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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0034157

Facility Name: Woodbridge Nursing Pavilion

Address: 2242 North Kedzie (Number) Chicago (City) 60647 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 8/1/1988

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. 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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(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: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	222	Skilled (SNF)	222	81,252	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	222	TOTALS	222	81,252	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,306	128	8,840	10,274	8
9	SNF/PED					9
10	ICF	59,831	521	3,329	63,681	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,137	649	12,169	73,955	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.02%

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 8,651

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	356,952	38,804	18,128	413,884		413,884		413,884			1
2	Food Purchase		394,041		394,041	(79,989)	314,052	(35)	314,017			2
3	Housekeeping	263,913	47,518		311,431		311,431		311,431			3
4	Laundry	131,145	17,183		148,328		148,328		148,328			4
5	Heat and Other Utilities			198,716	198,716		198,716	(3,213)	195,503			5
6	Maintenance	140,569	176,768	114,999	432,336		432,336	61,704	494,040			6
7	Other (specify):*							1,678	1,678			7
8	**TOTAL General Services**	892,579	674,314	331,843	1,898,736	(79,989)	1,818,747	60,134	1,878,881			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,613,573	241,860	16,177	3,871,610		3,871,610	1,822	3,873,432			10
10a	Therapy											10a
11	Activities	205,933	12,298	2,468	220,699		220,699		220,699			11
12	Social Services	137,581		4,427	142,008		142,008		142,008			12
13	CNA Training											13
14	Program Transportation			2,177	2,177		2,177	(70)	2,107			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,957,087	254,158	61,249	4,272,494		4,272,494	1,752	4,274,246			16
	C. General Administration											
17	Administrative	153,200			153,200		153,200	360,368	513,568			17
18	Directors Fees											18
19	Professional Services			1,271,713	1,271,713	(17,591)	1,254,122	(1,068,384)	185,738			19
20	Dues, Fees, Subscriptions & Promotions			90,940	90,940		90,940	(44,992)	45,948			20
21	Clerical & General Office Expenses	198,458	2,241	1,167,502	1,368,201		1,368,201	(907,668)	460,533			21
22	Employee Benefits & Payroll Taxes			998,933	998,933	79,989	1,078,922		1,078,922			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,541	6,541		6,541	3,400	9,941			24
25	Other Admin. Staff Transportation			9,864	9,864		9,864	2,946	12,810			25
26	Insurance-Prop.Liab.Malpractice			240,843	240,843		240,843	13,443	254,286			26
27	Other (specify):*							108,483	108,483			27
28	**TOTAL General Administration**	351,658	2,241	3,786,336	4,140,235	62,398	4,202,633	(1,532,404)	2,670,230			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,201,324	930,713	4,179,428	10,311,465	(17,591)	10,293,874	(1,470,518)	8,823,356			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: 01/01/16 Ending: 12/31/16

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			116,263	116,263		116,263	280,153	396,416			30
31	Amortization of Pre-Op. & Org.							(0)	(0)			31
32	Interest			64,550	64,550		64,550	221,253	285,803			32
33	Real Estate Taxes					17,591	17,591	372,238	389,829			33
34	Rent-Facility & Grounds			1,403,673	1,403,673		1,403,673	(1,399,807)	3,866			34
35	Rent-Equipment & Vehicles			720	720		720	22,891	23,611			35
36	Other (specify):*							47,702	47,702			36
37	TOTAL Ownership			1,585,206	1,585,206	17,591	1,602,797	(455,570)	1,147,227			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	955,969	290,672	5,993	1,252,634		1,252,634	(8,020)	1,244,614			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			518,084	518,084		518,084		518,084			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	955,969	290,672	524,077	1,770,718		1,770,718	(8,020)	1,762,698			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,157,293	1,221,385	6,288,711	13,667,389		13,667,389	(1,934,108)	11,733,281			45

*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: 01/01/16 Ending: 12/31/16

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	(5,102)	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	(92,434)	30		9
10	Interest and Other Investment Income	(135,368)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,871)	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	(513,000)	21		24
25	Fund Raising, Advertising and Promotional	(37,144)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(42,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(580,318)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,407,272)		$	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)	(526,836)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (526,836)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,934,108)		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: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration Expense	$ (91,118)	21	1
2	Bank Charges	(8,437)	21	2
3	Additional R&M	31,831	06	3
4	PPA - Various Expenses	(459,169)	21	4
5	PPA - Insurance	(4,921)	26	5
6	PPA - Patient Transportation	(70)	14	6
7	PPA - Oxygen	(61)	10	7
8	PPA - Ambulance	(5,428)	39	8
9	PAC Dues	(10,905)	20	9
10	Building Company - Legal	(250)	19	10
11	Building Company - Accounting	(15,995)	19	11
12	Building Company - Amortization	(11,106)	31	12
13	Building Company - Franchise Tax	(250)	20	13
14	Non-Allowable Legal Fees	(4,070)	19	14
15	Bldg. Co - Additional R&M	3,432	06	15
16	Capitalized R&M	(3,677)	06	16
17	Non-Allowable Seminar	(124)	24	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**	(580,318)		49

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(35)											(35)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,102)		1,889									(3,213)	5
6	Maintenance	31,586	5,582	12,091	12,445								61,704	6
7	Other (specify):*			388		1,290							1,678	7
8	**TOTAL General Services**	26,449	5,582	14,368	12,445	1,290							60,134	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(61)					1,883						1,822	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation	(70)											(70)	14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(131)					1,883						1,752	16
	C. General Administration													
17	Administrative				360,368								360,368	17
18	Directors Fees													18
19	Professional Services	(20,315)	16,245	(1,064,314)									(1,068,384)	19
20	Fees, Subscriptions & Promotions	(48,299)	250	3,057									(44,992)	20
21	Clerical & General Office Expenses	(1,115,595)		190,088	17,839								(907,668)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(124)		3,524									3,400	24
25	Other Admin. Staff Transportation			2,946									2,946	25
26	Insurance-Prop.Liab.Malpractice	(4,921)	12,732	5,632									13,443	26
27	Other (specify):*			31,825		76,658							108,483	27
28	**TOTAL General Administration**	(1,189,254)	29,227	(827,242)	378,207	76,658							(1,532,404)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,162,936)	34,809	(812,874)	390,652	77,948	1,883						(1,470,518)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	(92,434)	367,488	5,099									280,153	30
31	Amortization of Pre-Op. & Org.	(11,106)	11,106										(0)	31
32	Interest	(135,368)	352,184	4,437									221,253	32
33	Real Estate Taxes		364,790	7,448									372,238	33
34	Rent-Facility & Grounds		(1,399,807)										(1,399,807)	34
35	Rent-Equipment & Vehicles			22,891									22,891	35
36	Other (specify):*		47,702										47,702	36
37	TOTAL Ownership	(238,908)	(256,537)	39,875									(455,570)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(5,428)					(2,349)	(243)					(8,020)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(5,428)					(2,349)	(243)					(8,020)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,407,272)	(221,728)	(772,999)	390,652	77,948	(466)	(243)					(1,934,108)	45

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	607	Woodbridge Building LLC	100.00%		(607)	2
3	V	19	Legal Fees		Woodbridge Building LLC	100.00%	250	250	3
4	V	19	Accounting		Woodbridge Building LLC	100.00%	15,995	15,995	4
5	V	30	Depreciation		Woodbridge Building LLC	100.00%	367,488	367,488	5
6	V	31	Amortization of Mortgage Costs		Woodbridge Building LLC	100.00%	11,106	11,106	6
7	V	33	Real Estate Tax		Woodbridge Building LLC	100.00%	364,790	364,790	7
8	V	20	Franchise Tax		Woodbridge Building LLC	100.00%	250	250	8
9	V	06	Repairs & Maintenance		Woodbridge Building LLC	100.00%	5,582	5,582	9
10	V	32	Interest Expense - Heartland		Woodbridge Building LLC	100.00%	352,791	352,791	10
11	V	36	Mortgage Insurance		Woodbridge Building LLC	100.00%	47,702	47,702	11
12	V	26	Insurance		Woodbridge Building LLC	100.00%	12,732	12,732	12
13	V								13
14	Total			$ 1,400,414			$ 1,178,686	$ * (221,728)	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: 01/01/16 Ending: 12/31/16

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%	$ 1,889	$ 1,889	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	12,091	12,091	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	388	388	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	10,620	10,620	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	3,057	3,057	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	190,088	190,088	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	3,524	3,524	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	2,946	2,946	22
23	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	5,632	5,632	23
24	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	31,825	31,825	24
25	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	5,099	5,099	25
26	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	4,437	4,437	26
27	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	7,448	7,448	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%	21,423	21,423	29
30	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	1,468	1,468	30
31	V								31
32	V	19	HOME OFFICE	1,074,934	DYNAMIC HEALTH CARE CONS.	100.00%		(1,074,934)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,074,934			$ 301,935	$ * (772,999)	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: 01/01/16 Ending: 12/31/16

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%	$ 12,445	$ 12,445	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	37,412	37,412	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	42,672	42,672	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%	114,271	114,271	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%	24,298	24,298	23
24	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	31,461	31,461	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%	24,884	24,884	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%	39,481	39,481	28
29	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	45,889	45,889	29
30	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	16,669	16,669	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			$			$ 390,652	$ * 390,652	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: 01/01/16 Ending: 12/31/16

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%	$ 1,290	$ 1,290	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	7,761	7,761	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	8,088	8,088	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%	22,975	22,975	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%	9,194	9,194	23
24	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	2,213	2,213	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%	6,286	6,286	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%	11,169	11,169	28
29	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	4,822	4,822	29
30	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,429	3,429	30
31	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	721	721	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 77,948	$ * 77,948	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: 01/01/16 Ending: 12/31/16

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	10	NURSING EQUIPMENT	$ 1,185	INTEGRA HEALTHCARE EQUIPMENT	100.00%	$ 3,068	$ 1,883	15
16	V	39	DME & MEDICAL SUPPLIES	3,414	INTEGRA HEALTHCARE EQUIPMENT	100.00%	1,065	(2,349)	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			$ 4,599			$ 4,133	$ * (466)	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: 01/01/16 Ending: 12/31/16

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	$ 1,846	LIFELINE AMBULANCE	100.00%	$ 1,603	$ (243)	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			$ 1,846			$ 1,603	$ * (243)	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Maury Aaron	Owner	Administrative	24.87%	See Attached	8.53	17.07%	Alloc. Salary	$ 42,672	17-07	1
2	Marshall Mauer	Owner	Administrative	6.76%	See Attached	7.48	14.96%	Alloc. Salary	37,412	17-07	2
3	Dennis Nehmer	Owner	Maintenance	0.59%	See Attached	8.53	21.33%	Alloc. Salary	12,445	06-07	3
4	Sharon Aaron	Owner	Clerical	0.59%	See Attached	7.49	18.70%	Alloc. Salary	16,669	21-07	4
5	Sue Koplin-Haramaras	Owner	Administrative	0.59%	See Attached	10	25.00%	Alloc. Salary	24,298	17-07	5
6	Esther Maryles	Relative	Clerical	0%	See Attached	0.52	1.87%	Alloc. Salary	1,170	21-07	6
7	Diania Kufta	Owner	Administrative	0.59%	See Attached	10.67	21.33%	Alloc. Salary	31,461	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	$ 166,127		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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	415,748	13	$ 10,619	$	73,955	$ 1,889	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	415,748	13	67,972	32,339	73,955	12,091	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	415,748	13	2,182		73,955	388	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	415,748	13	59,702		73,955	10,620	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	415,748	13	17,185		73,955	3,057	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	415,748	13	1,068,604	741,401	73,955	190,088	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	415,748	13	19,810		73,955	3,524	7
8	25	AUTO EXP.	PATIENT DAYS	415,748	13	16,560		73,955	2,946	8
9	26	INSURANCE	PATIENT DAYS	415,748	13	31,660		73,955	5,632	9
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	415,748	13	178,906		73,955	31,825	10
11	30	DEPRECIATION	PATIENT DAYS	415,748	13	28,663		73,955	5,099	11
12	32	INTEREST	PATIENT DAYS	415,748	13	24,945		73,955	4,437	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	415,748	13	41,869		73,955	7,448	13
14	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	415,748	13			73,955		14
15	35	AUTO RENTAL	PATIENT DAYS	415,748	13	120,431		73,955	21,423	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	415,748	13	8,254		73,955	1,468	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,697,362	$ 773,741		$ 301,935	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	58,328	58,328	9	12,445	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	7	37,412	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	200,000	9	42,672	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	2,500	2,500			4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	76,541	76,541			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	182,833	182,833	25	114,271	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	60,541	60,541			8
9	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	3	72,895	72,895	10	24,298	9
10	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	147,459	147,459	11	31,461	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	133,035	133,035	7	24,884	12
13	17	ADMIN. CMP. - A. CASSATA (N	WGHTD. AVG. HOURS	40	1	94,167	94,167			13
14	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	185,179	185,179	10	39,481	14
15	17	ADMIN. CMP. - CFO (NON-OWI	WGHTD. AVG. HOURS	40	10	245,335	245,335	7	45,889	15
16	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	89,040	89,040	7	16,669	16
17	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	11	62,541	62,541	1	1,170	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,022,394	$ 2,022,394		$ 390,652	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	6,047		9	1,290	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	41,488		7	7,761	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	37,909		9	8,088	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	39,733				4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	6,379				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	36,760		25	22,975	6
7	27	EMP. BEN.- B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	10,395				7
8	27	EMP. BEN.- R. AARON	WGHTD. AVG. HOURS	40	1	4,779				8
9	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	3	27,583		10	9,194	9
10	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,371		11	2,213	10
11	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,060				11
12	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	10	33,608		7	6,286	12
13	27	EMP. BEN.-A. CASSATA (NON-(	WGHTD. AVG. HOURS	40	1	7,352				13
14	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	52,388		10	11,169	14
15	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	40	10	25,777		7	4,822	15
16	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	18,319		7	3,429	16
17	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	11	38,523		1	721	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 398,471	$		$ 77,948	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	10	NURSING EQUIPMENT	DIRECT ALLOCATION			$	$		$ 1,065	1
2	39	DME & MEDICAL SUPPLIES	DIRECT ALLOCATION						3,068	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					$	$		$ 4,133	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$ 1,603	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					$	$		$ 1,603	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank		X	Mortgage			$	$ 9,399,190			$ 352,791	1
2	Allocated - Dynamic HC	X									4,437	2
3												3
4												4
5					-							5
	Working Capital											
6	MB Financial		X	Line of Credit				1,331,815			64,550	6
7												7
8					-							8
9	TOTAL Facility Related						$	$ 10,731,005			$ 421,779	9
	B. Non-Facility Related*											
10	Interest Income		X								(135,368)	10
11	Interest Income - Bldg. Co		X								(607)	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (135,975)	14
15	TOTALS (line 9+line14)						$	$ 10,731,005			$ 285,804	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 47,702 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: 01/01/16 Ending: 12/31/16

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Woodbridge Nursing Pavilion **#** 0034157 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 295,000	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.)		$ 334,038	2
3. Under or (over) accrual (line 2 minus line 1).		$ 39,038	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 333,200	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.)**		$ 17,591	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** $ 23,425 **For** 2004/20 **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.		$ 389,829	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	244,369	8
	2012	279,806	9
	2013	283,593	10
	2014	289,306	11
	2015	326,590	12

2016 Accrual = $326,590 x 1.02 = $333,200 (Rounded)

Allocated Dynamic HC Consultants = $7,448

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 98,745.23	$ 98,745.23
2.	13-35-217-016-0000	Long Term Care Property	$ 129,099.12	$ 129,099.12
3.	13-35-217-017-0000	Long Term Care Property	$ 98,745.33	$ 98,745.33
4.	10-23-404-059-0000	Home Office	$ 40,971.35	$ 7,288.16
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 367,561.03	$ 333,877.84

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	$ 367,488	35	$ 193,622	$ (173,866)	$ 2,148,251	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			20,548	14
15	Various			1996	8,331		20	116	116	8,328	15
16	Various			1997	6,790		20	340	340	6,562	16
17	Various			1998	50,252		20	2,513	2,513	46,771	17
18	Various			1999	68,242		20	3,412	3,412	59,821	18
19	Various			2000	57,506		20	2,875	2,875	48,256	19
20	Various			2001	62,933		20	3,147	3,147	48,848	20
21	Various			2002	83,062		20	2,058	2,058	32,202	21
22	Various			2003	16,347		20	70	70	15,889	22
23	Various			2004	116,859		20			116,859	23
24	Various			2005	112,439		20	2,083	2,083	98,021	24
25	Various			2006	70,102		20	247	247	70,102	25
26	Various			2007	205,027		20	10,362	10,362	109,759	26
27	Various			2008	99,839		20	8,605	8,605	85,142	27
28	Various			2009	563,904		20	15,734	15,734	114,790	28
29	Various			2010	5,192		20	260	260	1,817	29
30	Various			2011	15,685		20	402	402	2,211	30
31	Various			2012	27,813		20	2,042	2,042	8,872	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: 01/01/16 Ending: 12/31/16

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
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51									51
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53									53
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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)		1,853,161			94,785	94,785	525,315	67
68	Related Party Allocations (Pages 12H & 12I)		78,909	2,023		2,255	232	52,606	68
69	Financial Statement Depreciation			116,263			(116,263)		69
70	TOTAL (lines 4 thru 69)		$ 10,471,490	$ 485,774		$ 344,927	$ (140,847)	$ 3,792,747	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: 01/01/16 Ending: 12/31/16

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		$ 10,471,490	$ 485,774		$ 344,927	$ (140,847)	$ 3,792,747	1
2	Fan Coils For 2Nd Floor Day Room	2013	3,841		20	768	768	3,073	2
3	Elevator Work-Replace Two Hydraulic Piston Packings	2013	3,400		20	170	170	652	3
4	Fabricate & Install Exterior Display In Front Of Building	2013	11,666		20	583	583	2,309	4
5	Remove Old And Install New Condensor	2013	6,270		20	1,254	1,254	4,389	5
6	Elevator Work-Replace 11 Elevator Hoistway Limit Switches; Inst	2013	4,489		20	224	224	776	6
7	Installed 2 New 60 Series Pump Pipes	2014	4,324		20	216	216	495	7
8	Remote Annunciator For Fire Pump; Tie Kitchen System To Fire	2014	5,255		20	263	263	723	8
9	3Rd Floor - Lights, Walls, Doors, Nurses Station	2014	6,152		20	308	308	641	9
10	Water Pump	2015	3,617		20	181	181	332	10
11	Water Valve Work In Therapy Room	2015	7,100		20	355	355	562	11
12	Installed Hose, Restricted Feeder & Water Feed Pump For Chiller	2015	2,722		20	219	219	364	12
13	Installed 3 Secuity Cameras & Monitor	2015	2,910		20	146	146	182	13
14	3Rd Floor - Lights, Walls, Doors, Nurses Station	2015	55,427		20	2,771	2,771	4,619	14
15	Lobby - Flooring, Replace Door, Wallcovering, Ceiling Panels	2015	10,681		20	534	534	846	15
16	Resident Room & Evacuation Interior Signage	2016	2,849		20	511	511	511	16
17	4Th Floor Nurse Call System	2016	3,575		20	596	596	596	17
18	4Th Floor - Vinyl Tile Flooring 2,232 Sq Ft	2016	26,099		20	4,350	4,350	4,350	18
19	Installed New Pump & Relay For Air Handler	2016	3,100		20	66	66	66	19
20	Install New Fittings And Sections To Leaking 2" Copper Pipe In K	2016	2,875		20	55	55	55	20
21	Install New 2" Ball Valve & 7Ft New Piping/Fittings	2016	2,850		20	48	48	48	21
22	Install New Section Of 4" Cast Iron Pipe With New Couplings	2016	3,200		20	30	30	30	22
23	Install 2X Di-Electric Unions/Piping/Ball Valves	2016	2,850		20	54	54	54	23
24	Wireless Equipment	2016	9,354		20	312	312	312	24
25	Firewall,Switches,Wireless Network/Cabinet	2016	3,677		20	184	184	184	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,659,773	$ 485,774		$ 359,125	$ (126,649)	$ 3,818,915	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: 01/01/16 Ending: 12/31/16

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		$ 10,659,773	$ 485,774		$ 359,125	$ (126,649)	$ 3,818,915	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,659,773	$ 485,774		$ 359,125	$ (126,649)	$ 3,818,915	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: 01/01/16 Ending: 12/31/16

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		$ 10,659,773	$ 485,774		$ 359,125	$ (126,649)	$ 3,818,915	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,659,773	$ 485,774		$ 359,125	$ (126,649)	$ 3,818,915	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: 01/01/16 Ending: 12/31/16

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		$ 10,659,773	$ 485,774		$ 359,125	$ (126,649)	$ 3,818,915	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 10,659,773	$ 485,774		$ 359,125	$ (126,649)	$ 3,818,915	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: 01/01/16 Ending: 12/31/16

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									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	46,757	9
10	Various	2010	734,652		20	38,859	38,859	282,523	10
11	Various	2011	288,244		20	14,412	14,412	86,473	11
12	Power for Ejector & Circulating Pumps	2012	3,950		20	198	198	988	12
13	Water coil for roof	2012	4,301		20	215	215	1,075	13
14	Fire Dampers & Insulation	2012	3,142		20	157	157	785	14
15	Sprinkler System, Sprinkler Head Piping	2012	2,850		20	143	143	713	15
16	Boiler Pump, New Boiler	2012	5,698		20	285	285	1,425	16
17	Fire alarm door release	2012	3,837		20	192	192	959	17
18	Doors for Resident Rooms and Floors and Lobby	2012	3,560		20	178	178	890	18
19	Ceramic Tiling in Basement bathrooms	2012	6,767		20	338	338	1,691	19
20	Ceramic Tiling in 1st floor bathroom/shower room	2012	6,917		20	346	346	1,729	20
21	Shower tub & base installation, valve & Wiring,	2012	14,821		20	741	741	3,705	21
22	Lighting for first floor resident rooms	2012	11,470		20	574	574	2,868	22
23	Service Sink Installation	2012	2,513		20	126	126	629	23
24	Condenser Installation	2012	4,675		20	234	234	1,169	24
25	Electrical Work for Air Handler, Laundry Room, Resident Rooms	2012	11,666		20	583	583	2,916	25
26	Install Condensate Pump	2012	3,165		20	158	158	791	26
27	Doors for Resident Rooms and Floors and Lobby	2012	4,956		20	248	248	1,239	27
28	Camera & Pacing System, Monitors, Lights, Alarms	2012	7,875		20	394	394	1,969	28
29	Exit Signs, Camera Outlets, Automatic Door Control	2012	7,410		20	371	371	1,853	29
30	Heat Curtain Installation	2012	3,365		20	168	168	841	30
31	Installed New Pipping in the Fourth Floor Ceiling for Hot and Col	2012	2,500		20	125	125	625	31
32	All Floors Shower Tub Rooms-Flooring,Wallcovering, Lighting, T	2013	154,632		20	7,732	7,732	38,658	32
33	Installed New Ejector Pumps in Basement	2013	4,900		20	245	245	980	33
34	TOTAL (lines 1 thru 33)		$ 1,388,606	$		$ 71,558	$ 71,558	$ 484,253	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: 01/01/16 Ending: 12/31/16

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		$ 1,388,606	$		$ 71,558	$ 71,558	$ 484,253	1
2	Installed New Blast Roof Top Furnace	2013	31,780		20	1,589	1,589	6,356	2
3	Installed Nurse Station and Replaced Two Doors on Second Floor	2013	9,832		20	492	492	1,967	3
4	Drop Ceiling Supplies for Second Floor Remodeling	2013	4,151		20	208	208	831	4
5	Remodeled Second Floor, Installed New Ceiling Tiles, Lights, Wall Pa	2013	23,750		20	1,188	1,188	4,751	5
6	Purchased Vinyl Wallcovering for Corridor and Dining Room and Flo	2013	21,037		20	1,052	1,052	4,208	6
7	Installed Window Treatements and Braille Signage on Second Floor	2013	4,992		20	250	250	999	7
8	Installed Handrails on Second Floor	2013	3,550		20	178	178	711	8
9	Installation on Vinyl Flooring on Second Floor	2013	7,333		20	367	367	1,467	9
10	Installed 3 Toilet Bowls and Tanks, 3 Faucets, and 12 Shower Rods or	2013	2,538		20	127	127	508	10
11	4th Floor Corridor Wall Guards and Corner Guards	2015	14,391		20	720	720	1,440	11
12	3rd and 4th Floor Dining Room Window Treatments	2015	4,358		20	218	218	436	12
13	Installed 4th Floor Nurses Station	2015	10,972		20	549	549	1,098	13
14	Windows/Radiator Covers/Parking Lot/Guardrails/Tuckpointing/Light	2016	296,150		20	14,808	14,808	14,808	14
15	Wall Protection System in Corridor	2016	14,391		20	720	720	720	15
16	Window Treatments	2016	4,358		20	218	218	218	16
17	4th Floor Nurses Station	2016	10,972		20	549	549	549	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)		$ 1,853,161	$		$ 94,785	$ 94,785	$ 525,315	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: 01/01/16 Ending: 12/31/16

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	78,909	2,023	35	2,255	232	52,606	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 78,909	$ 2,023		$ 2,255	$ 232	$ 52,606	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: 01/01/16 Ending: 12/31/16

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		$ 78,909	$ 2,023		$ 2,255	$ 232	$ 52,606	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 78,909	$ 2,023		$ 2,255	$ 232	$ 52,606	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: 01/01/16 Ending: 12/31/16

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	$ 356,473	$ 1,142	$ 26,436	$ 25,294	10	$ 295,000	71
72	Current Year Purchases	51,398		5,571	5,571	10	5,571	72
73	Fully Depreciated Assets	1,052,178		509	509	10	1,052,003	73
74								74
75	TOTALS	$ 1,460,049	$ 1,142	$ 32,516	$ 31,374		$ 1,352,573	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	2016	52,660	1,934	4,775	2,841	5	4,775	77
78										78
79										79
80	TOTALS			$ 104,299	$ 1,934	$ 4,775	$ 2,841		$ 56,414	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)	$ 12,974,121	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 488,850	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 396,416	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (92,434)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,227,902	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	CIP	$ 237,612	92
93			93
94			94
95		$ 237,612	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: 01/01/16 Ending: 12/31/16

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				3,866			5
6								6
7	TOTAL				$ 3,866 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 2,188 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		$	$ 21,423	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 21,423	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	hrs	$ 393,800		$	$		$ 393,800	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	218,152					218,152	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	344,017					344,017	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				250,702		250,702	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					5,993	39,970		45,963	13
14	TOTAL			$ 955,969		$ 5,993	$ 290,672		$ 1,252,634	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:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 658	$ 182,932	1
2	Cash-Patient Deposits	130,745	130,745	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,394,489	2,394,489	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	162,868	204,771	6
7	Other Prepaid Expenses	3,868	3,868	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	148,849	798,744	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,841,477	$ 3,715,549	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	1,943,572	3,822,804	15
16	Equipment, at Historical Cost	1,592,802	1,775,095	16
17	Accumulated Depreciation (book methods)	(2,318,445)	(5,474,256)	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)	(77,363)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	3,021,863	3,368,939	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,239,792	$ 11,249,796	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,081,269	$ 14,965,345	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 718,167	$ 718,167	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	130,745	130,745	28
29	Short-Term Notes Payable	1,331,815	1,331,815	29
30	Accrued Salaries Payable	417,406	417,406	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,241	6,241	31
32	Accrued Real Estate Taxes(Sch.IX-B)		333,200	32
33	Accrued Interest Payable	2,728	31,709	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	18,530	18,530	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	787	238,399	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,626,419	$ 3,226,212	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	22,115	546,076	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 22,115	$ 9,945,266	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,648,534	$ 13,171,478	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,432,735	$ 1,793,867	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,081,269	$ 14,965,345	48

***(See instructions.)**

Facility Name & ID Number Woodbridge Nursing Pavilion **#** 0034157 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,888,200	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,888,200	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,843,735	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,299,200)	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)**	$ 1,544,535	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)**	$ 4,432,735	24 *

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 15,473,589	1
2	Discounts and Allowances for all Levels	(3,487,447)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,986,142	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,511,350	6
7	Oxygen	72	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,511,422	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	361,864	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,977	19
20	Radiology and X-Ray	13,202	20
21	Other Medical Services	48,724	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 461,767	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	135,368	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 135,368	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	416,425	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 416,425	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,511,124	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,898,736	31
32	Health Care	4,272,494	32
33	General Administration	4,140,235	33
	B. Capital Expense		
34	Ownership	1,585,206	34
	C. Ancillary Expense		
35	Special Cost Centers	1,252,634	35
36	Provider Participation Fee	518,084	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,667,389	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,843,735	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,843,735	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,931,351	44
45	Private Pay - Net Inpatient Revenue	203,942	45
46	Medicare - Net Inpatient Revenue	1,287,219	46
47	Other-(specify) Hospice	563,630	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,986,142	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: 01/01/16 Ending: 12/31/16

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	2,028	2,069	$ 121,115	$ 58.54	1
2	Assistant Director of Nursing	1,440	1,619	60,954	37.65	2
3	Registered Nurses	21,157	22,145	742,036	33.51	3
4	Licensed Practical Nurses	43,170	45,351	1,268,744	27.98	4
5	CNAs & Orderlies	97,196	104,464	1,362,438	13.04	5
6	CNA Trainees					6
7	Licensed Therapist	21,691	22,999	955,969	41.57	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,918	2,113	32,185	15.23	9
10	Activity Assistants	15,225	16,033	173,748	10.84	10
11	Social Service Workers	6,338	6,737	137,581	20.42	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,303	56,848	24.68	13
14	Head Cook	4,996	5,648	68,869	12.19	14
15	Cook Helpers/Assistants	19,166	20,760	231,235	11.14	15
16	Dishwashers					16
17	Maintenance Workers	8,352	8,765	140,569	16.04	17
18	Housekeepers	21,337	22,930	263,913	11.51	18
19	Laundry	11,065	11,800	131,145	11.11	19
20	Administrator	1,881	2,011	134,096	66.68	20
21	Assistant Administrator	259	259	19,104	73.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,932	9,056	198,458	21.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,903	4,284	58,286	13.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	292,134	311,346	$ 6,157,293 *	$ 19.78	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	389	$ 18,128	01-03	35
36	Medical Director	120	36,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	per bed	16,177	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,468	11-03	44
45	Social Service Consultant	71	4,427	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	629	$ 77,200		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: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patty Correa	Administrator	0	$ 134,096
Steve Goldstein	Asst. Admin	0	19,104
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 153,201

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
Marcum LLP	Accounting	$ 40,709
Dynamic HC Consultants	Consulting	35,083
See Attached	Legal	54,771
Dynamic HC Consultants	Bookkeeping Services	1,004,100
Personnel Planners	Unemployment Consulting	2,546
IIT/Sourcetech	Data Processing	1,715
Casamba	Data Processing	1,590
PointClickCare Technologies	Data Processing	41,978
National Datacare Corporation	Data Processing	4,179
Health Data Systems	Data Processing	16,774
Phigenics, LLC	Water Management	8,500
See Supplemental Schedule		59,770
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,271,714

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 140,136
Unemployment Compensation Insurance	72,614
FICA Taxes	469,364
Employee Health Insurance	293,679
Employee Meals	79,989
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	23,140
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,078,922

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,795
Health Care Worker Background Check	3,214
(Indicate # of checks performed 321)	
Patient Background Checks	
Dues & Subscriptions	23,605
Licenses & Permits	7,277
Allocated from Dynamic HC Consultants	3,057
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,947

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,417
Allocated from Dynamic HC Consultants	3,524
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,941

**See instructions.

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: $33,044**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **14,017** 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 fo
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 Departmen
during this cost report period. $ **518,084**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **79,989** 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 fo
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 1**
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
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