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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0034157

Facility Name: Woodbridge Nursing Pavilion

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/17 to 12/31/17 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)
** Subject to the attached Accountants' Consulting Report*
(Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 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: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,325	131	7,395	8,851	8
9	SNF/PED					9
10	ICF	60,706	531	3,126	64,363	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,031	662	10,521	73,214	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.35%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 8/1/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 222 and days of care provided 7,218

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	404,061	44,178	17,956	466,195		466,195		466,195			1
2	Food Purchase		386,065		386,065	(79,205)	306,860	(35)	306,825			2
3	Housekeeping	268,718	62,834		331,552		331,552		331,552			3
4	Laundry	155,305	21,610	120	177,035		177,035		177,035			4
5	Heat and Other Utilities			199,616	199,616		199,616	(2,337)	197,279			5
6	Maintenance	122,463	114,469	97,266	334,198		334,198	71,080	405,278			6
7	Other (specify):*							1,944	1,944			7
8	**TOTAL General Services**	950,547	629,156	314,958	1,894,661	(79,205)	1,815,456	70,652	1,886,108			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,778,032	209,356	76,211	4,063,599		4,063,599		4,063,599			10
10a	Therapy	132,175	3,344		135,519		135,519		135,519			10a
11	Activities	176,694	19,682	2,516	198,892		198,892		198,892			11
12	Social Services	328,983		2,976	331,959		331,959		331,959			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,415,884	232,382	117,703	4,765,969		4,765,969		4,765,969			16
	C. General Administration											
17	Administrative	169,897			169,897		169,897	365,852	535,749			17
18	Directors Fees											18
19	Professional Services			1,316,239	1,316,239	(12,171)	1,304,068	(1,007,460)	296,608			19
20	Dues, Fees, Subscriptions & Promotions			90,125	90,125		90,125	(49,203)	40,922			20
21	Clerical & General Office Expenses	180,585	4,279	1,162,234	1,347,098		1,347,098	(892,617)	454,481			21
22	Employee Benefits & Payroll Taxes			1,065,648	1,065,648	79,205	1,144,853		1,144,853			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,698	3,698		3,698	715	4,413			24
25	Other Admin. Staff Transportation			10,788	10,788		10,788	7,324	18,112			25
26	Insurance-Prop.Liab.Malpractice			287,057	287,057		287,057	21,457	308,514			26
27	Other (specify):*							121,047	121,047			27
28	**TOTAL General Administration**	350,482	4,279	3,935,789	4,290,550	67,034	4,357,584	(1,432,885)	2,924,699			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,716,913	865,817	4,368,450	10,951,180	(12,171)	10,939,009	(1,362,232)	9,576,777			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: 01/01/17 Ending: 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			125,762	125,762		125,762	271,656	397,418			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102,443	102,443		102,443	154,940	257,383			32
33	Real Estate Taxes					12,171	12,171	394,436	406,607			33
34	Rent-Facility & Grounds			1,399,807	1,399,807		1,399,807	(1,399,807)				34
35	Rent-Equipment & Vehicles			50,526	50,526		50,526	16,191	66,717			35
36	Other (specify):*							46,170	46,170			36
37	**TOTAL Ownership**			1,678,538	1,678,538	12,171	1,690,709	(516,414)	1,174,295			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,048,726	295,134	30,041	1,373,901		1,373,901	(77)	1,373,824			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			519,750	519,750		519,750		519,750			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	1,048,726	295,134	549,791	1,893,651		1,893,651	(77)	1,893,574			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,765,639	1,160,951	6,596,779	14,523,369		14,523,369	(1,878,723)	12,644,646			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: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,472)	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	(106,267)	30		9
10	Interest and Other Investment Income	(189,214)	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	(394)	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	(663,178)	21		24
25	Fund Raising, Advertising and Promotional	(40,932)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(26,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(462,387)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,492,879)		$	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)	(385,844)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (385,844)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,878,723)		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: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (86,954)	21	1
2	Managed Care Sequestration	(3,336)	21	2
3	Bank Charges	(9,600)	21	3
4	PPA - Office	(318,035)	21	4
5	PPA - Nursing Supplies	(252)	21	5
6	PPA - Professional Fees	(23,117)	19	6
7	Non Allowable Auto	(10,703)	35	7
8	Bldg Co - Legal Fees	(250)	19	8
9	Bldg Co - Audit Fees	(13,431)	19	9
10	Bldg Co - Accounting Fees	(1,200)	19	10
11	Bldg Co - Amortization	(11,106)	31	11
12	Bldg Co - Franchise Tax	(250)	20	12
13	Non Allowable Legal Fees	(7,978)	19	13
14	PAC Dues	(15,962)	20	14
15	Additional R&M	40,537	06	15
16	Intercompany Interest	(750)	32	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(462,387)		49

Woodbridge Nursing Pavilion

ID# 0034157

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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:** 01/01/17 **Ending:** 12/31/17

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	(4,472)		2,135									(2,337)	5
6	Maintenance	40,537		16,582	13,961								71,080	6
7	Other (specify):*			435		1,509							1,944	7
8	**TOTAL General Services**	36,030		19,152	13,961	1,509							70,652	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative				365,852								365,852	17
18	Directors Fees													18
19	Professional Services	(45,976)	14,881	(976,365)									(1,007,460)	19
20	Fees, Subscriptions & Promotions	(57,144)	250	7,691									(49,203)	20
21	Clerical & General Office Expenses	(1,107,749)		198,931	16,201								(892,617)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			715									715	24
25	Other Admin. Staff Transportation			7,324									7,324	25
26	Insurance-Prop.Liab.Malpractice		12,865	8,592									21,457	26
27	Other (specify):*			31,661		89,386							121,047	27
28	**TOTAL General Administration**	(1,210,869)	27,996	(721,451)	382,053	89,386							(1,432,885)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,174,839)	27,996	(702,298)	396,014	90,895							(1,362,232)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	(106,267)	371,925	5,998									271,656	30
31	Amortization of Pre-Op. & Org.	(11,106)	11,106											31
32	Interest	(189,964)	341,231	3,673									154,940	32
33	Real Estate Taxes		387,764	6,672									394,436	33
34	Rent-Facility & Grounds		(1,399,807)										(1,399,807)	34
35	Rent-Equipment & Vehicles	(10,703)		26,894									16,191	35
36	Other (specify):*		46,170										46,170	36
37	TOTAL Ownership	(318,040)	(241,611)	43,237									(516,414)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(77)						(77)	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						(77)						(77)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,492,879)	(213,615)	(659,061)	396,014	90,895	(77)						(1,878,723)	45

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	457	Woodbridge Building LLC	100.00%		(457)	2
3	V	19	Legal Fees		Woodbridge Building LLC	100.00%	250	250	3
4	V	19	Audit Fees		Woodbridge Building LLC	100.00%	13,431	13,431	4
5	V	19	Accounting		Woodbridge Building LLC	100.00%	1,200	1,200	5
6	V	30	Depreciation		Woodbridge Building LLC	100.00%	371,925	371,925	6
7	V	31	Amortization of Mortgage Costs		Woodbridge Building LLC	100.00%	11,106	11,106	7
8	V	33	Real Estate Tax		Woodbridge Building LLC	100.00%	387,764	387,764	8
9	V	20	Franchise Tax		Woodbridge Building LLC	100.00%	250	250	9
10	V	32	Interest Expense - Heartland		Woodbridge Building LLC	100.00%	341,688	341,688	10
11	V	36	Mortgage Insurance		Woodbridge Building LLC	100.00%	46,170	46,170	11
12	V	26	Insurance		Woodbridge Building LLC	100.00%	12,865	12,865	12
13	V								13
14	Total			$ 1,400,264			$ 1,186,649	$ * (213,615)	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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 2,135	$ 2,135	15
16	V	6	REPAIRS & MAINT. - SALARIES		DYNAMIC HEALTH CARE CONS.	100.00%	6,475	6,475	16
17	V	6	REPAIRS & MAINT. - OTHER EXPENSE		DYNAMIC HEALTH CARE CONS.	100.00%	10,107	10,107	17
18	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	435	435	18
19	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	1,244	1,244	19
20	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	7,691	7,691	20
21	V	21	CLERICAL & GENERAL - SALARIES		DYNAMIC HEALTH CARE CONS.	100.00%	141,902	141,902	21
22	V	21	CLERICAL & GENERAL - OTHER EXPENSE		DYNAMIC HEALTH CARE CONS.	100.00%	57,029	57,029	22
23	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	715	715	23
24	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	7,324	7,324	24
25	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	8,592	8,592	25
26	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	31,661	31,661	26
27	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	5,998	5,998	27
28	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	3,673	3,673	28
29	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	6,672	6,672	29
30	V	19	REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%	536	536	30
31	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	25,790	25,790	31
32	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	1,104	1,104	32
33	V								33
34	V	19	HOME OFFICE	978,145	DYNAMIC HEALTH CARE CONS.	100.00%		(978,145)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 978,145			$ 319,084	$ * (659,061)	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: 01/01/17 Ending: 12/31/17

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%	$ 13,961	$ 13,961	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	41,447	41,447	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	47,863	47,863	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%	16,284	16,284	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	63,125	63,125	20
21	V	17	ADMIN. CMP. - R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	23,970	23,970	22
23	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	35,350	35,350	23
24	V	17	ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	17	ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	27,731	27,731	25
26	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	60,336	60,336	26
27	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	49,746	49,746	27
28	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	16,097	16,097	28
29	V	21	CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	104	104	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			$			$ 396,014	$ * 396,014	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: 01/01/17 Ending: 12/31/17

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%	$ 1,509	$ 1,509	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	7,803	7,803	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	9,949	9,949	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%	1,646	1,646	19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	23,513	23,513	20
21	V	27	EMP. BEN.- R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%	9,570	9,570	22
23	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	2,749	2,749	23
24	V	27	EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	27	EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	7,438	7,438	25
26	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	16,387	16,387	26
27	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	5,748	5,748	27
28	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,847	3,847	28
29	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	736	736	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			$			$ 90,895	$ * 90,895	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: 01/01/17 Ending: 12/31/17

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	$ 700	Lifeline Ambulance		$ 623	$ (77)	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			$ 700			$ 623	$ * (77)	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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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	24.87%	GROSSE POINTE MANOR	NILES	WOODBRIDGE BUILDING CO	CHICAOG	BUILDING CO	1
2	ABRAHAM J. STERN	17.15%	BRIDGEVIEW HEALTH CARE CENTER, LTD.	BRIDGEVIEW	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	MEDICAL SUPPLIES	4
5	MIRIAM LATINIK	4.51%	STERLING PAVILION, LTD.	STERLING	LIFELINE AMBULANCE	CHICAOG	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 NURSING PAVILION, LTD.	CHICAGO				9
10	SUSIE & HOWIE ALTER	1.17%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (S	GALESBURG				10
11	SYLVIA AARON	0.23%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLI	GENESEO				11
12	SUE KOPLIN	0.59%						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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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	9.57	19.15%	Alloc. Salary	$ 47,863	17-07	1
2	Daniel Aaron	Relative	Administrative	N/A	See Attached	8.51	21.29%	Alloc. Salary	16,284	17-07	2
3	Marshall Mauer	Owner	Administrative	6.76%	See Attached	8.29	16.58%	Alloc. Salary	41,447	17-07	3
4	Sharon Aaron	Owner	Clerical	0.59%	See Attached	8.3	20.74%	Alloc. Salary	16,097	21-07	4
5	Esther Maryles	Relative	Clerical	N/A	See Attached	0.58	2.07%	Alloc. Salary	104	21-07	5
6	Dennis Nehmer	Owner	Maintenance	0.59%	See Attached	9.57	23.93%	Alloc. Salary	13,961	06-07	6
7	Diana Kufta	Owner	Administrative	0.59%	See Attached	9.57	23.93%	Alloc. Salary	35,350	17-07	7
8	Sue Koplin-Haramaras	Owner	Administrative	0.59%	See Attached	10	25.00%	Alloc. Salary	23,970	17-07	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	$ 195,076		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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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	371,884	11	$ 10,844	$	73,214	$ 2,135	1
2	6	REPAIRS & MAINT. - SALARIE	PATIENT DAYS	371,884	11	32,891	32,891	73,214	6,475	2
3	6	REPAIRS & MAINT. - OTHER E	PATIENT DAYS	371,884	11	51,340		73,214	10,107	3
4	7	EMP. BEN-GEN SERV.	PATIENT DAYS	371,884	11	2,209		73,214	435	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	371,884	11	6,316		73,214	1,244	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	371,884	11	39,064		73,214	7,691	6
7	21	CLERICAL & GENERAL - SALA	PATIENT DAYS	371,884	11	720,780	720,780	73,214	141,902	7
8	21	CLERICAL & GENERAL - OTH	PATIENT DAYS	371,884	11	289,675		73,214	57,029	8
9	24	SEMINARS AND TRAVEL	PATIENT DAYS	371,884	11	3,633		73,214	715	9
10	25	AUTO EXP.	PATIENT DAYS	371,884	11	37,201		73,214	7,324	10
11	26	INSURANCE	PATIENT DAYS	371,884	11	43,644		73,214	8,592	11
12	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	371,884	11	160,819		73,214	31,661	12
13	30	DEPRECIATION	PATIENT DAYS	371,884	11	30,466		73,214	5,998	13
14	32	INTEREST	PATIENT DAYS	371,884	11	18,656		73,214	3,673	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	371,884	11	33,889		73,214	6,672	15
16	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	371,884	11	2,725		73,214	536	16
17	35	AUTO RENTAL	PATIENT DAYS	371,884	11	130,997		73,214	25,790	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	371,884	11	5,607		73,214	1,104	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,620,756	$ 753,671		$ 319,084	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	7	58,337	58,337	9.57	13,961	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	8.29	41,447	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	7	200,000	200,000	9.57	47,863	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	11	76,541	76,541	8.51	16,284	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	101,000	101,000	25.00	63,125	6
7	17	ADMIN. CMP. - R. AARON	WGHTD. AVG. HOURS	40	1	61,541	61,541	-		7
8	17	ADMIN. CMP. - S. HARAMARAS	WGHTD. AVG. HOURS	30	3	71,909	71,909	10.00	23,970	8
9	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	40	7	147,753	147,753	9.57	35,350	9
10	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		10
11	17	ADMIN. CMP. - V. DAVIS (NON-	WGHTD. AVG. HOURS	40	9	133,816	133,816	8.29	27,731	11
12	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	7	252,333	252,333	10.76	60,336	12
13	17	ADMIN. CMP. - CFO (NON-OWI	WGHTD. AVG. HOURS	40	9	240,048	240,048	8.29	49,746	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	9	77,614	77,614	8.30	16,097	14
15	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	11	5,000	5,000	0.58	104	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,640,392	$ 1,640,392		$ 396,014	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	7	6,305		9.57	1,509	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	37,655		8.29	7,803	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	7	41,575		9.57	9,949	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	42,544		-		4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	11	7,737		8.51	1,646	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,621		25.00	23,513	6
7	27	EMP. BEN.- R. AARON	WGHTD. AVG. HOURS	40	1	27,046		-		7
8	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	3	28,711		10.00	9,570	8
9	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	40	7	11,492		9.57	2,749	9
10	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,095		-		10
11	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	9	35,890		8.29	7,438	11
12	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	7	68,533		10.76	16,387	12
13	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	40	9	27,736		8.29	5,748	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	9	18,548		8.30	3,847	14
15	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	11	35,535		0.58	736	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 428,023	$		$ 90,895	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$ 623	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					$	$		$ 623	25

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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 - HUD		X	Mortgage			$	$ 9,093,990			$ 341,688	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				1,980,640			101,693	6
7												7
8												8
9	TOTAL Facility Related						$	$ 11,074,630			$ 443,381	9
	B. Non-Facility Related*											
10	Interest Income		X								(189,214)	10
11	Allocated from Dynamic HC	X									3,673	11
12	Interest Income - Bldg Co	X									(457)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (185,998)	14
15	TOTALS (line 9+line14)						$	$ 11,074,630			$ 257,383	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 46,170 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:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	333,200	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.)	$	363,630	2
3. Under or (over) accrual (line 2 minus line 1).	$	30,430	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	364,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	12,171	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** $ 34,732 **For** 14 **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.	$	406,601	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	279,806	8
	2013	283,593	9
	2014	289,306	10
	2015	326,590	11
	2016	356,958	12

2017 Accrual = 356,958 x 1.02 = $364,000 (rounded)

Allocated From Dynamic HC $6,672

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 107,923.15	$ 107,923.15
2.	13-35-217-016-0000	Long Term Care Property	$ 141,105.96	$ 141,105.96
3.	13-35-217-017-0000	Long Term Care Property	$ 107,929.15	$ 107,929.15
4.	10-23-404-059-0000	Home Office	$ 37,460.03	$ 7,368.97
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 394,418.29	$ 364,327.23

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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) 282-6300 FAX #: (847) 282-6301

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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	$ 371,925	35	$ 193,622	$ (178,303)	$ 2,341,873	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			8,328	15
16	Various			1997	6,790		20	226	226	6,787	16
17	Various			1998	50,252		20	2,511	2,511	49,282	17
18	Various			1999	68,242		20	3,412	3,412	63,233	18
19	Various			2000	57,506		20	2,875	2,875	51,131	19
20	Various			2001	62,933		20	3,147	3,147	51,994	20
21	Various			2002	83,062		20	2,058	2,058	34,260	21
22	Various			2003	16,347		20	70	70	15,959	22
23	Various			2004	116,859		20			116,859	23
24	Various			2005	112,439		20	2,046	2,046	100,067	24
25	Various			2006	70,102		20			70,102	25
26	Various			2007	205,027		20	10,036	10,036	119,795	26
27	Various			2008	99,839		20	8,605	8,605	93,748	27
28	Various			2009	563,904		20	15,734	15,734	130,524	28
29	Various			2010	5,192		20	260	260	2,077	29
30	Various			2011	15,685		20	402	402	2,613	30
31	Various			2012	27,813		20	1,974	1,974	10,846	31
32	Various			2013	29,666		20	3,000	3,000	14,199	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,866,804			95,473	95,473	620,795	67
68	Related Party Allocations (Pages 12H & 12I)		87,333	2,239		2,496	257	60,716	68
69	Financial Statement Depreciation			125,762			(125,762)		69
70	TOTAL (lines 4 thru 69)		$ 10,523,223	$ 499,926		$ 347,946	$ (151,980)	$ 4,157,513	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: 01/01/17 Ending: 12/31/17

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		$ 10,523,223	$ 499,926		$ 347,946	$ (151,980)	$ 4,157,513	1
2	Installed 2 New 60 Series Pump Pipes	2014	4,324		20	216	216	712	2
3	Remote Annunciator For Fire Pump; Tie Kitchen System To Fire	2014	5,255		20	263	263	985	3
4	3Rd Floor - Lights, Walls, Doors, Nurses Station	2014	6,152		20	308	308	948	4
5	Water Pump	2015	3,617		20	181	181	512	5
6	Water Valve Work In Therapy Room	2015	7,100		20	355	355	917	6
7	Installed Hose, Restricted Feeder & Water Feed Pump For Chiller	2015	2,722		20	136	136	363	7
8	Installed 3 Secuity Cameras & Monitor	2015	2,910		20	146	146	327	8
9	3Rd Floor - Lights, Walls, Doors, Nurses Station	2015	55,427		20	2,771	2,771	7,390	9
10	Lobby - Flooring, Replace Door, Wallcovering, Ceiling Panels	2015	10,681		20	534	534	1,380	10
11	Resident Room & Evacuation Interior Signage	2016	2,849		20	570	570	1,140	11
12	4Th Floor Nurse Call System	2016	3,575		20	715	715	1,311	12
13	4Th Floor - Vinyl Tile Flooring 2232 Sq Ft	2016	26,099		20	5,220	5,220	9,570	13
14	Installed New Pump & Relay For Air Handler	2016	3,100		20	89	89	155	14
15	Install New Fittings & Sections To Leaking 2" Copper Pipe In Kit	2016	2,875		20	82	82	137	15
16	Install New 2" Ball Valve & 7 Ft New Piping/Fittings	2016	2,850		20	81	81	129	16
17	Install New Section Of 4" Cast Iron Pipe With New Couplings	2016	3,200		20	91	91	122	17
18	Install 2X Di-Electric Unions / Piping / Ball Valves	2016	2,850		20	81	81	136	18
19	Wireless Equipment	2016	9,354		20	1,871	1,871	2,183	19
20	Firewall, Switches, Wireless Network / Cabinet	2016	3,677		20	105	105	123	20
21	Signage - 2Nd Floor Corrdor	2017	2,893		20	76	76	76	21
22	Protection System - 2Nd Floor Corridor	2017	6,213		20	163	163	163	22
23	Water Pressure Restoration	2017	6,350		20	151	151	151	23
24	Installed New Lighting, Sinks, Faucets - Rm 101	2017	13,850		20	297	297	297	24
25	Wall - Ac Unit	2017	2,950		20	344	344	344	25
26	Plumbing Parts - Bathroom	2017	2,841		20	47	47	47	26
27	Installed New Pumps - Boiler Room	2017	6,400		20	107	107	107	27
28	Installed New Call Light System - 2Nd Floor	2017	7,166		20	102	102	102	28
29	Installed New Piping - Kitchen Sewer	2017	3,800		20	45	45	45	29
30	Installed Mirrors - Therapy Room	2017	2,860		20	27	27	27	30
31	Boiler Upgrade	2017	3,443		20	16	16	16	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,740,605	$ 499,926		$ 363,137	$ (136,789)	$ 4,187,428	34

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 10,740,605	$ 499,926		$ 363,137	$ (136,789)	$ 4,187,428	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		$ 10,740,605	$ 499,926		$ 363,137	$ (136,789)	$ 4,187,428	34

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 10,740,605	$ 499,926		$ 363,137	$ (136,789)	$ 4,187,428	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 10,740,605	$ 499,926		$ 363,137	$ (136,789)	$ 4,187,428	34

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 10,740,605	$ 499,926		$ 363,137	$ (136,789)	$ 4,187,428	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,740,605	$ 499,926		$ 363,137	$ (136,789)	$ 4,187,428	34

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	51,295	9
10	Various	2010	734,652		20	38,859	38,859	321,382	10
11	Various	2011	288,244		20	14,412	14,412	100,885	11
12	Power for Ejector & Circulating Pumps	2012	3,950		20	198	198	1,186	12
13	Water coil for roof	2012	4,301		20	215	215	1,290	13
14	Fire Dampers & Insulation	2012	3,142		20	157	157	943	14
15	Sprinkler System, Sprinkler Head Piping	2012	2,850		20	143	143	856	15
16	Boiler Pump, New Boiler	2012	5,698		20	285	285	1,710	16
17	Fire alarm door release	2012	3,837		20	192	192	1,151	17
18	Doors for Resident Rooms and Floors and Lobby	2012	3,560		20	178	178	1,068	18
19	Ceramic Tiling in Basement bathrooms	2012	6,767		20	338	338	2,030	19
20	Ceramic Tiling in 1st floor bathroom/shower room	2012	6,917		20	346	346	2,075	20
21	Shower tub & base installation, valve & Wiring,	2012	14,821		20	741	741	4,446	21
22	Lighting for first floor resident rooms	2012	11,470		20	574	574	3,442	22
23	Service Sink Installation	2012	2,513		20	126	126	754	23
24	Condenser Installation	2012	4,675		20	234	234	1,403	24
25	Electrical Work for Air Handler, Laundry Room, Resident Rooms	2012	11,666		20	583	583	3,500	25
26	Install Condensate Pump	2012	3,165		20	158	158	949	26
27	Doors for Resident Rooms and Floors and Lobby	2012	4,956		20	248	248	1,487	27
28	Camera & Pacing System, Monitors, Lights, Alarms	2012	7,875		20	394	394	2,363	28
29	Exit Signs, Camera Outlets, Automatic Door Control	2012	7,410		20	371	371	2,224	29
30	Heat Curtain Installation	2012	3,365		20	168	168	1,009	30
31	Installed New Pipping in the Fourth Floor Ceiling for Hot and Col	2012	2,500		20	125	125	750	31
32	All Floors Shower Tub Rooms-Flooring,Wallcovering, Lighting, T	2013	154,632		20	7,732	7,732	46,390	32
33	Installed New Ejector Pumps in Basement	2013	4,900		20	245	245	1,225	33
34	TOTAL (lines 1 thru 33)		$ 1,388,606	$		$ 71,558	$ 71,558	$ 555,813	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: 01/01/17 Ending: 12/31/17

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	$	$ 555,813	1
2	Installed New Blast Roof Top Furnace	2013	31,780		20	1,589	1,589	7,945	2
3	Installed Nurse Station and Replaced Two Doors on Second Floor	2013	9,832		20	492	492	2,459	3
4	Drop Ceiling Supplies for Second Floor Remodeling	2013	4,151		20	208	208	1,039	4
5	Remodeled Second Floor, Installed New Ceiling Tiles, Lights, Wall Pa	2013	23,750		20	1,188	1,188	5,939	5
6	Purchased Vinyl Wallcovering for Corridor and Dining Room and Flo	2013	21,037		20	1,052	1,052	5,260	6
7	Installed Window Treatements and Braille Signage on Second Floor	2013	4,992		20	250	250	1,249	7
8	Installed Handrails on Second Floor	2013	3,550		20	178	178	889	8
9	Installation on Vinyl Flooring on Second Floor	2013	7,333		20	367	367	1,834	9
10	Installed 3 Toilet Bowls and Tanks, 3 Faucets, and 12 Shower Rods or	2013	2,538		20	127	127	635	10
11	4th Floor Corridor Wall Guards and Corner Guards	2015	14,391		20	720	720	2,160	11
12	3rd and 4th Floor Dining Room Window Treatments	2015	4,358		20	218	218	654	12
13	Installed 4th Floor Nurses Station	2015	10,972		20	549	549	1,647	13
14	Windows/Radiator Covers/Parking Lot/Guardrails/Tuckpointing/Light	2016	296,150		20	14,808	14,808	29,616	14
15	Wall Protection System in Corridor	2016	14,391		20	720	720	1,440	15
16	Window Treatments	2016	4,358		20	218	218	436	16
17	4th Floor Nurses Station	2016	10,972		20	549	549	1,098	17
18	Elevator Rehab	2017	13,643		20	682	682	682	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)		$ 1,866,804	$		$ 95,473	$ 23,915	$ 620,795	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: 01/01/17 Ending: 12/31/17

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 Healthcare Consulting	1993	87,333	2,239	20	2,496	257	60,716	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 87,333	$ 2,239		$ 2,496	$ 257	$ 60,716	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: 01/01/17 Ending: 12/31/17

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		$ 87,333	$ 2,239		$ 2,496	$ 257	$ 60,716	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)		$ 87,333	$ 2,239		$ 2,496	$ 257	$ 60,716	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: 01/01/17 Ending: 12/31/17

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	$ 327,177	$ 776	$ 28,591	$ 27,815	10	$ 248,180	71
72	Current Year Purchases	38,412		3,176	3,176	10	3,176	72
73	Fully Depreciated Assets	1,137,953		63	63	10	1,137,760	73
74								74
75	TOTALS	$ 1,503,542	$ 776	$ 31,830	$ 31,054		$ 1,389,116	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2005 FORD E350 BUS	2005	$ 51,639	$	$	$	5	$ 51,639	76
77		Allocated from Dynamic Healthcare		58,282	2,983	2,451	(532)	5	46,401	77
78										78
79										79
80	TOTALS			$ 109,921	$ 2,983	$ 2,451	$ (532)		$ 98,040	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)	$ 13,104,068	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 503,685	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 397,418	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (106,267)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,674,584	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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							5
6								6
7	TOTAL				$ **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 32,921 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility		$	$ 8,006	17
18	Allocated Dynamic HC Consultants			25,790	18
19					19
20					20
21	TOTAL		$	$ 33,796	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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	$ 416,133		$	$		$ 416,133	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	255,845					255,845	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	376,748					376,748	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				258,973		258,973	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					30,041	36,161		66,202	13
14	TOTAL			$ 1,048,726		$ 30,041	$ 295,134		$ 1,373,901	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:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 821,846	$ 923,616	1
2	Cash-Patient Deposits	130,745	130,745	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,037,671	3,037,671	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	209,585	250,203	6
7	Other Prepaid Expenses	43,933	43,933	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	17,258	566,235	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,261,038	$ 4,952,403	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	2,022,633	3,915,508	15
16	Equipment, at Historical Cost	1,651,456	1,833,748	16
17	Accumulated Depreciation (book methods)	(2,444,207)	(5,971,943)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	3,865,125	4,431,549	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,095,007	$ 11,735,622	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,356,045	$ 16,688,025	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 420,503	$ 420,503	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	130,745	130,745	28
29	Short-Term Notes Payable	1,980,640	2,297,326	29
30	Accrued Salaries Payable	491,804	491,804	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,316	28,316	31
32	Accrued Real Estate Taxes(Sch.IX-B)		364,000	32
33	Accrued Interest Payable	4,704	32,744	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	132,680	146,323	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,189,392	$ 3,911,761	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,777,304	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		480,145	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,257,449	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,189,392	$ 13,169,210	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,166,653	$ 3,518,815	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,356,045	$ 16,688,025	48

***(See instructions.)**

Facility Name & ID Number Woodbridge Nursing Pavilion **#** 0034157 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,432,735	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,432,735	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,533,118	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(799,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,733,918	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)**	$ 6,166,653	24 *

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

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 16,355,202	1
2	Discounts and Allowances for all Levels	(815,753)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,539,449	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	989,450	6
7	Oxygen	10	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 989,460	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	6,579	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	27,053	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 33,632	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	189,214	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 189,214	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	304,732	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 304,732	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,056,487	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,894,661	31
32	Health Care	4,765,969	32
33	General Administration	4,290,550	33
	B. Capital Expense		
34	Ownership	1,678,538	34
	C. Ancillary Expense		
35	Special Cost Centers	1,373,901	35
36	Provider Participation Fee	519,750	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,523,369	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,533,118	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,533,118	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,863,566	44
45	Private Pay - Net Inpatient Revenue	142,130	45
46	Medicare - Net Inpatient Revenue	3,808,857	46
47	Other-(specify) Medicare Replacement	143,043	47
48	Other-(specify) Private Insurance/Hospice/Ancillary Contractual	581,853	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,539,449	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: 01/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,616	1,973	$ 91,291	$ 46.27	1
2	Assistant Director of Nursing	1,984	2,112	85,001	40.25	2
3	Registered Nurses	20,509	21,578	700,486	32.46	3
4	Licensed Practical Nurses	50,331	53,146	1,436,192	27.02	4
5	CNAs & Orderlies	103,387	110,126	1,399,305	12.71	5
6	CNA Trainees					6
7	Licensed Therapist	22,746	24,746	1,048,726	42.38	7
8	Rehab/Therapy Aides	8,226	8,929	132,175	14.80	8
9	Activity Director	2,025	2,281	34,265	15.02	9
10	Activity Assistants	12,094	12,743	142,429	11.18	10
11	Social Service Workers	9,459	9,922	228,287	23.01	11
12	Dietician					12
13	Food Service Supervisor	2,400	2,632	66,415	25.23	13
14	Head Cook	4,948	5,244	73,662	14.05	14
15	Cook Helpers/Assistants	20,658	22,795	263,984	11.58	15
16	Dishwashers					16
17	Maintenance Workers	7,777	8,353	122,463	14.66	17
18	Housekeepers	21,044	22,972	268,718	11.70	18
19	Laundry	12,525	13,635	155,305	11.39	19
20	Administrator	1,944	2,080	131,403	63.17	20
21	Assistant Administrator	404	439	38,494	87.69	21
22	Other Administrative					22
23	Office Manager	421	455	12,784	28.10	23
24	Clerical	11,659	12,401	167,801	13.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,070	4,453	65,757	14.77	31
32	Other Health Care(specify)					32
33	Other(specify)	7,886	8,128	100,696	12.39	33
34	TOTAL (lines 1 - 33)	328,113	351,143	$ 6,765,639 *	$ 19.27	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	382	$ 17,956	01-03	35
36	Medical Director	Monthly	36,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Per Bed	16,621	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	50	2,516	11-03	44
45	Social Service Consultant	48	2,976	12-03	45
46	Other(specify)				46
47	Special Care Consultant	240	12,000	10-03	47
48	MDS Consultant	Monthly	46,862	10-03	48
49	TOTAL (lines 35 - 48)	720	$ 134,931		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	29	728	10-03	52
53	TOTAL (lines 50 - 52)	29	$ 728		53

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Correa	Administrator	0	$ 131,403
Shimon Goldstein	Assnt Admin.	0	38,494
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,897

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
See Attached	Legal	$ 109,749
Paycor	Payroll Services	38,396
PointClickCare	Clinical Software	77,771
IIT/SourceTech	IT Services	1,715
Dynamic Healthcare	Data Processing	4,730
Health Data Systems	Data Processing	3,598
Optima Healthcare	Data Processing	4,578
National Datacare	Data Processing	4,077
Ability	Eligibility Software	8,181
Cerner	Medical Records Software	9,629
Dynamic HC Consultants	Bookkeeping Services	978,145
See Supplemental Schedule		75,672
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,316,241

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 144,401
Unemployment Compensation Insurance	81,140
FICA Taxes	511,611
Employee Health Insurance	286,217
Employee Meals	79,205
Illinois Municipal Retirement Fund (IMRF)*	
Dental	4,706
Employee Benefits Other	37,573
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,144,853

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,310
Health Care Worker Background Check	
(Indicate # of checks performed 481)	5,237
Patient Background Checks	
Dues and Subscriptions	17,052
Licenses and Fees	9,632
Allocated Dynamic Healthcare	7,691
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,922

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,698
Allocated from Dynamic Healthcare	715
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,413

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Woodbridge Nursing Pavilion # 0034157 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 $31,924**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,741** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **519,750**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **79,205** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

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