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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0034157

Facility Name: Woodbridge Nursing Pavilion

Address: 2242 North Kedzie (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: 8/1/1988

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 01/01/13 to 12/31/13 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: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,542	149	6,700	12,391	8
9	SNF/PED					9
10	ICF	52,782	755	3,290	56,827	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,324	904	9,990	69,218	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.42%

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 8/01/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/01/1988 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 5,488

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: 12/31/2013 Fiscal Year: 12/31/2013

* 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: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	333,364	36,951	14,700	385,015		385,015		385,015			1
2	Food Purchase		413,297		413,297	(88,257)	325,040	(54)	324,986			2
3	Housekeeping		4,813	270,500	275,313		275,313		275,313			3
4	Laundry		5,592	164,000	169,592		169,592		169,592			4
5	Heat and Other Utilities			182,947	182,947		182,947	(1,615)	181,332			5
6	Maintenance	88,852	87,452	93,385	269,689		269,689	47,159	316,848			6
7	Other (specify):*							1,647	1,647			7
8	TOTAL General Services	422,216	548,105	725,532	1,695,853	(88,257)	1,607,596	47,137	1,654,733			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,242,294	248,985	16,208	3,507,487		3,507,487		3,507,487			10
10a	Therapy	120,799			120,799		120,799		120,799			10a
11	Activities	144,499	5,293	2,400	152,192		152,192		152,192			11
12	Social Services	185,391		5,610	191,001		191,001		191,001			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,692,983	254,278	48,218	3,995,479		3,995,479		3,995,479			16
	C. General Administration											
17	Administrative	128,596			128,596		128,596	278,495	407,091			17
18	Directors Fees											18
19	Professional Services			908,312	908,312	(28,386)	879,926	(772,058)	107,868			19
20	Dues, Fees, Subscriptions & Promotions			78,018	78,018		78,018	(55,127)	22,891			20
21	Clerical & General Office Expenses	73,330	2,429	862,548	938,307		938,307	(694,497)	243,810			21
22	Employee Benefits & Payroll Taxes			804,522	804,522	88,257	892,779		892,779			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,245	6,245		6,245	1,460	7,705			24
25	Other Admin. Staff Transportation			26,063	26,063		26,063	3,636	29,699			25
26	Insurance-Prop.Liab.Malpractice			401,613	401,613		401,613	(115,610)	286,003			26
27	Other (specify):*							84,651	84,651			27
28	TOTAL General Administration	201,926	2,429	3,087,321	3,291,676	59,871	3,351,547	(1,269,050)	2,082,497			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,317,125	804,812	3,861,071	8,983,008	(28,386)	8,954,622	(1,221,913)	7,732,709			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: 01/01/13 Ending: 12/31/13

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			95,528	95,528		95,528	394,681	490,209			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,981	80,981		80,981	404,451	485,432			32
33	Real Estate Taxes					28,386	28,386	321,880	350,266			33
34	Rent-Facility & Grounds			1,368,052	1,368,052		1,368,052	(1,364,443)	3,609			34
35	Rent-Equipment & Vehicles			7,698	7,698		7,698	16,307	24,005			35
36	Other (specify):*							51,459	51,459			36
37	**TOTAL Ownership**			1,552,259	1,552,259	28,386	1,580,645	(175,665)	1,404,980			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	462,464	202,207	17,764	682,435		682,435	(9,228)	673,207			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			508,380	508,380		508,380		508,380			42
43	Other (specify):*	65,514		67	65,581		65,581	(65,581)				43
44	**TOTAL Special Cost Centers**	527,978	202,207	526,211	1,256,396		1,256,396	(74,809)	1,181,587			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,845,103	1,007,019	5,939,541	11,791,663	(0)	11,791,663	(1,472,387)	10,319,276			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	(3,448)	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	66,411	30		9
10	Interest and Other Investment Income	(63,741)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(54)	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	(1,430)	21		18
19	Entertainment				19
20	Contributions	(2,300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(713,000)	21		24
25	Fund Raising, Advertising and Promotional	(43,782)	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	(350,416)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,111,760)		$	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)	(360,627)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (360,627)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,472,387)		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

STATE OF ILLINOIS **Page 5A**

Woodbridge Nursing Pavilion

ID# **0034157**

Report Period Beginning: **01/01/13**

Ending: **12/31/13**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration Expense	$ (28,603)	21	1
2	Bank Charges	(15,823)	21	2
3	State Replacement Tax	(10,054)	21	3
4	PPA - Office Expenses	(51,035)	21	4
5	Marketing Salary	(65,514)	43	5
6	Marketing Expense	(67)	43	6
7	Additional R&M	19,868	06	7
8	PPA - Professional Fees	(8,757)	19	8
9	Building Co. - Legal	(250)	19	9
10	Building Co. - Accounting	(11,230)	19	10
11	Building Co. - Amortization	(11,106)	31	11
12	Building Co. - Franchise Tax	(250)	20	12
13	Building Co. - State Replacement Tax	(4,148)	21	13
14	PPA - Dividend Income	(4,390)	21	14
15	Non Allowable Travel	(157)	25	15
16	COPE Dues	(10,956)	20	16
17	Intercompany Interest	(10,042)	32	17
18	Non Allowable Legal	(731)	19	18
19	PPA - Liability Settlement	(129,089)	26	19
20	PPA - Ambulance	(8,082)	39	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**	(350,416)		49

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/13

Ending: 12/31/13

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Woodbridge Nursing Pavilion **#** 0034157 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(54)											(54)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,448)		1,833									(1,615)	5
6	Maintenance	19,868		15,211	12,080								47,159	6
7	Other (specify):*			370		1,277							1,647	7
8	**TOTAL General Services**	16,366		17,414	12,080	1,277							47,137	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative				278,495								278,495	17
18	Directors Fees													18
19	Professional Services	(20,968)	11,480	(762,570)									(772,058)	19
20	Fees, Subscriptions & Promotions	(57,288)	250	1,911									(55,127)	20
21	Clerical & General Office Expenses	(828,483)	4,148	113,396	16,442								(694,497)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,460									1,460	24
25	Other Admin. Staff Transportation	(157)		3,793									3,636	25
26	Insurance-Prop.Liab.Malpractice	(129,089)	11,901	1,578									(115,610)	26
27	Other (specify):*			21,184		63,467							84,651	27
28	**TOTAL General Administration**	(1,035,985)	27,779	(619,248)	294,937	63,467							(1,269,050)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,019,619)	27,779	(601,834)	307,017	64,744							(1,221,913)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	66,411	324,718	3,552									394,681	30
31	Amortization of Pre-Op. & Org.	(11,106)	11,106											31
32	Interest	(73,783)	472,609	5,625									404,451	32
33	Real Estate Taxes		314,806	7,074									321,880	33
34	Rent-Facility & Grounds		(1,364,443)										(1,364,443)	34
35	Rent-Equipment & Vehicles			16,307									16,307	35
36	Other (specify):*		51,459										51,459	36
37	TOTAL Ownership	(18,478)	(189,745)	32,558									(175,665)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(8,082)					(649)	(497)					(9,228)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(65,581)											(65,581)	43
44	TOTAL Special Cost Centers	(73,663)					(649)	(497)					(74,809)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,111,760)	(161,966)	(569,276)	307,017	64,744	(649)	(497)					(1,472,387)	45

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 1,364,443	Woodbridge Building LLC	100.00%	$	$ (1,364,443)	1
2	V	32	Interest Income & Expense	851	Woodbridge Building LLC	100.00%	473,460	472,609	2
3	V	19	Legal Fees		Woodbridge Building LLC	100.00%	250	250	3
4	V	19	Accounting		Woodbridge Building LLC	100.00%	11,230	11,230	4
5	V	30	Depreciation		Woodbridge Building LLC	100.00%	324,718	324,718	5
6	V	31	Amortization of Mrtge Costs		Woodbridge Building LLC	100.00%	11,106	11,106	6
7	V	33	Real Estate Tax		Woodbridge Building LLC	100.00%	314,806	314,806	7
8	V	20	Franchise Tax		Woodbridge Building LLC	100.00%	250	250	8
9	V	21	State Replacement Tax		Woodbridge Building LLC	100.00%	4,148	4,148	9
10	V	36	Mortgage Insurance		Woodbridge Building LLC	100.00%	51,459	51,459	10
11	V	26	Insurance		Woodbridge Building LLC	100.00%	11,901	11,901	11
12	V								12
13	V								13
14	Total			$ 1,365,294			$ 1,203,328	$ * (161,966)	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: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 1,833	$ 1,833	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	15,211	15,211	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	370	370	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	3,930	3,930	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	1,911	1,911	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	113,396	113,396	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	1,460	1,460	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	3,793	3,793	22
23	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	1,578	1,578	23
24	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	21,184	21,184	24
25	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	3,552	3,552	25
26	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	5,625	5,625	26
27	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	7,074	7,074	27
28	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	16,176	16,176	28
29	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	131	131	29
30	V								30
31	V								31
32	V	19	BOOKKEEPING FEES	766,500	DYNAMIC HEALTH CARE CONS.	100.00%		(766,500)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 766,500			$ 197,224	$ * (569,276)	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: 01/01/13 Ending: 12/31/13

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%	$ 12,080	$ 12,080	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	35,812	35,812	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	40,590	40,590	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%	56,500	56,500	20
21	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	18,966	18,966	21
22	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	32,082	32,082	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%	21,154	21,154	24
25	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	36,933	36,933	25
26	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	36,458	36,458	26
27	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	15,537	15,537	27
28	V	21	CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	905	905	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			$			$ 307,017	$ * 307,017	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: 01/01/13 Ending: 12/31/13

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%	$ 1,277	$ 1,277	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	1,964	1,964	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	2,857	2,857	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%	25,657	25,657	20
21	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	6,485	6,485	21
22	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	2,259	2,259	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%	5,448	5,448	24
25	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	11,209	11,209	25
26	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	4,426	4,426	26
27	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,088	3,088	27
28	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	74	74	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			$			$ 64,744	$ * 64,744	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: 01/01/13 Ending: 12/31/13

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	$ 14,797	Integra Healthcare Equipment	100.00%	$ 14,148	$ (649)	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			$ 14,797			$ 14,148	$ * (649)	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: 01/01/13 Ending: 12/31/13

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	Ambulance	$ 2,844	Lifeline Ambulance	100.00%	$ 2,347	$ (497)	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			$ 2,844			$ 2,347	$ * (497)	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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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	MAURICE I. AARON C/O DYNAMIC HEALTH	24.865%	BRIDGEVIEW HEALTH CARE CENTER, LTD.	BRIDGEVIEW	WOODBRIDGE BUILING LLC		BUILDING CO.	1
2	ABRAHAM J. STERN	17.153%	GROSSE POINTE MANOR, L.L.C.	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULT	2
3	FRED L. AARON	22.703%	OTTAWA PAVILION, LTD.	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	MARSHALL A. MAUER	6.757%	PARK RIDGE CARE CENTER, LTD.	PARK RIDGE	INTEGRA HEALTHCARE EQUI	ELMHURST	DME	4
5	MIRIAM LATINIK	4.505%	STERLING PAVILION, LTD.	STERLING	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	5
6	JOSEPH MAUER	4.505%	WARREN PARK HEALTH AND LIVING CENTER,LLC	CHICAGO				6
7	SHARON S. AARON	0.586%	WATERFRONT TERRACE, INC.	CHICAGO				7
8	DENNIS NEHMER	0.586%	WILLOW CREST NURSING PAVILION, LTD.	SANDWICH				8
9	DIANIA KUFTA	0.586%	WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				9
10	SUSIE & HOWIE ALTER	1.171%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (	GALESBURG				10
11	SYLVIA AARON	0.234%	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%	RIVER NORTH OF BRADLEY HEALTH & REHAB	BRADLEY				13
14	FRANCES MAUER	6.757%						14
15	FREDA MAUER	4.505%						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	7.16	14.32%	Alloc. Salary	$ 35,812	17-07	1
2	Sharon Aaron	Owner	Clerical	0.59%	See Attached	7.17	17.90%	Alloc. Salary	15,537	21-07	2
3	Maury Aaron	Owner	Administrative	24.86%	See Attached	8.12	16.24%	Alloc. Salary	40,590	17-07	3
4	Diania Kufta	Owner	Administrative	0.59%	See Attached	10.15	20.29%	Alloc. Salary	32,082	17-07	4
5	Dennis Nehmer	Owner	Maintenance	0.59%	See Attached	8.12	20.29%	Alloc. Salary	12,080	06-07	5
6	Sue Koplin-Haramaras	Owner	Administrative	0.59%	See Attached	7.5	18.75%	Alloc. Salary	18,966	17-07	6
7	Esther Maryles	Relative	Clerical	0%	See Attached	0.5	1.79%	Alloc. Salary	905	21-07	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	$ 155,972		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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	407,371	14	$ 10,786	$	69,218	$ 1,833	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	407,371	14	89,523	37,553	69,218	15,211	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	407,371	14	2,175		69,218	370	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	407,371	14	23,130		69,218	3,930	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	407,371	14	11,247		69,218	1,911	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	407,371	14	667,372	493,233	69,218	113,396	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	407,371	14	8,593		69,218	1,460	7
8	25	AUTO EXP.	PATIENT DAYS	407,371	14	22,321		69,218	3,793	8
9	26	INSURANCE	PATIENT DAYS	407,371	14	9,284		69,218	1,578	9
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	407,371	14	124,673		69,218	21,184	10
11	30	DEPRECIATION	PATIENT DAYS	407,371	14	20,906		69,218	3,552	11
12	32	INTEREST	PATIENT DAYS	407,371	14	33,103		69,218	5,625	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	407,371	14	41,631		69,218	7,074	13
14	35	AUTO RENTAL	PATIENT DAYS	407,371	14	95,202		69,218	16,176	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	407,371	14	770		69,218	131	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,160,716	$ 530,786		$ 197,224	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	9	59,522	59,522	8.12	12,080	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	7.16	35,812	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	200,000	8.12	40,590	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	12,500	12,500	-		4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	60,271	60,271	-		5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	90,400	90,400	25.00	56,500	6
7	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	4	75,862	75,862	7.50	18,966	7
8	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	9	158,070	158,070	10.15	32,082	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	11	118,147	118,147	7.16	21,154	10
11	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	181,559	181,559	9.15	36,933	11
12	17	ADMIN. CMP. - CFO (NON-OW	WGHTD. AVG. HOURS	40	11	203,618	203,618	7.16	36,458	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	86,700	86,700	7.17	15,537	13
14	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	12	50,541	50,541	0.50	905	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,509,190	$ 1,509,190		$ 307,017	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	9	6,291		8.12	1,277	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	10,970		7.16	1,964	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	14,077		8.12	2,857	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	37,685		-		4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	4,884		-		5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	41,051		25.00	25,657	6
7	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	4	25,938		7.50	6,485	7
8	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	9	11,132		10.15	2,259	8
9	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,080		-		9
10	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	11	30,426		7.16	5,448	10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	55,102		9.15	11,209	11
12	27	EMP. BEN.- CFO (NON-OWNEF	WGHTD. AVG. HOURS	40	11	24,720		7.16	4,426	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	17,233		7.17	3,088	13
14	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	12	4,119		0.50	74	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 284,708	$		$ 64,744	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
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			$	$		$ 14,148	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					$	$		$ 14,148	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: Lifeline Ambulance
Street Address: 2424 S. Wabash Avenue
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	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	Ambulance	Direct Allocation			$	$		$ 2,347	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					$	$		$ 2,347	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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			$	$ 9,945,422			$ 473,460	1
2	Allocated from Dynamic	X									5,625	2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				1,530,297			67,096	6
7	Omnicare		X	Vendor Financing				47,874			3,843	7
8	See Supplemental Schedule							240,865				8
9	TOTAL Facility Related						$	$ 11,764,458			$ 550,024	9
	B. Non-Facility Related*											
10	Interest Income		X								(63,741)	10
11	Interest Income-Bldg Co.		X								(851)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (64,592)	14
15	TOTALS (line 9+line14)						$	$ 11,764,458			$ 485,432	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 51,459 **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: 01/01/13 Ending: 12/31/13

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	HUD - Current Portion		X	Mortgage			$	$ 240,865			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							240,865				14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)		$ 286,880	2
3. Under or (over) accrual (line 2 minus line 1).		$ 36,880	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 285,000	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.)		$ 28,386	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** $ 84,721 **For** 2009-2011 **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.		$ 350,266	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	242,027	8
	2009	235,152	9
	2010	245,390	10
	2011	244,369	11
	2012	279,806	12

2013 Accrual - $279,806 x 1.02 = $285,000 (Rounded)

Allocated from Dynamic - $7,074

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Woodbridge Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(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	$ 84,694.30	$ 84,694.30
2.	13-35-217-016-0000	Long Term Care Property	$ 110,417.73	$ 110,417.73
3.	13-35-217-017-0000	Long Term Care Property	$ 84,694.30	$ 84,694.30
4.	10-23-404-059-0000	Allocated from Dynamic	$ 39,448.80	$ 6,702.90
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 319,255.13	$ 286,509.23

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Woodbridge Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

	(A) 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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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	$ 324,718	35	$ 193,622	$ (131,096)	$ 1,567,385	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			14,075	12
13	Various			1993	122,812		20	2,365	2,365	122,806	13
14	Various			1995	20,549		20	1,027	1,027	18,790	14
15	Various			1996	8,331		20	417	417	7,380	15
16	Various			1997	35,913		20	1,796	1,796	29,923	16
17	Various			1998	50,252		20	2,513	2,513	39,233	17
18	Various			1999	68,242		20	3,412	3,412	49,584	18
19	Various			2000	57,506		20	2,875	2,875	39,630	19
20	Various			2001	62,933		20	3,147	3,147	39,408	20
21	Various			2002	83,062		20	2,058	2,058	26,029	21
22	Various			2003	16,347		20	422	422	15,679	22
23	Various			2004	116,859		20	11,686	11,686	106,819	23
24	Various			2005	112,439		20	8,705	8,705	82,370	24
25	Various			2006	70,102		20	2,388	2,388	65,658	25
26	Various			2007	205,027		20	11,568	11,568	77,708	26
27	Various			2008	99,839		20	10,547	10,547	59,326	27
28	Various			2009	563,904		20	15,734	15,734	67,589	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,067,911			52,990	52,990	227,870	67
68	Related Party Allocations (Pages 12H & 12I)		75,374	1,933		2,154	221	43,788	68
69	Financial Statement Depreciation			95,528			(95,528)		69
70	TOTAL (lines 4 thru 69)		$ 9,663,138	$ 422,179		$ 329,423	$ (92,756)	$ 2,735,945	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: 01/01/13 Ending: 12/31/13

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		$ 9,663,138	$ 422,179		$ 329,423	$ (92,756)	$ 2,735,945	1
2	Faucet Handles, P-Trap, Supply Cover	2010	5,192		20	260	260	1,038	2
3	Roof Work	2011	7,800		20	200	200	592	3
4	Electrical Wiring	2011	38,821		20	995	995	2,032	4
5	Bldg. Co. Handrails And Bumpers- 1St Floor-Corridors	2011	9,416		20	471	471	1,413	5
6	Bldg. Co. Screens And Paint With Doors And Frames- Lobby/Base	2011	6,254		20	313	313	1,878	6
7	Bldg. Co. Ceiling Tiles And Doors For 1St Floor And Basement Ro	2011	7,066		20	353	353	1,059	7
8	Bldg. Co, - Duct Work - Hvac- For Dining Room	2011	3,380		20	169	169	507	8
9	Bldg. Co. Ceiling Tile- First Floor And Basement Rooms	2011	4,375		20	219	219	657	9
10	Bldg. Co. Wallpaper & Corner Guards In Basement And 1St Fl. O	2011	13,125		20	656	656	1,968	10
11	Bldg. Co. - Pumps And Piping	2011	6,010		20	301	301	903	11
12	Bldg. Co. - Drain System And New Valves	2011	4,475		20	224	224	672	12
13	Bldg. Co. - Fire Alarm And Sprinkler System	2011	3,625		20	181	181	543	13
14	Bldg Co. Corner Guards And End Caps For 1St Floor Hallways/R	2011	4,341		20	217	217	651	14
15	Bldg. Co. - Hvac System	2011	4,018		20	201	201	603	15
16	Bldg. Co. - Pump And Piping For Heating And Chilling System	2011	6,180		20	309	309	927	16
17	Bldg Co. New Lamps And Light Accessories In Lobby/Res Rooms	2011	4,969		20	248	248	744	17
18	Bldg Co. Window Treatments W Frame In Res Rms, Lobby/1St Fl	2011	4,329		20	216	216	648	18
19	Bldg. Co. - 28 Through The Wall Air Conditioners	2011	10,722		20	536	536	1,608	19
20	Elevator Work	2012	13,960		20	698	698	1,163	20
21	Wire And Generator	2012	3,175		20	81	81	119	21
22	En Ergy Supply Fan Cool Air	2012	3,459		20	288	288	408	22
23	Elevator Work	2012	3,129		20	156	156	170	23
24	Camera Monitor	2012	4,090		20	660	660	715	24
25	Bldg. Co. - Power For Ejector & Circulating Pumps	2012	3,950		20	379	379	758	25
26	Bldg. Co. -Water Coil For Roof	2012	4,301		20	413	413	826	26
27	Bldg. Co. - Fire Dampers & Insulation	2012	3,142		20	301	301	602	27
28	Bldg. Co. - Sprinkler System, Sprinkler Head Piping	2012	2,850		20	273	273	546	28
29	Bldg. Co. - Boiler Pump, New Boiler	2012	5,698		20	546	546	1,092	29
30	Bldg. Co. - Fire Alarm Door Release	2012	3,837		20	367	367	734	30
31	Bldg Co. Doors For Resident Rooms And Floors And Lobby	2012	3,560		20	427	427	854	31
32	Bldg Co. Ceramic Tiling In Basement Bathrooms	2012	6,767		20	649	649	1,298	32
33	Bldg Co. Ceramic Tiling In 1St Floor Bathroom/Shower Room	2012	6,917		20	663	663	1,326	33
34	TOTAL (lines 1 thru 33)		$ 9,876,071	$ 422,179		$ 341,395	$ (80,784)	$ 2,764,999	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: 01/01/13 Ending: 12/31/13

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		$ 9,876,071	$ 422,179		$ 341,395	$ (80,784)	$ 2,764,999	1
2	Bldg. Co. - Shower Tub & Base Installation, Valve & Wiring,	2012	16,021		20	1,536	1,536	3,072	2
3	Bldg. Co. Lighting For First Floor Resident Rooms	2012	11,470		20	1,099	1,099	2,198	3
4	Bldg. Co. - Service Sink Installation	2012	2,513		20	241	241	482	4
5	Bldg. Co. - Condenser Installation	2012	4,675		20	448	448	896	5
6	Bldg. Co. - Electrical Work For Air Handler, Laundry Room, Resi	2012	11,666		20	1,118	1,118	2,236	6
7	Bldg. Co. - Install Condensate Pump	2012	3,165		20	303	303	606	7
8	Bldg Co. Doors For Resident Rooms And Floors And Lobby	2012	4,956		20	475	475	950	8
9	Bldg. Co.-Camera & Pacing System, Monitors, Lights, Alarms	2012	7,875		20	1,575	1,575	3,150	9
10	Bldg. Co -Exit Signs, Camera Outlets, Automatic Door Control	2012	7,410		20	1,482	1,482	2,964	10
11	Bldg. Co.-Heat Curtain Installation	2012	3,365		20	673	673	1,346	11
12	Fan Coils For 2Nd Floor Day Room	2013	3,841		20	768	768	768	12
13	Replace Two Hydraulic Piston Packings On Elevator	2013	3,400		20	142	142	142	13
14	Fabricate,Install Exterior Display In Front Of Building	2013	6,266		20	154	154	154	14
15	New Sign On Front	2013	5,400		20	180	180	180	15
16	Remove Old Condensor And Install New Condensor	2013	6,270		20	627	627	627	16
17	Replace 11 Elevator Hoistway Limit Swtiches, Install Lockout Acc	2013	4,489		20	53	53	53	17
18	Bldg Co. -All Floors Shower Tub Rooms-Flooring,Wallcovering, L	2013	161,402		20	4,035	4,035	4,035	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,140,255	$ 422,179		$ 356,303	$ (65,876)	$ 2,788,858	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: 01/01/13 Ending: 12/31/13

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		$ 10,140,255	$ 422,179		$ 356,303	$ (65,876)	$ 2,788,858	1
2									2
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4									4
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,140,255	$ 422,179		$ 356,303	$ (65,876)	$ 2,788,858	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: 01/01/13 Ending: 12/31/13

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		$ 10,140,255	$ 422,179		$ 356,303	$ (65,876)	$ 2,788,858	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,140,255	$ 422,179		$ 356,303	$ (65,876)	$ 2,788,858	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: 01/01/13 Ending: 12/31/13

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	27,038	9
10	Elevator (Electrical)	2005	16,710		20	836	836	6,105	10
11	Heating System Boiler Repair	2010	4,385		20	219	219	876	11
12	Materials for Therapy Room	2010	5,309		20	265	265	1,060	12
13	Air Handler Unit in Basement	2010	10,188		20	509	509	2,036	13
14	Air Conditioning Work	2010	7,685		20	384	384	1,536	14
15	Sprinkler System Repair	2010	4,795		20	240	240	960	15
16	Exhaust Fan/Dampers/Duct - Elevator Room	2010	3,855		20	193	193	772	16
17	Fix Closets In Patient Rooms	2010	4,140		20	207	207	828	17
18	Materials For Therapy Room	2010	3,560		20	178	178	712	18
19	Plumbing	2010	6,497		20	325	325	1,300	19
20	Custom Cabinets For Therapy Room	2010	14,843		20	742	742	2,968	20
21	Wall Covering For Therapy Room	2010	3,280		20	164	164	656	21
22	Flooring For Therapy Room	2010	18,260		20	913	913	3,652	22
23	Fire Alarm System	2010	4,785		20	239	239	956	23
24	Fan Coil Units For Lobby	2010	3,400		20	170	170	680	24
25	Metal Door And Frame	2010	1,911		20	96	96	384	25
26	Window Treatment & Cubicle Curtains - Therapy Room	2010	68,886		20	3,444	3,444	13,776	26
27	Laundry Room Work	2010	3,200		20	160	160	640	27
28	Installation Of Ramp	2010	313,956		20	15,698	15,698	62,792	28
29	Lighting For Therapy Room Corridor	2010	64,109		20	3,205	3,205	12,820	29
30	Drywall And Piping	2010	5,372		20	269	269	1,076	30
31	Carpeting & Wallcovering For Lobby	2010	2,830		20	142	142	568	31
32	Piping Repairs	2010	4,910		20	246	246	984	32
33	Conduit For Fire Alarm System	2010	7,030		20	352	352	1,408	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	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	755	2
3	10 Air Conditioner Sleeve Units	2010	5,621		20	281	281	1,405	3
4	2 new Boilers For Hot Water System	2010	59,941		20	2,997	2,997	14,985	4
5	Therapy Room/Lobby/Bathroom/Fire Doors/Wallpaper	2010	26,569		20	1,328	1,328	6,642	5
6	Wiring, Cameras, Alarms	2010	5,305		20	265	265	1,327	6
7	Electrical Work In Laundry Room	2010	10,360		20	518	518	2,590	7
8	Electrical For Lobby	2010	11,550		20	578	578	2,888	8
9	Air Exchanger in Basement	2010	8,200		20	410	410	2,050	9
10	Engineering Costs For Renovation	2010	37,935		20	1,897	1,897	9,485	10
11	Wallcovering	2010	10,605		20	530	530	2,652	11
12	Flooring	2010	12,772		20	639	639	3,193	12
13	Lighting Fixtures	2010	14,557		20	728	728	3,640	13
14	Flooring- Lobby/Therapy Rooom	2010	3,578		20	179	179	895	14
15	Shelving in Kitchen	2011	3,253		20	163	163	489	15
16	Nurses Station on First Floor	2011	7,266		20	363	363	1,089	16
17	Vinyl Flooring- First Floor Corridor and Dining Room	2011	6,692		20	335	335	1,005	17
18	Vinyl Flooring- First Floor Corridor and Dining Room	2011	24,304		20	1,215	1,215	3,645	18
19	Wallpaper and Handrails: 1st Fl. and Basement Rms/corridors	2011	16,500		20	825	825	2,475	19
20	Drop Ceiling: First Floor and Basement Rooms and Corridor	2011	5,525		20	276	276	828	20
21	Window Treatment/Curtains- Res Rooms/Basement Dining	2011	12,162		20	608	608	1,824	21
22	Flooring:Hardware,Vinyl,Wall Guards-Basement Therapy/Dine Rm	2011	6,581		20	329	329	987	22
23	Painting/Room Buildout- Therapy Room & Basement Dining Rm	2011	27,911		20	1,396	1,396	4,188	23
24	Corner Gaurds, Blinds, Vinyl Base Boards:1st Fl Res Rooms	2011	6,735		20	337	337	1,011	24
25	Blinds, Bumpers, & Baseboards-1st Floor Resident Rooms	2011	4,551		20	228	228	684	25
26	Vinyl Flooring- Basement Dining Room/Corridor	2011	25,882		20	1,294	1,294	3,882	26
27	Ramp Replacement	2011	3,310		20	166	166	498	27
28	Vinyl Flooring- Lower Level Bathroom and in Elevators	2011	2,554		20	128	128	384	28
29	Landscaping - Irrigation System	2011	3,625		20	181	181	543	29
30	Landscaping - Install Sod	2011	3,450		20	173	173	519	30
31	Security Alarm System	2011	7,965		20	398	398	1,194	31
32	Doors, Windows, and Drywall: Basement Dining & Hallway	2011	23,579		20	1,179	1,179	3,537	32
33	Handrails in First floor- Hallways	2011	8,132		20				33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 1,067,911	$		$ 52,990	$ 52,990	$ 227,870	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Dynamic	1993	75,374	1,933	35	2,154	221	43,788	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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									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: 01/01/13 Ending: 12/31/13

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)		$ 75,374	$ 1,933		$ 2,154	$ 221	$ 43,788	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: 01/01/13 Ending: 12/31/13

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	$ 884,970	$	$ 123,029	$ 123,029	10	$ 664,064	71
72	Current Year Purchases	21,496	400	2,307	1,907	10	2,307	72
73	Fully Depreciated Assets	530,221				10	530,054	73
74								74
75	TOTALS	$ 1,436,688	$ 400	$ 125,336	$ 124,936		$ 1,196,426	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	$	$	$	5	$ 51,639	76
77		Allocated from Dynamic	2013	40,047	1,219	8,569	7,350	5	18,657	77
78										78
79										79
80	TOTALS			$ 91,686	$ 1,219	$ 8,569	$ 7,350		$ 70,296	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)	$ 12,418,629	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 423,798	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 490,209	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 66,411	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,055,580	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	Construction in Progress	$ 375,945	92
93			93
94			94
95		$ 375,945	95

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage Unit				3,609			5
6								6
7	TOTAL				$ 3,609 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 7,829 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		$	$ 16,176	17
18					18
19					19
20					20
21	TOTAL		$	$ 16,176	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 92,121		$	$		$ 92,121	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	89,188		1,325			90,513	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	281,154		6,731			287,885	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				153,721		153,721	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					9,708	48,486		58,194	13
14	TOTAL			$ 462,463		$ 17,764	$ 202,207		$ 682,434	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 7,957	$ 310,648	1
2	Cash-Patient Deposits	102,505	102,505	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,634,267	1,634,267	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	175,787	220,846	6
7	Other Prepaid Expenses	3,342	3,342	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	330,996	1,219,727	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,254,854	$ 3,491,335	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	1,813,013	3,195,217	15
16	Equipment, at Historical Cost	1,454,360	1,561,029	16
17	Accumulated Depreciation (book methods)	(1,938,894)	(3,999,784)	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	708,596	1,329,445	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,037,075	$ 9,612,667	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,291,929	$ 13,104,002	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 590,872	$ 802,088	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	147,550	147,550	28
29	Short-Term Notes Payable	1,578,171	1,819,036	29
30	Accrued Salaries Payable	283,223	283,223	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,714	6,714	31
32	Accrued Real Estate Taxes(Sch.IX-B)		285,000	32
33	Accrued Interest Payable	6,279	45,326	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,545	9,545	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,622,354	$ 3,398,482	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,945,422	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	253,000	253,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 253,000	$ 10,198,422	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,875,354	$ 13,596,904	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,416,575	$ (492,902)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,291,929	$ 13,104,002	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,846,389	1
2	Restatements (describe):		2
3	**Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,846,390	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	36,385	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	(466,200)	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)**	$ (429,815)	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)**	$ 1,416,575	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 10,814,306	1
2	Discounts and Allowances for all Levels	(2,112,979)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,701,327	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,028,390	6
7	Oxygen	744	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,029,134	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	290,108	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,697	19
20	Radiology and X-Ray	5,480	20
21	Other Medical Services	78,450	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 396,735	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	68,131	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 68,131	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	632,721	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 632,721	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,828,048	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,695,853	31
32	Health Care	3,995,479	32
33	General Administration	3,291,676	33
	B. Capital Expense		
34	Ownership	1,552,259	34
	C. Ancillary Expense		
35	Special Cost Centers	748,016	35
36	Provider Participation Fee	508,380	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,791,663	40
41	**Income before Income Taxes (line 30 minus line 40)****	36,385	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 36,385	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,822,066	44
45	Private Pay - Net Inpatient Revenue	217,514	45
46	Medicare - Net Inpatient Revenue	580,559	46
47	Other-(specify) Hopsice	81,188	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,701,327	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: 01/01/13 Ending: 12/31/13

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,037	2,086	$ 100,888	$ 48.36	1
2	Assistant Director of Nursing	2,191	2,240	86,564	38.64	2
3	Registered Nurses	15,701	16,678	483,523	28.99	3
4	Licensed Practical Nurses	41,430	44,030	1,186,827	26.95	4
5	CNAs & Orderlies	110,510	119,744	1,319,450	11.02	5
6	CNA Trainees					6
7	Licensed Therapist	11,511	12,291	462,464	37.63	7
8	Rehab/Therapy Aides	11,123	11,123	120,799	10.86	8
9	Activity Director	2,019	2,276	28,903	12.70	9
10	Activity Assistants	12,393	13,079	115,596	8.84	10
11	Social Service Workers	9,396	10,091	185,391	18.37	11
12	Dietician					12
13	Food Service Supervisor	2,689	2,788	63,036	22.61	13
14	Head Cook	7,069	7,724	89,234	11.55	14
15	Cook Helpers/Assistants	16,957	18,326	181,093	9.88	15
16	Dishwashers					16
17	Maintenance Workers	5,258	5,620	88,852	15.81	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,037	2,086	109,544	52.51	20
21	Assistant Administrator	265	265	19,052	71.89	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,153	8,770	73,330	8.36	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	4,321	4,792	65,042	13.57	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,976	2,243	65,514	29.21	33
34	TOTAL (lines 1 - 33)	267,036	286,252	$ 4,845,102 *	$ 16.93	34

* 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	387	$ 14,700	01-03	35
36	Medical Director	240	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	16,208	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,400	11-03	44
45	Social Service Consultant	94	5,610	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	866	$ 62,918		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Phil Birn	Administrator	0	$ 109,544
Steve Goldstein	Asst. Administrator	0	19,052
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 128,596

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
Dynamic HC Consultants	Bookkeeping/Home Office	$ 766,500
Frost, Ruttenberg & Rothblatt	Accounting	20,810
Casamba	Data Processing	3,600
Dynamic HC Consultants	Data Processing	30,184
eHealth Solutions	Data Processing	6,446
Health Data Systems Inc	Data Processing	8,025
NTT Data LTC Solutions	Data Processing	413
Personnel Planners	Unemployment Consulting	3,125
Adjusted on Page 5A	Legal & Other Professional	9,488
Various	Legal	31,335
Skidelsky & Associates	Real Estate Legal Fee	28,386
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 908,312

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 138,358
Unemployment Compensation Insurance	61,983
FICA Taxes	368,646
Employee Health Insurance	219,746
Employee Meals	88,257
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	2,790
Other Employee Benefits	12,999
TOTAL (agree to Schedule V, line 22, col.8)	$ 892,779

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	1,276
Health Care Worker Background Check	
(Indicate # of checks performed 98)	1,960
Patient Background Checks 170	1,700
Dues & Subscriptions	12,554
Licenses & Permits	3,490
Allocated from Dynamic-Dues & Subs	1,911
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,891

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,245
Allocated from Dynamic	1,460
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,705

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/13 Ending: 12/31/13

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:** 01/01/13 **Ending:** 12/31/13

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $23,310**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,501** Line **10-02**

(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. $ **508,380**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **88,257** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.