subscriptions & Promotions	(78,140)	250	1,297									(76,593)	20
21	Clerical & General Office Expenses	(906,229)	506	104,710	16,195								(784,818)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			4,812									4,812	24
25	Other Admin. Staff Transportation			130									130	25
26	Insurance-Prop.Liab.Malpractice		10,496										10,496	26
27	Other (specify):*			20,198		61,495							81,693	27
28	**TOTAL General Administration**	(1,013,088)	28,661	(746,868)	323,859	61,495							(1,345,941)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(990,925)	49,733	(726,531)	336,275	62,790							(1,268,658)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	77,917	320,253	5,254									403,424	30
31	Amortization of Pre-Op. & Org.	(11,106)	11,106											31
32	Interest	(49,091)	482,973	6,165									440,047	32
33	Real Estate Taxes		244,369	6,732									251,101	33
34	Rent-Facility & Grounds		(1,354,090)										(1,354,090)	34
35	Rent-Equipment & Vehicles			17,230									17,230	35
36	Other (specify):*		52,586										52,586	36
37	TOTAL Ownership	17,720	(242,803)	35,381									(189,702)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(614)						(614)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(82,390)											(82,390)	43
44	TOTAL Special Cost Centers	(82,390)					(614)						(83,004)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,055,595)	(193,070)	(691,150)	336,275	62,790	(614)						(1,541,364)	45

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

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. [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)	
1	V	34	Rental Income	$ 1,354,090	Woodbridge Building LLC	100.00%	$	$ (1,354,090)	1
2	V	32	Interest Income	850	Woodbridge Building LLC	100.00%		(850)	2
3	V	19	Legal & Accounting Fees		Woodbridge Building LLC	100.00%	17,409	17,409	3
4	V	30	Depreciation		Woodbridge Building LLC	100.00%	320,253	320,253	4
5	V	31	Amortization of Mortgage Cts		Woodbridge Building LLC	100.00%	11,106	11,106	5
6	V	33	Real Estate Tax		Woodbridge Building LLC	100.00%	244,369	244,369	6
7	V	20	Franchise Tax		Woodbridge Building LLC	100.00%	250	250	7
8	V	21	State Replacement Tax		Woodbridge Building LLC	100.00%	506	506	8
9	V	06	Repairs and Maintenance		Woodbridge Building LLC	100.00%	21,072	21,072	9
10	V	32	Interest Expense - Heartland		Woodbridge Building LLC	100.00%	483,823	483,823	10
11	V	36	Mortgage Insurance		Woodbridge Building LLC	100.00%	52,586	52,586	11
12	V	26	Insurance		Woodbridge Building LLC	100.00%	10,496	10,496	12
13	V								13
14	Total			$ 1,354,940			$ 1,161,870	$ * (193,070)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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%	$ 2,081	$ 2,081	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	17,873	17,873	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	383	383	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	2,539	2,539	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	1,297	1,297	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	104,710	104,710	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	4,812	4,812	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	130	130	22
23	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	20,198	20,198	23
24	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	5,254	5,254	24
25	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	6,165	6,165	25
26	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	6,732	6,732	26
27	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	16,627	16,627	27
28	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	603	603	28
29	V								29
30	V								30
31	V								31
32	V	19	HOME OFFICE	880,554	DYNAMIC HEALTH CARE CONS.	100.00%		(880,554)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 880,554			$ 189,404	$ * (691,150)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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%	$ 12,416	$ 12,416	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	37,214	37,214	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	42,275	42,275	17
18	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			18
19	V	17	ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	63,804	63,804	20
21	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	18,467	18,467	21
22	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	32,169	32,169	22
23	V	17	ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	17	ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	41,195	41,195	24
25	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	39,042	39,042	25
26	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	33,498	33,498	26
27	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	15,899	15,899	27
28	V	21	CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	296	296	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 336,275	$ * 336,275	39

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

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

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	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 1,295	$ 1,295	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	2,018	2,018	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	2,917	2,917	17
18	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			18
19	V	27	EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	23,643	23,643	20
21	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	5,944	5,944	21
22	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	2,256	2,256	22
23	V	27	EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	27	EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	7,077	7,077	24
25	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	10,464	10,464	25
26	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	4,195	4,195	26
27	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	2,955	2,955	27
28	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	26	26	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 62,790	$ * 62,790	39

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

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

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	39	DME and Medical Supplies	3,339	Integra Healthcare Equipment	100.00%	2,725	$ (614)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,339			$ 2,725	$ * (614)	39

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

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

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

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

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.

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

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

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

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	ESTATE OF LEO MAUER	4.505%	PARK RIDGE CARE CENTER, LTD.	PARK RIDGE	INTEGRA HEALTHCARE EQUI	ELMHURST	DME	4
5	FRANCES MAUER	6.757%	STERLING PAVILION, LTD.	STERLING	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	5
6	FRED L. AARON	22.703%	WARREN PARK HEALTH AND LIVING CENTER,LLC	CHICAGO				6
7	JOSEPH MAUER	4.505%	WATERFRONT TERRACE, INC.	CHICAGO				7
8	MARSHALL A. MAUER	6.757%	WILLOW CREST NURSING PAVILION, LTD.	SANDWICH				8
9	MAURICE I. AARON C/O DYNAMIC HEALTH	24.865%	WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				9
10	MIRIAM LATINIK	4.505%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (S	GALESBURG				10
11	SHARON S. AARON	0.586%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLI	GENESEO				11
12	SUE KOPLIN	0.586%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC (SLF	PONTIAC				12
13	SUSAN L. STERN	4.505%						13
14	SUSIE & HOWIE ALTER	1.171%						14
15	SYLVIA AARON	0.234%						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	413,728	13	$ 11,773	$	73,115	$ 2,081	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	413,728	13	101,134	34,519	73,115	17,873	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	413,728	13	2,165		73,115	383	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	413,728	13	14,369		73,115	2,539	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	413,728	13	7,338		73,115	1,297	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	413,728	13	592,509	421,664	73,115	104,710	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,728	13	27,227		73,115	4,812	7
8	25	AUTO EXP.	PATIENT DAYS	413,728	13	736		73,115	130	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	413,728	13	114,290		73,115	20,198	9
10	30	DEPRECIATION	PATIENT DAYS	413,728	13	29,732		73,115	5,254	10
11	32	INTEREST	PATIENT DAYS	413,728	13	34,887		73,115	6,165	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,728	13	38,096		73,115	6,732	12
13	35	AUTO RENTAL	PATIENT DAYS	413,728	13	94,085		73,115	16,627	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	3,415		73,115	603	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,071,756	$ 456,183		$ 189,404	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	58,740	58,740	8.45	12,416	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	200,000	200,000	7.44	37,214	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	200,000	200,000	8.45	42,275	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	47,000	47,000	-		4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	52,765	52,765	-		5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	102,086	102,086	25.00	63,804	6
7	17	ADMIN. CMP. - S. HARAMARAS	WGHTD. AVG. HOURS	30	4	73,867	73,867	7.50	18,467	7
8	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	152,170	152,170	10.57	32,169	8
9	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		9
10	17	ADMIN. CMP. - V. DAVIS (NON-	WGHTD. AVG. HOURS	40	8	117,701	117,701	14.00	41,195	10
11	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	184,393	184,393	9.53	39,042	11
12	17	ADMIN. CMP. - CFO (NON-OWI	WGHTD. AVG. HOURS	45	10	180,028	180,028	8.37	33,498	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	85,386	85,386	7.45	15,899	13
14	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	12	15,265	15,265	0.54	296	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,481,401	$ 1,481,401		$ 336,275	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	8	6,127		8.45	1,295	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	10,847		7.44	2,018	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	13,801		8.45	2,917	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	36,183				4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	4,278				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,829		25.00	23,643	6
7	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	4	23,776		7.50	5,944	7
8	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,672		10.57	2,256	8
9	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,076				9
10	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	8	20,219		14.00	7,077	10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	49,423		9.53	10,464	11
12	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	45	10	22,545		8.37	4,195	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	15,870		7.45	2,955	13
14	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	12	1,340		0.54	26	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 253,986	$		$ 62,790	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	DME and Medical Supplies	Direct Allocation						2,725	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,725	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/12 Ending: 12/31/12

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

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

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

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

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** 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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Omincare		X	Vendor Financing			$	$ 102,632			$ 7,327	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							102,632			7,327	14
	B. Non-Facility Related*											
15	Allocated from Dynamic		X				$	$			$ 6,165	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										6,165	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 250,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 251,101	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,101	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 250,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$ 15,105	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 266,206	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	239,623	8
	2008	242,027	9
	2009	235,152	10
	2010	245,390	11
	2011	244,369	12

2012 Accrual = $244,369 x 1.025 = $250,000 (Rounded)
Allocated from Dynamic - $6,586

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2011 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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) 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	$ 73,990.15	$ 73,990.15
2.	13-35-217-016-0000	Long Term Care Property	$ 96,388.65	$ 96,388.65
3.	13-35-217-017-0000	Long Term Care Property	$ 73,990.15	$ 73,990.15
4.	10-23-404-059-0000	Allocated from Dynamic	$ 37,266.21	$ 6,585.77
5.			$	$ `
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 281,635.16	$ 250,954.72

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Woodbridge Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) 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: 01/01/12 Ending: 12/31/12

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

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 320,253	35	$ 193,622	$ (126,631)	$ 1,373,763	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			11,181	11
12	Various			1992	14,078		20	316	316	14,075	12
13	Various			1993	122,812		20	5,770	5,770	120,441	13
14	Various			1995	20,549		20	1,027	1,027	17,763	14
15	Various			1996	8,331		20	417	417	6,963	15
16	Various			1997	35,913		20	1,796	1,796	28,127	16
17	Various			1998	50,252		20	2,513	2,513	36,721	17
18	Various			1999	68,242		20	3,412	3,412	46,172	18
19	Various			2000	57,506		20	2,875	2,875	36,754	19
20	Various			2001	62,933		20	3,147	3,147	36,261	20
21	Various			2002	83,062		20	2,160	2,160	23,971	21
22	Various			2003	16,347		20	1,565	1,565	15,257	22
23	Various			2004	116,859		20	11,686	11,686	95,133	23
24	Various			2005	112,439		20	8,705	8,705	73,665	24
25	Various			2006	70,102		20	2,566	2,566	63,269	25
26	Various			2007	205,027		20	11,568	11,568	66,140	26
27	Various			2008	99,839		20	10,864	10,864	48,780	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,067,911			52,990	52,990	164,375	67
68	Related Party Allocations (Pages 12H & 12I)		78,394	2,010		2,240	230	43,303	68
69	Financial Statement Depreciation			88,650			(88,650)		69
70	TOTAL (lines 4 thru 69)		$ 9,102,254	$ 410,913		$ 319,238	$ (91,675)	$ 2,345,830	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,952,207	$ 410,913		$ 354,739	$ (56,174)	$ 2,418,205	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,952,207	$ 410,913		$ 354,739	$ (56,174)	$ 2,418,205	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 9,952,207	$ 410,913		$ 354,739	$ (56,174)	$ 2,418,205	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,952,207	$ 410,913		$ 354,739	$ (56,174)	$ 2,418,205	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 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	23,336	9
10	Elevator (Electrical)	2005	16,710		20	836	836	5,269	10
11	Heating System Boiler Repair	2010	4,385		20	219	219	657	11
12	Materials for Therapy Room	2010	5,309		20	265	265	795	12
13	Air Handler Unit in Basement	2010	10,188		20	509	509	1,527	13
14	Air Conditioning Work	2010	7,685		20	384	384	1,152	14
15	Sprinkler System Repair	2010	4,795		20	240	240	720	15
16	Exhaust Fan/Dampers/Duct - Elevator Room	2010	3,855		20	193	193	579	16
17	Fix Closets In Patient Rooms	2010	4,140		20	207	207	621	17
18	Materials For Therapy Room	2010	3,560		20	178	178	534	18
19	Plumbing	2010	6,497		20	325	325	975	19
20	Custom Cabinets For Therapy Room	2010	14,843		20	742	742	2,226	20
21	Wall Covering For Therapy Room	2010	3,280		20	164	164	492	21
22	Flooring For Therapy Room	2010	18,260		20	913	913	2,739	22
23	Fire Alarm System	2010	4,785		20	239	239	717	23
24	Fan Coil Units For Lobby	2010	3,400		20	170	170	510	24
25	Metal Door And Frame	2010	1,911		20	96	96	288	25
26	Window Treatment & Cubicle Curtains - Therapy Room	2010	68,886		20	3,444	3,444	10,332	26
27	Laundry Room Work	2010	3,200		20	160	160	480	27
28	Installation Of Ramp	2010	313,956		20	15,698	15,698	47,094	28
29	Lighting For Therapy Room Corridor	2010	64,109		20	3,205	3,205	9,615	29
30	Drywall And Piping	2010	5,372		20	269	269	807	30
31	Carpeting & Wallcovering For Lobby	2010	2,830		20	142	142	426	31
32	Piping Repairs	2010	4,910		20	246	246	738	32
33	Conduit For Fire Alarm System	2010	7,030		20	352	352	1,056	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Dynamic HC Consultants	1993	78,394	2,010	35	2,240	230	43,303	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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)		$ 78,394	$ 2,010		$ 2,240	$ 230	$ 43,303	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 878,298	$	$ 115,758	$ 115,758	10	$ 609,417	71
72	Current Year Purchases	86,481	569	11,778	11,209	10	11,778	72
73	Fully Depreciated Assets	451,988		50	50	10	451,814	73
74								74
75	TOTALS	$ 1,416,767	$ 569	$ 127,587	$ 127,018		$ 1,073,009	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2005 FORD E350 BUS	2005	$ 51,639	$	$ 3,163	$ 3,163	5	$ 51,639	76
77		Allocated from Dynamic	2012	44,343	2,676	6,587	3,911	5	12,511	77
78										78
79										79
80	TOTALS			$ 95,982	$ 2,676	$ 9,750	$ 7,074		$ 64,150	80

E. Summary of Care-Related Assets

		1 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)	$ 12,214,956	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 414,158	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 492,075	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 77,917	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,555,364	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building - Section 754 Step-up - 2005	$ 641,573	$	$	86
87	Land - Section 754 Step-Up - 2005	71,004			87
88					88
89					89
90					90
91	TOTALS	$ 712,577	$	$	91

G. Construction-in-Progress

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

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

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

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

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				3,503			5
6								6
7	TOTAL				$ 3,503 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 6,693 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Dynamic		$	$ 16,627	17
18					18
19					19
20					20
21	TOTAL		$	$ 16,627	21

* 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.

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion

STATE OF ILLINOIS
0034157 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$ 130,354		$	$		$ 130,354	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	160,224		1,590			161,814	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	287,289					287,289	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts			(607)	234,742		234,135	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						83,557		83,557	13
14	TOTAL			$ 577,867		$ 983	$ 318,299		$ 897,149	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$ 163,692	$ 278,148	1
2	Cash-Patient Deposits	111,566	111,566	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,858,438	1,858,438	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	183,165	229,144	6
7	Other Prepaid Expenses	1,875	1,875	7
8	Accounts Receivable (owners or related parties)	925,923	1,282,999	8
9	Other(specify): See Attached Schedule	184,560	958,752	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,429,219	$ 4,720,922	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		750,000	13
14	Buildings, at Historical Cost		6,776,760	14
15	Leasehold Improvements, at Historical Cost	1,770,220	2,991,023	15
16	Equipment, at Historical Cost	1,426,772	1,514,530	16
17	Accumulated Depreciation (book methods)	(1,843,366)	(3,560,627)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,949	7,949	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,949)	(7,949)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	172,959	447,838	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,526,585	$ 8,919,524	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,955,804	$ 13,640,446	25

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

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,497,657	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,497,654	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,147,935	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(799,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 348,735	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,846,389	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,535,967	1
2	Discounts and Allowances for all Levels	(2,606,514)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,929,453	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,340,680	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,340,680	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	357,487	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,878	19
20	Radiology and X-Ray	41,791	20
21	Other Medical Services	89,209	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 518,365	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	49,091	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 49,091	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	434,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 434,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,271,589	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,763,039	31
32	Health Care	3,966,213	32
33	General Administration	3,372,804	33
	B. Capital Expense		
34	Ownership	1,523,360	34
	C. Ancillary Expense		
35	Special Cost Centers	979,539	35
36	Provider Participation Fee	518,699	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,123,654	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,147,935	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,147,935	43

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,929	2,067	$ 97,320	$ 47.08	1
2	Assistant Director of Nursing	1,897	1,955	74,598	38.16	2
3	Registered Nurses	16,990	17,757	590,921	33.28	3
4	Licensed Practical Nurses	37,437	39,917	1,093,566	27.40	4
5	CNAs & Orderlies	106,349	114,434	1,273,210	11.13	5
6	CNA Trainees					6
7	Licensed Therapist	9,060	9,655	577,867	59.85	7
8	Rehab/Therapy Aides	20,095	21,413	111,309	5.20	8
9	Activity Director	1,104	1,403	16,181	11.53	9
10	Activity Assistants	12,531	13,220	117,636	8.90	10
11	Social Service Workers	11,647	12,939	232,496	17.97	11
12	Dietician					12
13	Food Service Supervisor	2,675	2,879	62,871	21.84	13
14	Head Cook	7,705	8,388	101,237	12.07	14
15	Cook Helpers/Assistants	16,574	18,218	173,853	9.54	15
16	Dishwashers					16
17	Maintenance Workers	6,387	6,911	116,612	16.87	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,821	1,854	100,449	54.18	20
21	Assistant Administrator	272	272	19,104	70.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,788	5,235	70,184	13.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,642	4,114	56,566	13.75	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,024	2,232	82,058	36.76	33
34	TOTAL (lines 1 - 33)	264,927	284,863	$ 4,968,038 *	$ 17.44	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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

C. CONTRACT NURSES

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

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Phil Birn	Administrator	0%	$ 100,449
Steve Goldstein	Asst. Administrator	0%	19,104
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 119,553

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
Frost, Ruttenberg, Rothblatt	Accounting Fees	$ 23,956
Dynamic HC Consultants	Bookkeeping	864,500
Personnel Planners	Unemployment Consulting	3,726
Various	Legal Fees	85,635
Adj on Page 5A	Legal	9,727
Casamba	Data Processing	3,616
First Real Estate Services	Appraisal Fee	2,750
Health Data Systems	Data Processing	12,671
E Health Solutions	Data Processing	333
Dynamic HC Consultants	Data Processing	16,054
Adj on Page 5A	Other Professional	1,583
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,024,551

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,020
Unemployment Compensation Insurance	50,383
FICA Taxes	374,208
Employee Health Insurance	236,339
Employee Meals	84,528
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	3,948
Other Employee Benefits	22,448
TOTAL (agree to Schedule V, line 22, col.8)	$ 894,874

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	19,427
Health Care Worker Background Check	6,026
(Indicate # of checks performed 602)	
Patient Background Checks	
Advertising & Promotion	59,406
Dues & Subscriptions	10,435
Licenses and Permits	3,825
Allocated from Dynamic HC Consultants	1,297
Less: Public Relations Expense	( )
Non-allowable advertising	(59,406)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,010

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,413
Allocated from Dynamic	4,812
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,225

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC - $21,978**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,541** 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. $ **518,699**
This amount is to be recorded on line 42 of Schedule V.

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

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. $ **84,528** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.