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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0034157

Facility Name: Woodbridge Nursing Pavilion

Address: 2242 N. Kedzie Ave. (Number) Chicago (City) 60647 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,373	49	7,292	8,714	8
9	SNF/PED					9
10	ICF	57,169	970	3,283	61,422	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,542	1,019	10,575	70,136	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.56%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/01/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 222 and days of care provided 7,292

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	345,748	33,796	18,187	397,731		397,731		397,731			1
2	Food Purchase		389,401		389,401	(82,600)	306,802	(57)	306,745			2
3	Housekeeping	235,400	42,568		277,968		277,968		277,968			3
4	Laundry	119,469	19,845		139,314		139,314	(780)	138,534			4
5	Heat and Other Utilities			176,512	176,512		176,512	(2,799)	173,713			5
6	Maintenance	113,079	79,712	88,785	281,576		281,576	76,901	358,477			6
7	Other (specify):*							1,668	1,668			7
8	**TOTAL General Services**	813,696	565,322	283,484	1,662,502	(82,600)	1,579,903	74,933	1,654,836			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,153,349	213,113	16,177	3,382,639		3,382,639	(13)	3,382,626			10
10a	Therapy			2,123	2,123		2,123		2,123			10a
11	Activities	145,928	5,001	2,525	153,454		153,454		153,454			11
12	Social Services	173,595		4,743	178,338		178,338		178,338			12
13	CNA Training											13
14	Program Transportation			503	503		503		503			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,472,872	218,114	62,071	3,753,057		3,753,057	(13)	3,753,044			16
	C. General Administration											
17	Administrative	140,808			140,808		140,808	299,527	440,335			17
18	Directors Fees											18
19	Professional Services			1,245,852	1,245,852	(7,790)	1,238,062	(1,012,796)	225,266			19
20	Dues, Fees, Subscriptions & Promotions			92,058	92,058		92,058	(51,655)	40,403			20
21	Clerical & General Office Expenses	96,563	2,556	1,731,191	1,830,310		1,830,310	(1,503,788)	326,522			21
22	Employee Benefits & Payroll Taxes			932,513	932,513	82,600	1,015,113		1,015,113			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,187	5,187		5,187	4,634	9,821			24
25	Other Admin. Staff Transportation			8,389	8,389		8,389	3,833	12,222			25
26	Insurance-Prop.Liab.Malpractice			238,849	238,849		238,849	17,648	256,497			26
27	Other (specify):*							85,086	85,086			27
28	**TOTAL General Administration**	237,371	2,556	4,254,039	4,493,966	74,809	4,568,775	(2,157,510)	2,411,265			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,523,939	785,992	4,599,594	9,909,525	(7,790)	9,901,735	(2,082,590)	7,819,145			29

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

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: 01/01/15 Ending: 12/31/15

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			117,813	117,813		117,813	277,964	395,777			30
31	Amortization of Pre-Op. & Org.							(0)	(0)			31
32	Interest			75,282	75,282		75,282	275,368	350,650			32
33	Real Estate Taxes					7,790	7,790	302,234	310,024			33
34	Rent-Facility & Grounds			1,403,505	1,403,505		1,403,505	(1,399,807)	3,698			34
35	Rent-Equipment & Vehicles			3,760	3,760		3,760	18,798	22,558			35
36	Other (specify):*							49,042	49,042			36
37	TOTAL Ownership			1,600,360	1,600,360	7,790	1,608,150	(476,401)	1,131,749			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	753,160	286,547	126	1,039,833		1,039,833	(290)	1,039,543			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			503,161	503,161		503,161		503,161			42
43	Other (specify):*	2,644			2,644		2,644	(2,644)				43
44	TOTAL Special Cost Centers	755,804	286,547	503,287	1,545,638		1,545,638	(2,934)	1,542,704			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,279,743	1,072,539	6,703,241	13,055,523	0	13,055,523	(2,561,925)	10,493,598			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.

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(4,627)	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	(93,116)	30		9
10	Interest and Other Investment Income	(111,942)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(57)	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	(627)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(891,035)	21		24
25	Fund Raising, Advertising and Promotional	(45,555)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(801,118)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,950,576)		$	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)	(611,349)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (611,349)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,561,925)		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

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PPA - Office Expense	$ (679,486)	21	1
2	PPA - Linen Replacement	(780)	04	2
3	PPA - Collections	(41,396)	21	3
4	Marketing Salary	(2,644)	43	4
5	Intercompany Interest	(3,333)	32	5
6	Sequestration Expense	(52,813)	21	6
7	Bank Charges	(9,770)	21	7
8	Building Company - Bank Charges	(671)	21	8
9	Building Company - Legal	(250)	19	9
10	Building Company - Accounting	(21,090)	19	10
11	Building Company - Amortization	(11,106)	31	11
12	Building Company - Franchise Tax	(250)	20	12
13	Non-allowable Legal	(2,701)	19	13
14	Additional R&M	36,091	06	14
15	PAC Dues	(10,919)	20	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
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**	(801,118)		49

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(57)											(57)	2
3	Housekeeping													3
4	Laundry	(780)											(780)	4
5	Heat and Other Utilities	(4,627)		1,828									(2,799)	5
6	Maintenance	36,091	15,005	13,545	12,260								76,901	6
7	Other (specify):*			394		1,274							1,668	7
8	**TOTAL General Services**	30,627	15,005	15,767	12,260	1,274							74,933	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records						(13)						(13)	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**						(13)						(13)	16
	C. General Administration													
17	Administrative				299,527								299,527	17
18	Directors Fees													18
19	Professional Services	(24,041)	21,340	(1,010,095)									(1,012,796)	19
20	Fees, Subscriptions & Promotions	(56,724)	250	4,819									(51,655)	20
21	Clerical & General Office Expenses	(1,678,298)	671	157,453	16,386								(1,503,788)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			4,634									4,634	24
25	Other Admin. Staff Transportation			3,833									3,833	25
26	Insurance-Prop.Liab.Malpractice		12,244	5,404									17,648	26
27	Other (specify):*			23,912		61,174							85,086	27
28	**TOTAL General Administration**	(1,759,062)	34,505	(810,040)	315,913	61,174							(2,157,510)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,728,435)	49,510	(794,273)	328,173	62,448	(13)						(2,082,590)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(93,116)	366,634	4,446									277,964	30
31	Amortization of Pre-Op. & Org.	(11,106)	11,106										(0)	31
32	Interest	(115,275)	386,941	3,702									275,368	32
33	Real Estate Taxes		295,306	6,928									302,234	33
34	Rent-Facility & Grounds		(1,399,807)										(1,399,807)	34
35	Rent-Equipment & Vehicles			18,959			(161)						18,798	35
36	Other (specify):*		49,042										49,042	36
37	TOTAL Ownership	(219,497)	(290,778)	34,035			(161)						(476,401)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(281)	(9)					(290)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(2,644)											(2,644)	43
44	TOTAL Special Cost Centers	(2,644)					(281)	(9)					(2,934)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,950,576)	(241,268)	(760,238)	328,173	62,448	(455)	(9)					(2,561,925)	45

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 1,399,807	Woodbridge Building LLC	100.00%	$	$ (1,399,807)	1
2	V	32	Interest Income	626	Woodbridge Building LLC	100.00%		(626)	2
3	V	21	Bank Charges		Woodbridge Building LLC	100.00%	671	671	3
4	V	19	Legal Fees		Woodbridge Building LLC	100.00%	250	250	4
5	V	19	Accounting		Woodbridge Building LLC	100.00%	21,090	21,090	5
6	V	30	Depreciation		Woodbridge Building LLC	100.00%	366,634	366,634	6
7	V	31	Amortization - Mortgage		Woodbridge Building LLC	100.00%	11,106	11,106	7
8	V	33	Real Estate Tax		Woodbridge Building LLC	100.00%	295,306	295,306	8
9	V	20	Franchise Tax		Woodbridge Building LLC	100.00%	250	250	9
10	V	06	Repairs and Maintenance		Woodbridge Building LLC	100.00%	15,005	15,005	10
11	V	32	Interest Expense - Heartland		Woodbridge Building LLC	100.00%	387,567	387,567	11
12	V	36	Mortgage Insurance		Woodbridge Building LLC	100.00%	49,042	49,042	12
13	V	26	Insurance		Woodbridge Building LLC	100.00%	12,244	12,244	13
14	Total			$ 1,400,433			$ 1,159,165	$ * (241,268)	14

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 1,828	$ 1,828	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	13,545	13,545	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	394	394	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	5,248	5,248	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	4,819	4,819	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	157,453	157,453	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	4,634	4,634	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	3,833	3,833	22
23	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	5,404	5,404	23
24	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	23,912	23,912	24
25	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	4,446	4,446	25
26	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	3,702	3,702	26
27	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	6,928	6,928	27
28	V	19	REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%			28
29	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	18,826	18,826	29
30	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	133	133	30
31	V								31
32	V	19	HOME OFFICE	1,015,343	DYNAMIC HEALTH CARE CONS.	100.00%		(1,015,343)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,015,343			$ 255,105	$ * (760,238)	39

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 12,260	$ 12,260	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	36,244	36,244	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	41,297	41,297	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%	83,299	83,299	20
21	V	17	ADMIN. CMP. - B. FRIEDMAN		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	17	ADMIN. CMP. - R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	25,089	25,089	23
24	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	30,435	30,435	24
25	V	17	ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			25
26	V	17	ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	20,803	20,803	26
27	V	17	ADMIN. CMP. - A. CASSATA (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%			27
28	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	27,015	27,015	28
29	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	35,345	35,345	29
30	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	15,216	15,216	30
31	V	21	CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	1,170	1,170	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 328,173	$ * 328,173	39

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 1,274	$ 1,274	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	2,087	2,087	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	2,919	2,919	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%	21,956	21,956	20
21	V	27	EMP. BEN.- B. FRIEDMAN		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	27	EMP. BEN.- R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	9,015	9,015	23
24	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	2,168	2,168	24
25	V	27	EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			25
26	V	27	EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	5,812	5,812	26
27	V	27	EMP. BEN.-A. CASSATA (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%			27
28	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	8,914	8,914	28
29	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	4,492	4,492	29
30	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,131	3,131	30
31	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	680	680	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 62,448	$ * 62,448	39

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	35	EQUIPMENT RENTAL	$ 1,591	INTEGRA HEALTHCARE EQUIPMENT	100.00%	$ 1,430	$ (161)	15
16	V	10	NURSING EQUIPMENT	128	INTEGRA HEALTHCARE EQUIPMENT	100.00%	115	(13)	16
17	V	39	DME & MEDICAL SUPPLIES	2,774	INTEGRA HEALTHCARE EQUIPMENT	100.00%	2,493	(281)	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			$ 4,493			$ 4,038	$ * (455)	39

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 142	LIFELINE AMBULANCE	100.00%	$ 133	$ (9)	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			$ 142			$ 133	$ * (9)	39

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	24.87%	BRIDGEVIEW HEALTH CARE CENTER, LTD	BRIDGEVIEW	WOODBRIDGE BUILDING LLC	CHICAGO	BUILDING CO.	1
2	ABRAHAM J. STERN	17.15%	GROSSE POINTE MANOR, LLC	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULTING	2
3	FRED L. AARON	22.70%	OTTAWA PAVILION, LTD	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	MARSHALL A. MAUER	6.76%	PARK RIDGE CARE CENTER LTD	PARK RIDGE	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME	4
5	MIRIAM LATINIK	4.51%	STERLING PAVILION	STERLING	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	5
6	JOSEPH MAUER	4.51%	WATERFRONT TERRACE, INC	CHICAGO				6
7	SHARON S. AARON	0.59%	WILLOW CREST NURSING PAVILION, LTD	SANDWICH				7
8	DENNIS NEHMER	0.59%	WINDMILL NURSING PAVILION, LTD	SOUTH HOLLAND				8
9	DIANIA KUFTA	0.59%	WOODBRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG	GALESBURG				9
10	SUSIE & HOWIE ALTER	1.17%	WOODBRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO SLI	GENESEO				10
11	SYLVIA AARON	0.23%	WOODBRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC SLF	PONTIAC				11
12	SUE KOPLIN	0.59%	RIVER NORTH OF BRADLEY HEALTH AND REHAB	BRADLEY				12
13	SUSAN L. STERN	4.51%						13
14	FRANCES MAUER	6.76%						14
15	FREDA MAUER	4.51%						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Maury Aaron	Owner	Administrative	24.87%	See Attached	8.26	16.52%	Alloc. Salary	$ 41,297	17-07	1
2	Marshall Mauer	Owner	Administrative	6.76%	See Attached	7.25	14.50%	Alloc. Salary	36,244	17-07	2
3	Dennis Nehmer	Owner	Maintenance	0.59%	See Attached	8.26	20.65%	Alloc. Salary	12,260	06-07	3
4	Sharon Aaron	Owner	Clerical	0.59%	See Attached	7.26	18.12%	Alloc. Salary	15,216	21-07	4
5	Sue Koplin-Haramaras	Owner	Administrative	0.59%	See Attached	10.00	25.00%	Alloc. Salary	25,089	17-07	5
6	Esther Maryles	Relative	Clerical	0%	See Attached	0.51	1.81%	Alloc. Salary	1,170	21-07	6
7	Diania Kufta	Owner	Administrative	0.59%	See Attached	10.32	20.65%	Alloc. Salary	30,435	17-07	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	$ 161,711		13

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	407,367	13	$ 10,618	$	70,136	$ 1,828	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	407,367	13	78,675	35,168	70,136	13,545	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	407,367	13	2,289		70,136	394	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	407,367	13	30,482		70,136	5,248	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	407,367	13	27,992		70,136	4,819	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	407,367	13	914,524	670,657	70,136	157,453	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	407,367	13	26,915		70,136	4,634	7
8	25	AUTO EXP.	PATIENT DAYS	407,367	13	22,263		70,136	3,833	8
9	26	INSURANCE	PATIENT DAYS	407,367	13	31,386		70,136	5,404	9
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	407,367	13	138,888		70,136	23,912	10
11	30	DEPRECIATION	PATIENT DAYS	407,367	13	25,822		70,136	4,446	11
12	32	INTEREST	PATIENT DAYS	407,367	13	21,500		70,136	3,702	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	407,367	13	40,240		70,136	6,928	13
14	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	407,367	13			70,136		14
15	35	AUTO RENTAL	PATIENT DAYS	407,367	13	109,345		70,136	18,826	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	407,367	13	770		70,136	133	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,481,709	$ 705,825		$ 255,105	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	59,373	59,373	8.26	12,260	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	7.25	36,244	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	200,000	8.26	41,297	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	5,500	5,500	-		4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	64,041	64,041	-		5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	133,279	133,279	25.00	83,299	6
7	17	ADMIN. CMP. - B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	200,000	200,000	-		7
8	17	ADMIN. CMP. - R. AARON	WGHTD. AVG. HOURS	40	1	15,271	15,271	-		8
9	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	3	75,266	75,266	10.00	25,089	9
10	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	147,459	147,459	10.32	30,435	10
11	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		11
12	17	ADMIN. CMP. - V. DAVIS (NON	WGHTD. AVG. HOURS	40	10	114,789	114,789	7.25	20,803	12
13	17	ADMIN. CMP. - A. CASSATA (N	WGHTD. AVG. HOURS	40	1	68,028	68,028	-		13
14	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	130,998	130,998	9.28	27,015	14
15	17	ADMIN. CMP. - CFO (NON-OWI	WGHTD. AVG. HOURS	40	10	195,028	195,028	7.25	35,345	15
16	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	83,832	83,832	7.26	15,216	16
17	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	11	64,541	64,541	0.51	1,170	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,769,405	$ 1,769,407		$ 328,173	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	6,168		8.26	1,274	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,514		7.25	2,087	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	14,139		8.26	2,919	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	39,260		-		4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	5,167		-		5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	35,129		25.00	21,956	6
7	27	EMP. BEN.- B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	10,844		-		7
8	27	EMP. BEN.- R. AARON	WGHTD. AVG. HOURS	40	1	1,340		-		8
9	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	3	27,046		10.00	9,015	9
10	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,501		10.32	2,168	10
11	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,078		-		11
12	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	10	32,072		7.25	5,812	12
13	27	EMP. BEN.-A. CASSATA (NON-(	WGHTD. AVG. HOURS	40	1	5,480		-		13
14	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	43,223		9.28	8,914	14
15	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	40	10	24,786		7.25	4,492	15
16	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	17,251		7.26	3,131	16
17	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	11	37,525		0.51	680	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 322,523	$		$ 62,448	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	35	EQUIPMENT RENTAL	DIRECT ALLOCATION			$	$		$ 1,430	1
2	10	NURSING EQUIPMENT	DIRECT ALLOCATION						115	2
3	39	DME & MEDICAL SUPPLIES	DIRECT ALLOCATION						2,493	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					$	$		$ 4,038	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 133	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					$	$		$ 133	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Heartland Bank		X	Mortgage			$	$ 9,399,190			$ 387,567	1
2	Allocated - Dynamic HC	X									3,702	2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				1,312,563			71,921	6
7	Omnicare		X	Vendor Financing							28	7
8	See Supplemental Schedule							294,131				8
9	TOTAL Facility Related						$	$ 11,005,884			$ 463,217	9
	B. Non-Facility Related*											
10	Interest Income		X								(111,942)	10
11	Interest Income - Bldg. Co.		X								(626)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (112,568)	14
15	TOTALS (line 9+line14)						$	$ 11,005,884			$ 350,649	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 49,042 **Line #** 36

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Heartland Bank - Current		X	Mortgage			$	$ 294,131			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							294,131				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:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 289,000	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.)		$ 296,234	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,234	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 295,000	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.**		$ 7,790	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** $ 23,259 **For** 2012 **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.		$ 310,024	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	245,390	8
	2011	244,369	9
	2012	279,806	10
	2013	283,593	11
	2014	289,306	12

2015 Accrual = $289,306 x 1.02 = $295,000 (Rounded)

Allocated Dynamic HC Consultants = $6,928

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 87,569.67	$ 87,569.67
2.	13-35-217-016-0000	Long Term Care Property	$ 114,166.42	$ 114,166.42
3.	13-35-217-017-0000	Long Term Care Property	$ 87,569.67	$ 87,569.67
4.	10-23-404-059-0000	Allocated Dynamic HC Consultants	$ 40,073.45	$ 6,899.41
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 329,379.21	$ 296,205.17

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Woodbridge Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT 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: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 366,634	35	$ 193,622	$ (173,012)	$ 1,954,629	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			122,806	13
14	Various			1995	20,549		20	731	731	20,548	14
15	Various			1996	8,331		20	417	417	8,213	15
16	Various			1997	6,790		20	340	340	6,222	16
17	Various			1998	50,252		20	2,513	2,513	44,258	17
18	Various			1999	68,242		20	3,412	3,412	56,408	18
19	Various			2000	57,506		20	2,875	2,875	45,380	19
20	Various			2001	62,933		20	3,147	3,147	45,701	20
21	Various			2002	83,062		20	2,058	2,058	30,144	21
22	Various			2003	16,347		20	70	70	15,819	22
23	Various			2004	116,859		20			116,859	23
24	Various			2005	112,439		20	4,864	4,864	95,938	24
25	Various			2006	70,102		20	2,098	2,098	69,855	25
26	Various			2007	205,027		20	10,363	10,363	99,398	26
27	Various			2008	99,839		20	8,605	8,605	76,537	27
28	Various			2009	563,904		20	15,734	15,734	99,057	28
29	Various			2010	5,192		20	260	260	1,557	29
30	Various			2011	15,685		20	402	402	1,809	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,548,617			77,287	77,287	430,023	67
68	Related Party Allocations (Pages 12H & 12I)		76,374	1,958		2,182	224	48,733	68
69	Financial Statement Depreciation			117,813			(117,813)		69
70	TOTAL (lines 4 thru 69)		$ 10,136,598	$ 486,405		$ 330,979	$ (155,426)	$ 3,438,865	70

**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: 01/01/15 Ending: 12/31/15

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		$ 10,136,598	$ 486,405		$ 330,979	$ (155,426)	$ 3,438,865	1
2	Elevator Work	2012	13,960		20	698	698	2,559	2
3	Wire And Generator	2012	3,175		20	81	81	282	3
4	En Ergy Supply Fan Cool Air	2012	3,459		20	288	288	985	4
5	Elevator Work	2012	3,129		20	156	156	482	5
6	Camera Monitor	2012	4,090		20	818	818	2,522	6
7	Fan Coils For 2Nd Floor Day Room	2013	3,841		20	768	768	2,305	7
8	Elevator Work-Replace Two Hydraulic Piston Packings	2013	3,400		20	170	170	482	8
9	Fabricate & Install Exterior Display In Front Of Building	2013	11,666		20	583	583	1,726	9
10	Remove Old And Install New Condensor	2013	6,270		20	1,254	1,254	3,135	10
11	Elevator Work-Replace 11 Elevator Hoistway Limit Switches; Inst	2013	4,489		20	224	224	552	11
12	Installed 2 New 60 Series Pump Pipes	2014	4,324		20	216	216	279	12
13	Purchased Supplies & Installed 6 Eye Wash Stations	2014	9,200		20	236	236	285	13
14	Remote Annunciator For Fire Pump; Tie Kitchen System To Fire	2014	5,255		20	263	263	460	14
15	2 License Plate Cameras, 1 Dvr, 2 High Resolution Cameras, 2Nd	2014	2,525		20	126	126	242	15
16	3Rd Floor - Lights, Walls, Doors, Nurses Station	2014	6,152		20	308	308	308	16
17	Water Pump	2015	3,617		20	86	86	86	17
18	Water Valve Work In Therapy Room	2015	7,100		20	118	118	118	18
19	Hydralic System For Sprinklers	2015	4,800		20	80	80	80	19
20	Installed Mixing Valve On Domestic Hot Water Heater	2015	2,500		20	6	6	6	20
21	Installed Hose, Restricted Feeder And Water Feed Pump For Chil	2015	4,372		20	219	219	219	21
22	Installed 3 Security Cameras And Monitor	2015	2,910		20	146	146	146	22
23	3Rd Floor - Lights, Walls, Doors, Nurses Station	2015	55,427		20	2,771	2,771	2,771	23
24	Lobby - Flooring, Replace Door, Wallcovering, Ceiling Panels	2015	10,681		20	534	534	534	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)		$ 10,312,940	$ 486,405		$ 341,129	$ (145,276)	$ 3,459,428	34

**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: 01/01/15 Ending: 12/31/15

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		$ 10,312,940	$ 486,405		$ 341,129	$ (145,276)	$ 3,459,428	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,312,940	$ 486,405		$ 341,129	$ (145,276)	$ 3,459,428	34

**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: 01/01/15 Ending: 12/31/15

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		$ 10,312,940	$ 486,405		$ 341,129	$ (145,276)	$ 3,459,428	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,312,940	$ 486,405		$ 341,129	$ (145,276)	$ 3,459,428	34

**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: 01/01/15 Ending: 12/31/15

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		$ 10,312,940	$ 486,405		$ 341,129	$ (145,276)	$ 3,459,428	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,312,940	$ 486,405		$ 341,129	$ (145,276)	$ 3,459,428	34

**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: 01/01/15 Ending: 12/31/15

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		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2005	90,740		20	4,538	4,538	42,219	9
10	Various	2010	777,194		20	38,859	38,859	243,664	10
11	Various	2011	288,244		20	14,412	14,412	72,061	11
12	Power for Ejector & Circulating Pumps	2012	3,950		20	198	198	790	12
13	Water coil for roof	2012	4,301		20	215	215	860	13
14	Fire Dampers & Insulation	2012	3,142		20	157	157	628	14
15	Sprinkler System, Sprinkler Head Piping	2012	2,850		20	143	143	570	15
16	Boiler Pump, New Boiler	2012	5,698		20	285	285	1,140	16
17	Fire alarm door release	2012	3,837		20	192	192	767	17
18	Doors for Resident Rooms and Floors and Lobby	2012	3,560		20	178	178	712	18
19	Ceramic Tiling in Basement bathrooms	2012	6,767		20	338	338	1,353	19
20	Ceramic Tiling in 1st floor bathroom/shower room	2012	6,917		20	346	346	1,383	20
21	Shower tub & base installation, valve & Wiring,	2012	14,821		20	741	741	2,964	21
22	Lighting for first floor resident rooms	2012	11,470		20	574	574	2,294	22
23	Service Sink Installation	2012	2,513		20	126	126	503	23
24	Condenser Installation	2012	4,675		20	234	234	935	24
25	Electrical Work for Air Handler, Laundry Room, Resident Rooms	2012	11,666		20	583	583	2,333	25
26	Install Condensate Pump	2012	3,165		20	158	158	633	26
27	Doors for Resident Rooms and Floors and Lobby	2012	4,956		20	248	248	991	27
28	Camera & Pacing System, Monitors, Lights, Alarms	2012	7,875		20	394	394	1,575	28
29	Exit Signs, Camera Outlets, Automatic Door Control	2012	7,410		20	371	371	1,482	29
30	Heat Curtain Installation	2012	3,365		20	168	168	673	30
31	Installed New Pipping in the Fourth Floor Ceiling for Hot and Col	2012	2,500		20	125	125	500	31
32	All Floors Shower Tub Rooms-Flooring,Wallcovering, Lighting, T	2013	154,632		20	7,732	7,732	30,926	32
33	New Pump for Heating and Cooling in Boiler Room	2013	2,815		20	141	141	563	33
34	TOTAL (lines 1 thru 33)		$ 1,429,063	$		$ 71,453	$ 71,453	$ 412,521	34

**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: 01/01/15 Ending: 12/31/15

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 12F, Carried Forward		$ 1,429,063	$		$ 71,453	$ 71,453	$ 412,521	1
2	Installed New Boiler in Boiler Room	2013	2,815		20	141	141	422	2
3	Installed New Ejector Pumps in Basement	2013	4,900		20	245	245	735	3
4	Installed New Blast Roof Top Furnace	2013	31,780		20	1,589	1,589	4,767	4
5	Installed Nurse Station and Replaced Two Doors on Second Floor	2013	9,832		20	492	492	1,475	5
6	Drop Ceiling Supplies for Second Floor Remodeling	2013	4,151		20	208	208	623	6
7	Remodeled Second Floor, Installed New Ceiling Tiles, Lights, Wall Pa	2013	23,750		20	1,188	1,188	3,563	7
8	Purchased Vinyl Wallcovering for Corridor and Dining Room and Flo	2013	21,037		20	1,052	1,052	3,156	8
9	Installed Window Treatements and Braille Signage on Second Floor	2013	4,992		20	250	250	749	9
10	Installed Handrails on Second Floor	2013	3,550		20	178	178	533	10
11	Installation on Vinyl Flooring on Second Floor	2013	7,333		20	367	367	1,100	11
12	Installed 3 Toilet Bowls and Tanks, 3 Faucets, and 12 Shower Rods or	2013	2,538		20	127	127	381	12
13	Installed 3rd Floor Ceiling Tiles	2015	2,876						13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,548,617	$		$ 77,287	$ 77,287	$ 430,023	34

****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: 01/01/15 Ending: 12/31/15

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		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Dynamic HC Consultants	1993	76,374	1,958	35	2,182	224	48,733	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 76,374	$ 1,958		$ 2,182	$ 224	$ 48,733	34

**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: 01/01/15 Ending: 12/31/15

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 12H, Carried Forward		$ 76,374	$ 1,958		$ 2,182	$ 224	$ 48,733	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 76,374	$ 1,958		$ 2,182	$ 224	$ 48,733	34

**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: 01/01/15 Ending: 12/31/15

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	$ 541,598	$ 1,842	$ 47,417	$ 45,575	10	$ 435,639	71
72	Current Year Purchases	21,411		823	823	10	823	72
73	Fully Depreciated Assets	908,109				10	907,940	73
74								74
75	TOTALS	$ 1,471,119	$ 1,842	$ 48,240	$ 46,398		$ 1,344,401	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 Dynamic HC Consultar	2005	40,579	646	6,408	5,762	5	32,027	77
78										78
79										79
80	TOTALS			$ 92,218	$ 646	$ 6,408	$ 5,762		$ 83,666	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)	$ 12,626,276	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 488,893	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 395,777	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (93,116)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,887,495	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 - 2(	$ 641,573	$	$	86
87	Land - Section 754 Step Up 2005 - 2005	71,004			87
88					88
89					89
90					90
91	TOTALS	$ 712,577	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Invacare - Various Improv.	$ 41,940	92
93			93
94			94
95		$ 41,940	95

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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				3,698			5
6								6
7	TOTAL				$ 3,698 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 3,893 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 Dynamic HC Consultants		$	$ 18,826	17
18					18
19					19
20					20
21	TOTAL		$	$ 18,826	21

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 294,833		$	$		$ 294,833	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	120,550					120,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	337,777					337,777	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				249,917		249,917	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					126	36,630		36,756	13
14	TOTAL			$ 753,160		$ 126	$ 286,547		$ 1,039,833	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.

STATE OF ILLINOIS

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 99,550	$ 290,994	1
2	Cash-Patient Deposits	130,745	130,745	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,733,168	1,733,168	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	147,859	190,917	6
7	Other Prepaid Expenses	3,458	3,458	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	23,334	680,640	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,138,114	$ 3,029,922	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		750,000	13
14	Buildings, at Historical Cost		6,776,760	14
15	Leasehold Improvements, at Historical Cost	1,880,334	3,488,240	15
16	Equipment, at Historical Cost	1,519,480	1,640,666	16
17	Accumulated Depreciation (book methods)	(2,202,182)	(4,990,505)	17
18	Deferred Charges		299,868	18
19	Organization & Pre-Operating Costs	7,949	7,949	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,949)	(66,257)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	2,375,591	2,732,667	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,573,223	$ 10,639,388	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,711,337	$ 13,669,310	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 408,009	$ 408,008	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	130,745	130,745	28
29	Short-Term Notes Payable	1,312,563	1,606,694	29
30	Accrued Salaries Payable	348,724	348,724	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,020	15,020	31
32	Accrued Real Estate Taxes(Sch.IX-B)		295,000	32
33	Accrued Interest Payable	2,539	32,427	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	15,120	15,120	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	204,090	204,090	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,436,810	$ 3,055,828	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,399,190	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	386,327	386,327	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 386,327	$ 9,785,517	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,823,137	$ 12,841,345	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,888,200	$ 827,965	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,711,337	$ 13,669,310	48

*(See instructions.)

Facility Name & ID Number Woodbridge Nursing Pavilion **#** 0034157 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,196,393	1
2	Restatements (describe):		2
3	**Book/Tax Capitalization Entries 2014**	(78,751)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,117,642	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,569,758	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(799,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 770,558	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)**	$ 2,888,200	24 *

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 13,832,619	1
2	Discounts and Allowances for all Levels	(3,015,078)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,817,541	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,917,920	6
7	Oxygen	1,143	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,919,063	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	370,467	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,249	19
20	Radiology and X-Ray	7,187	20
21	Other Medical Services	54,573	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 458,476	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	111,942	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 111,942	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	318,259	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 318,259	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,625,281	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,662,502	31
32	Health Care	3,753,057	32
33	General Administration	4,493,966	33
	B. Capital Expense		
34	Ownership	1,600,360	34
	C. Ancillary Expense		
35	Special Cost Centers	1,042,477	35
36	Provider Participation Fee	503,161	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,055,523	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,569,758	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,569,758	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,392,364	44
45	Private Pay - Net Inpatient Revenue	245,028	45
46	Medicare - Net Inpatient Revenue	670,345	46
47	Other-(specify) Hospice	509,804	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,817,541	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.**

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2,095	2,185	$ 91,939	$ 42.08	1
2	Assistant Director of Nursing	1,607	1,741	67,750	38.91	2
3	Registered Nurses	20,832	21,826	667,370	30.58	3
4	Licensed Practical Nurses	33,108	34,707	896,419	25.83	4
5	CNAs & Orderlies	107,783	117,066	1,358,512	11.60	5
6	CNA Trainees					6
7	Licensed Therapist	18,257	19,119	753,160	39.39	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,993	2,212	28,508	12.89	9
10	Activity Assistants	11,777	12,427	117,420	9.45	10
11	Social Service Workers	8,376	8,832	173,595	19.66	11
12	Dietician					12
13	Food Service Supervisor	2,596	2,788	63,372	22.73	13
14	Head Cook	5,886	6,490	70,844	10.92	14
15	Cook Helpers/Assistants	18,893	20,752	211,532	10.19	15
16	Dishwashers					16
17	Maintenance Workers	6,638	6,887	113,079	16.42	17
18	Housekeepers	21,178	21,980	235,400	10.71	18
19	Laundry	11,403	11,854	119,469	10.08	19
20	Administrator	2,005	2,086	121,756	58.37	20
21	Assistant Administrator	258	258	19,052	73.84	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,324	5,727	96,563	16.86	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	4,900	5,225	71,359	13.66	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	100	100	2,644	26.44	33
34	TOTAL (lines 1 - 33)	285,009	304,262	$ 5,279,743 *	$ 17.35	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	399	$ 18,187	01-03	35
36	Medical Director	120	36,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	16,177	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	51	2,123	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	53	2,525	11-03	44
45	Social Service Consultant	77	4,743	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	795	$ 79,755		49

C. CONTRACT NURSES

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patty Correa	Administrator	0	$ 121,756
Steve Goldstein	Asst. Administrator	0	19,052
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 140,808

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	$ 1,015,343
Personnel Planners	Unemployment Consulting	1,620
Dynamic HC Consultants	Data Processing	37,534
Legat Architects	Architectural Consulting	1,238
Stout Risius Ross	Investment Banking Valuation	6,042
Casamba	EMR for Therapy	3,600
IIT SourceTech	Data Processing	1,935
National Data Corporation	Data Processing	4,392
Health Data Solutions	Clinical / E.H.R	9,332
eHealth Solutions	Risk Management Software	5,634
Wescom Solutions	MDS Software	24,361
See Supplemental Schedule		134,822
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,245,852

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 116,466
Unemployment Compensation Insurance	86,757
FICA Taxes	400,143
Employee Health Insurance	317,039
Employee Meals	82,600
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	12,109
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,015,112

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	1,014
Health Care Worker Background Check	
(Indicate # of checks performed 158)	1,580
Patient Background Checks	
Dues and Subscriptions	26,810
Licenses and Permits	6,180
Allocated - Dynamic HC Consultants	4,819
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,403

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,187
Allocated Dynamic HC Consultants	4,634
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,821

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Woodbridge Nursing Pavilion **#** 0034157 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 $33,088**

(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. $ **12,273** Line **10**

(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. $ **503,161**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **82,600** 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? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.