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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: KATHLEEN MCNAMARA **Telephone Number:** (847) 675-3585
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 01/01/2018 to 12/31/2018 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) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) KATHLEEN MCNAMARA, VICE-PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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: 01/01/2018 Ending: 12/31/2018

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 _____

	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	63,389	220	8,592	72,201	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,389	220	8,592	72,201	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.10%

D. How many bed reserve days during this year were paid by the Department?
0 (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/ 01 /1988

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 8/01/1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 222 and days of care provided 8,008

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	437,064	43,376	18,717	499,157		499,157		499,157			1
2	Food Purchase		388,546		388,546	(21,590)	366,956	(823)	366,133			2
3	Housekeeping	297,247	62,563		359,810		359,810		359,810			3
4	Laundry	178,596	18,488	7,464	204,548		204,548		204,548			4
5	Heat and Other Utilities			215,315	215,315		215,315	2,517	217,832			5
6	Maintenance	123,137	86,651	28,934	238,722		238,722	73,286	312,008			6
7	Other (specify):*			24,986	24,986		24,986	1,712	26,698			7
8	TOTAL General Services	1,036,044	599,624	295,416	1,931,084	(21,590)	1,909,494	76,692	1,986,186			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	4,197,929	216,509	114,950	4,529,388		4,529,388		4,529,388			10
10a	Therapy	147,903	2,186		150,089		150,089		150,089			10a
11	Activities	187,009	19,156	2,288	208,453		208,453		208,453			11
12	Social Services	181,211		1,120	182,331		182,331		182,331			12
13	CNA Training											13
14	Program Transportation			344	344		344		344			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,714,052	237,851	154,702	5,106,605		5,106,605		5,106,605			16
	C. General Administration											
17	Administrative	130,692		28,217	158,909		158,909	385,560	544,469			17
18	Directors Fees											18
19	Professional Services			296,559	296,559		296,559	3,896	300,455			19
20	Dues, Fees, Subscriptions & Promotions			111,177	111,177		111,177	(70,907)	40,270			20
21	Clerical & General Office Expenses	254,375	26,414	1,128,380	1,409,169		1,409,169	(870,734)	538,435			21
22	Employee Benefits & Payroll Taxes			1,138,867	1,138,867	21,590	1,160,457		1,160,457			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,926	7,926		7,926	1,170	9,096			24
25	Other Admin. Staff Transportation			21,493	21,493		21,493	12,251	33,744			25
26	Insurance-Prop.Liab.Malpractice			369,143	369,143		369,143	23,863	393,006			26
27	Other (specify):*			322,657	322,657		322,657	(185,281)	137,376			27
28	TOTAL General Administration	385,067	26,414	3,424,419	3,835,900	21,590	3,857,490	(700,182)	3,157,308			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,135,163	863,889	3,874,537	10,873,589		10,873,589	(623,490)	10,250,099			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#: WOODBRIDGE NURSING PAVILION **#0034157** **Report Period Beginning: 01/01/2018** **Ending: 12/31/2018**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	18,717	
	REPAIRS & MAINTENANCE			
				18,717
3	**HOUSEKEEPING**			
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		7,464	
				7,464
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		66,117	
	ELECTRICITY		67,982	
	WATER		76,926	
	CABLE TV - LOBBY		4,290	
				215,315
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,850	
	PAINTING & DECORATING		666	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,308	
	ELEVATOR MAINTENANCE & REPAIR		5,630	
	OUTSIDE LABOR			
	EXTERMINATING SERVICE		4,480	
	FIRE SERVICE			
				28,934
7	**OTHER**			
	SCAVENGER		24,986	
	SECURITY SERVICE			
				24,986
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	36,000	36,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE			
	PURCHASED SERVICES			
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2		
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2		
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	69,156	
	PHARMACY CONSULTANT	XVIII B 39-2	24,635	
	UTILIZATION REVIEW FEES	XVIII B __-2		
	PHYSICIANS	XVIII B __-2		
	PSYCHIATRIC	XVIII B __-2		
	RN CONSULTANT	XVIII B 38-2	21,159	
				114,950
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2		
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2		
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2		
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2		
	SPEECH THERAPY CONSULTANT	XVIII B 43-2		
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,288	
				2,288
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2		
	SOCIAL WORKER	XVIII B 45-2	1,120	
				1,120
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number WOODBRIDGE NURSING PAVILION **#0034157** **Report Period Beginning: 01/01/2018** **Ending: 12/31/2018**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		344	
				344
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	28,217	28,217
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	137,782	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	158,777	
				296,559
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	55,797	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	753	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	19,800	
	LICENSES & PERMITS	XIX F	9,990	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F		
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	19,838	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	2,889	
	PATIENT BACKGROUND CHECKS	XIX F	2,110	
				111,177
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,927	
	EQUIPMENT REPAIR & MAINTENANCE		30,019	
	OUTSIDE CLERICAL SERVICES		1,070,412	
	PENALTIES / OVERDRAFT CHARGES	VI 18	274	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE		23,748	
	MESSENGER SERVICE			
				1,128,380

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	543,194	
	UNEMPLOYMENT COMPENSATION	XIX D	54,873	
	WORKERS COMPENSATION INSURANC	XIX D	193,078	
	HOSPITALIZATION INSURANCE	XIX D	304,752	
	EMPLOYEE BENEFITS - OTHER	XIX D	42,970	
	EMPLOYEE PHYSICAL EXAMS	XIX D		
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D		
				1,138,867
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS			
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	7,926	
	TRAVEL	XIX G		
				7,926
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		21,493	
				21,493
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		369,143	
				369,143
27	**OTHER**			
	BAD DEBTS	VI 24	322,657	
				322,657

GRAND TOTAL COLUMN 3 OTHER **3,874,537**

WOODBRIDGE NURSING PAVILION
SCHEDULES
12/31/2018

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	388,546
LESS SALES TAX	(823)
NET FOOD	387,723
TOTAL PATIENT CENSUS	72,201
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	216,603
ADD # EMPLOYEE MEALS/DAY	35
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	12,775
PATIENT MEALS	216,603
ADD EMPLOYEE MEALS	12,775
TOTAL MEALS/YEAR	229,378
NET FOOD	387,723
DIVIDE TOTAL MEALS/YEAR	229,378
COST PER MEAL	1.69
TIMES EMPLOYEE MEALS	12,775
EMPLOYEE MEAL RECLASSIFIC	**21,590**

Facility Name & ID Number WOODBRIDGE NURSING PAVILION #0034157 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			124,681	124,681		124,681	279,395	404,076			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			92,655	92,655		92,655	70,234	162,889			32
33	Real Estate Taxes							413,410	413,410			33
34	Rent-Facility & Grounds			1,618,620	1,618,620		1,618,620	(1,618,620)				34
35	Rent-Equipment & Vehicles			62,228	62,228		62,228	23,437	85,665			35
36	Other (specify):* MIP ins							44,613	44,613			36
37	**TOTAL Ownership**			1,898,184	1,898,184		1,898,184	(787,531)	1,110,653			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,072,031		306,845	1,378,876		1,378,876		1,378,876			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			510,594	510,594		510,594		510,594			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	1,072,031		817,439	1,889,470		1,889,470		1,889,470			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,207,194	863,889	6,590,160	14,661,243		14,661,243	(1,411,021)	13,250,222			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: 01/01/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(84,357)	30		9
10	Interest and Other Investment Income	(275,203)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(823)	2		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	(274)	21		18
19	Entertainment				19
20	Contributions	(19,838)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,907)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(322,657)	27		24
25	Fund Raising, Advertising and Promotional	(55,797)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule 5A	(18,785)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (781,641)		$	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)	(629,380)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (629,380)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,411,021)		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: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (3,927)	21	1
2				2
3	Bldg Co-Professional Fees	(14,783)	19	3
4	Bldg Co-Franchise Fees	(75)	20	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				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**	(18,785)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(823)	0	0	0	0	0	0	0	0	0	0	(823)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,517	0	0	0	0	0	0	0	0	2,517	5
6	Maintenance	0	42,011	14,075	17,200	0	0	0	0	0	0	0	73,286	6
7	Other (specify):*	0	0	1,712	0	0	0	0	0	0	0	0	1,712	7
8	**TOTAL General Services**	(823)	42,011	18,304	17,200	0	0	0	0	0	0	0	76,692	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	385,560	0	0	0	0	0	0	0	385,560	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,690)	14,783	7,803	0	0	0	0	0	0	0	0	3,896	19
20	Fees, Subscriptions & Promotions	(75,710)	75	4,728	0	0	0	0	0	0	0	0	(70,907)	20
21	Clerical & General Office Expenses	(4,201)	0	(885,349)	18,816	0	0	0	0	0	0	0	(870,734)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,170	0	0	0	0	0	0	0	0	1,170	24
25	Other Admin. Staff Transportation	0	0	12,251	0	0	0	0	0	0	0	0	12,251	25
26	Insurance-Prop.Liab.Malpractice	0	13,058	10,805	0	0	0	0	0	0	0	0	23,863	26
27	Other (specify):*	(322,657)	0	137,376	0	0	0	0	0	0	0	0	(185,281)	27
28	**TOTAL General Administration**	(421,258)	27,916	(711,216)	404,376	0	0	0	0	0	0	0	(700,182)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(422,081)	69,927	(692,912)	421,576	0	0	0	0	0	0	0	(623,490)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(84,357)	358,524	5,228	0	0	0	0	0	0	0	0	279,395	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(275,203)	340,759	4,678	0	0	0	0	0	0	0	0	70,234	32
33	Real Estate Taxes	0	403,329	10,081	0	0	0	0	0	0	0	0	413,410	33
34	Rent-Facility & Grounds	0	(1,618,620)	0	0	0	0	0	0	0	0	0	(1,618,620)	34
35	Rent-Equipment & Vehicles	0	0	23,437	0	0	0	0	0	0	0	0	23,437	35
36	Other (specify):*	0	44,613	0	0	0	0	0	0	0	0	0	44,613	36
37	TOTAL Ownership	(359,560)	(471,395)	43,424	0	0	0	0	0	0	0	0	(787,531)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(781,641)	(401,468)	(649,488)	421,576	0	0	0	0	0	0	0	(1,411,021)	45

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 SUPP		SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		

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	$ 1,618,620	Woodbridge Building LLC	100.00%	$	$ (1,618,620)	1
2	V	32	Interest	513	Woodbridge Building LLC	100.00%		(513)	2
3	V	19	Professional Fees		Woodbridge Building LLC	100.00%	14,783	14,783	3
4	V	30	Depreciation		Woodbridge Building LLC	100.00%	358,524	358,524	4
5	V	32	Amortization of Mortgage Costs		Woodbridge Building LLC	100.00%	11,106	11,106	5
6	V	33	Real Estate Tax		Woodbridge Building LLC	100.00%	403,329	403,329	6
7	V	20	Franchise Tax		Woodbridge Building LLC	100.00%	75	75	7
8	V	32	Interest Expense-Heartland		Woodbridge Building LLC	100.00%	330,166	330,166	8
9	V	36	Mortgage Insurance		Woodbridge Building LLC	100.00%	44,613	44,613	9
10	V	26	Insurance		Woodbridge Building LLC	100.00%	13,058	13,058	10
11	V	6	Repairs & Maintenance		Woodbridge Building LLC		42,011	42,011	11
12	V								12
13	V								13
14	Total			$ 1,619,133			$ 1,217,665	$ * (401,468)	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: 01/01/2018 Ending: 12/31/2018

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	21	HOME OFFICE	$ 1,070,412	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$ (1,070,412)	15
16	V	5	UTILITIES		DYNAMIC HEALTHCARE CONSULTANTS		2,517	2,517	16
17	V	6	REPAIR & MAINT. - SALARIES		DYNAMIC HEALTHCARE CONSULTANTS		2,993	2,993	17
18	V	6	REPAIR & MAINT.-OTHER EXPENSE		DYNAMIC HEALTHCARE CONSULTANTS		11,082	11,082	18
19	V	7	EMP BEN-GEN SERV		DYNAMIC HEALTHCARE CONSULTANTS		1,712	1,712	19
20	V	19	PROFESSIONAL FEES		DYNAMIC HEALTHCARE CONSULTANTS		7,803	7,803	20
21	V	20	DUES AND SUBSCRIPTION		DYNAMIC HEALTHCARE CONSULTANTS		4,728	4,728	21
22	V	21	CLERICAL & GENERAL - SALARIES		DYNAMIC HEALTHCARE CONSULTANTS		137,040	137,040	22
23	V	21	CLERICAL & GENERAL-OTHER EXPENSE		DYNAMIC HEALTHCARE CONSULTANTS		48,023	48,023	23
24	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTHCARE CONSULTANTS		1,170	1,170	24
25	V	25	AUTO EXPENSE		DYNAMIC HEALTHCARE CONSULTANTS		12,251	12,251	25
26	V	26	INSURANCE		DYNAMIC HEALTHCARE CONSULTANTS		10,805	10,805	26
27	V	27	EMP. BEN. - GEN, ADMIN.		DYNAMIC HEALTHCARE CONSULTANTS		137,376	137,376	27
28	V	30	DEPRECIATION		DYNAMIC HEALTHCARE CONSULTANTS		5,228	5,228	28
29	V	32	INTEREST		DYNAMIC HEALTHCARE CONSULTANTS		4,678	4,678	29
30	V	33	REAL ESTATE TAXES		DYNAMIC HEALTHCARE CONSULTANTS		10,081	10,081	30
31	V	35	AUTO RENTAL		DYNAMIC HEALTHCARE CONSULTANTS		22,035	22,035	31
32	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTHCARE CONSULTANTS		1,402	1,402	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,070,412			$ 420,924	$ * (649,488)	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: 01/01/2018 Ending: 12/31/2018

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 COMP - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 17,200	$ 17,200	15
16	V	17	ADMIN COMP - M MAUER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	43,200	43,200	16
17	V	17	ADMIN COMP - M AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	56,350	56,350	17
18	V	17	ADMIN COMP - F AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			18
19	V	17	ADMIN COMP - D AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	20,896	20,896	19
20	V	17	ADMIN COMP - S GOLDSTEIN		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	99,951	99,951	20
21	V	17	ADMIN COMP - R AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			21
22	V	17	ADMIN COMP - S HARAMARAS		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	33,930	33,930	22
23	V	17	ADMIN COMP - D KUFTA		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	44,100	44,100	23
24	V	17	ADMIN COMP - HOWARD ALTER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			24
25	V	17	ADMIN COMP - NON OWNER - V DAVIS		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	30,841	30,841	25
26	V	17	ADMIN COMP - VAR NON OWNER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	10,273	10,273	26
27	V	17	ADMIN COMP - CFO NON OWNER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	50,429	50,429	27
28	V	17	ADMIN COMP - CONTROLLER-NON OWNER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	23,807	23,807	28
29	V	21	CLERICAL COMP - S AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	18,816	18,816	29
30	V	17	DYNAMIC HEALTHCARE CONST	28,217				(28,217)	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			$ 28,217			$ 449,793	$ * 421,576	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: 01/01/2018 Ending: 12/31/2018

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 Aaron	24.87%	Grosse Pointe Manor	Niles	Woodbridge Building (	Chicago	Building Company	1
2	Abraham Stern	17.15%	Bridgeview Health Care Center	Bridgeview	Dynamic Healthcare	Skokie	Bookkeeping/Consu	2
3	Fred Aaron	22.70%	Ottawa Pavillion Ltd	Ottawa	Seasons Hospice	Park Ridge	Hospice	3
4	Marshall Mauer	6.76%	Park Ridge Care Center Ltd	Park Ridge	Integra Healthcare	Elmhurst	Medical Supplies	4
5	Miriam Latinik	4.51%	Sterling Pavilion Ltd	Sterling	Lifeline Ambulance	Chicago	Ambulance	5
6	Joseph Mauer	4.51%	Waterfront Terrace Inc	Chicago				6
7	Sharon 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 and Howie Alter	1.17%	Woodbridge Supportive Living Residence of Ga	Galesberg				10
11	Sylvia Aaron	0.23%	Woodbridge Supportive Living Residence of Ga	Galesberg				11
12	Sue Koplin	0.59%	The Loft Rehabilitation & Nursing	Eureka				12
13	Susan Stern	4.51%	The Loft Rehabilitation & Nursing of Canton	Canton				13
14	Frances Mauer	6.76%	The Loft Rehabilitation & Nursing of Normal	Normal				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: 01/01/2018 Ending: 12/31/2018

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	MAURICE AARON	OWNER	ADMINISTRATIVE		SEE ATTACHED			SALARY	$ 56,350	17-07	1
2	DANIEL AARON	RELATIVE	ADMINISTRATIVE		SEE ATTACHED			SALARY	20,896	17-07	2
3	MARSHALL MAUER	OWNER	ADMINISTRATIVE		SEE ATTACHED			SALARY	43,200	17-07	3
4	SHARON AARON	OWNER	CLERICAL		SEE ATTACHED			SALARY	18,816	21-07	4
5	SHIMON GOLDSTEIN	RELATIVE	CLERICAL		SEE ATTACHED			SALARY	20,000	21-01	5
6	DENNIS NEHMER	OWNER	MAINTENANCE		SEE ATTACHED			SALARY	17,200	06-07	6
7	DIANA KUFTA	OWNER	ADMINISTRATIVE		SEE ATTACHED			SALARY	44,100	17-07	7
8	SUE KOPLIN-HARAMARAS	OWNER	ADMINISTRATIVE		SEE ATTACHED			SALARY	33,930	17-07	8
9	SHIMON GOLDSTEIN	RELATIVE	ADMINISTRATIVE		SEE ATTACHED			SALARY	59,971	17-07	9
10											10
11											11
12											12
13								TOTAL	$ 314,463		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: 01/01/2018 Ending: 2/31/2018

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: 01/01/2018 Ending: 2/31/2018

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 CONSULTANTS
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	302,492	10	$ 10,544	$	72,201	$ 2,517	1
2	6	REPAIR & MAINT. - SALARIES	PATIENT DAYS	302,492	10	12,541	12,541	72,201	2,993	2
3	6	REPAIR & MAINT.-OTHER EXPE	PATIENT DAYS	302,492	10	46,430		72,201	11,082	3
4	7	EMP BEN-GEN SERV	PATIENT DAYS	302,492	10	7,174		72,201	1,712	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	302,492	10	32,693		72,201	7,803	5
6	20	DUES AND SUBSCRIPTION	PATIENT DAYS	302,492	10	19,807		72,201	4,728	6
7	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	302,492	10	574,139	574,139	72,201	137,040	7
8	21	CLERICAL & GENERAL-OTHER I	PATIENT DAYS	302,492	10	201,196		72,201	48,023	8
9	24	SEMINARS AND TRAVEL	PATIENT DAYS	302,492	10	4,903		72,201	1,170	9
10	25	AUTO EXPENSE	PATIENT DAYS	302,492	10	51,327		72,201	12,251	10
11	26	INSURANCE	PATIENT DAYS	302,492	10	45,267		72,201	10,805	11
12	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	302,492	10	575,549		72,201	137,376	12
13	30	DEPRECIATION	PATIENT DAYS	302,492	10	21,903		72,201	5,228	13
14	32	INTEREST	PATIENT DAYS	302,492	10	19,599		72,201	4,678	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	302,492	10	42,234		72,201	10,081	15
16	35	AUTO RENTAL	PATIENT DAYS	302,492	10	92,319		72,201	22,035	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	302,492	10	5,875		72,201	1,402	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,763,500	$ 586,680		$ 420,924	25

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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 CONSULTANTS
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 COMP - D NEHMER	WGHTD AVG HOURS	40	7	$ 60,778	$ 60,778	11	$ 17,200	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	200,000	200,000	9	43,200	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	7	200,000	200,000	11	56,350	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	2,500	2,500			4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	30	10	76,541	76,541	8	20,896	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	159,922	159,922	25	99,951	6
7	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	30	5	26,000	26,000			7
8	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	3	69,011	69,011	15	33,930	8
9	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	7	156,522	156,522	11	44,100	9
10	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			10
11	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	9	132,083	132,083	9	30,841	11
12	17	ADMIN COMP - VAR NON OWNEI	WGHTD AVG HOURS	45	7	36,458	36,458	13	10,273	12
13	17	ADMIN COMP - CFO NON OWNEI	WGHTD AVG HOURS	40	9	215,972	215,972	9	50,429	13
14	17	ADMIN COMP - CONTROLLER-N	WGHTD AVG HOURS	40	9	101,958	101,958	9	23,807	14
15	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	80,583	80,583	9	18,816	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,530,328	$ 1,530,328		$ 449,793	25

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank		x	Mortgage			$	$ 8,777,304			$ 330,166	1
2												2
3												3
4	Loan Costs	X		Loan Costs	W/O OVER LOAN		299,868	208,242			11,106	4
5												5
	Working Capital											
6	Mb Financial		x	Line of Credit							92,655	6
7												7
8												8
9	TOTAL Facility Related						$ 299,868	$ 8,985,546			$ 433,927	9
	B. Non-Facility Related*											
10	Interest Income		x								(275,203)	10
11	Allocated from Dynamic HC	x									4,678	11
12	Interest Income Bldg Co	x									(513)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (271,038)	14
15	TOTALS (line 9+line14)						$ 299,868	$ 8,985,546			$ 162,889	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 44,613 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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	364,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	393,746	2
3. Under or (over) accrual (line 2 minus line 1).	$	29,746	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	383,664	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.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	413,410	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	283,593	8
	2014	289,306	9
	2015	326,590	10
	2016	356,958	11
	2017	383,664	12

2018 REAL ESTATE TAX ACCRUAL IS BASED ON 100% OF THE 2017 REAL ESTATE TAX BILL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOODBRIDGE NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 116,001.98	$ 116,001.98
2.	13-35-217-016-0000	Long Term Care Property	$ 151,660.38	$ 151,660.38
3.	13-35-217-017-0000	Long Term Care Property	$ 116,001.98	$ 116,001.98
4.	10-23-404-059-0000	Home Office	$ 42,234.00	$ 10,081.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 425,898.34	$ 393,745.34

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/2018 Ending: 12/31/2018

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. [ ] (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] 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: 01/01/2018 Ending: 12/31/2018

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	$ 358,524	35	$ 193,622	$ (164,902)	$ 2,535,495	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			20,717	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	3	3	6,790	16
17	Various			1998	50,252		20	970	970	50,252	17
18	Various			1999	68,242		20	3,412	3,412	66,645	18
19	Various			2000	57,506		20	2,875	2,875	54,006	19
20	Various			2001	62,933		20	3,147	3,147	55,141	20
21	Various			2002	83,062		20	2,058	2,058	36,318	21
22	Various			2003	16,347		20	70	70	16,029	22
23	Various			2004	116,859		20			116,859	23
24	Various			2005	112,439		20	2,046	2,046	102,113	24
25	Various			2006	70,102		20			70,102	25
26	Various			2007	205,027		20	10,036	10,036	129,831	26
27	Various			2008	99,839		20	8,605	8,605	102,353	27
28	Various			2009	563,904		20	15,734	15,734	146,258	28
29	Various			2010	5,192		20	260	260	2,337	29
30	Various			2011	15,685		20	402	402	3,015	30
31	Various			2012	27,813		20	1,974	1,974	12,820	31
32	Various			2013	29,666		20	3,000	3,000	17,199	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: 01/01/2018 Ending: 12/31/2018

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
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50									50
51									51
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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									67
68									68
69	Financial Statement Depreciation			124,681			(124,681)		69
70	TOTAL (lines 4 thru 69)		$ 8,569,087	$ 483,205		$ 248,214	$ (234,991)	$ 3,724,218	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: 01/01/2018 Ending: 12/31/2018

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		$ 8,569,087	$ 483,205		$ 248,214	$ (234,991)	$ 3,724,218	1
2	Installed 2 new 60 series pump pipes	2014	4,324		20	216	216	927	2
3	Remote annunciator for fire pump; Tie kitchen to fire	2014	5,255		20	263	263	1,248	3
4	3rd floor - lights, walls, doors, nurses station	2014	6,152		20	308	308	1,256	4
5	Water pump	2015	3,617		20	181	181	693	5
6	Water valve work in therapy room	2015	7,100		20	355	355	1,272	6
7	Installed hose, restricted feeder & water feed pump for chiller	2015	2,722		20	136	136	499	7
8	Installed 3 security cameras & monitor	2015	2,910		20	146	146	473	8
9	3rd floor - lights, walls, doors, nurses station	2015	55,427		20	2,771	2,771	10,161	9
10	Lobby - flooring, replace door, wallcovering, ceiling panels	2015	10,681		20	534	534	1,914	10
11	Resident room & evacuation Interior Signage	2016	2,849		20	570	570	1,710	11
12	4th floor nurse call system	2016	3,575		20	715	715	2,026	12
13	4th floor - vinyl tile flooring 2232 sq ft	2016	26,099		20	5,220	5,220	14,790	13
14	Installed new pump & relay for air handler	2016	3,100		20	89	89	244	14
15	Install new fittings & sections to leaking 2" copper pipe in kit	2016	2,875		20	82	82	219	15
16	Install new 2" ball valve &7 ft new piping/fittings	2016	2,850		20	81	81	210	16
17	Install new section of 4" cast iron pipe with new couplings	2016	3,200		20	91	91	213	17
18	Install 2x di-electric unions/pipings/ball valves	2016	2,850		20	81	81	217	18
19	Wireless Equipment	2016	9,354		20	1,871	1,871	4,054	19
20	Firewall, switches, wireless network/cabinet	2016	3,677		20	105	105	228	20
21	Signage - 2nd floor corridor	2017	2,893		20	76	76	152	21
22	Protection system - 2nd floor corridor	2017	6,213		20	163	163	326	22
23	Water pressure restoration	2017	6,350		20	151	151	302	23
24	Installed new lighting sinks, faucets - room 101	2017	13,850		20	297	297	594	24
25	Wall - ac unit	2017	2,950		20	344	344	688	25
26	Plumbing parts - bathroom	2017	2,841		20	47	47	94	26
27	Installed new pumps - boiler room	2017	6,400		20	107	107	214	27
28	Installed new call light system - 2nd floor	2017	7,166		20	102	102	204	28
29	Installed new piping - kithcen sewer	2017	3,800		20	45	45	90	29
30	Installed mirrors - therapy room	2017	2,860		20	27	27	54	30
31	Boiler upgrade	2017	3,443		20	16	16	32	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,786,470	$ 483,205		$ 263,404	$ (219,801)	$ 3,769,322	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: 01/01/2018 Ending: 12/31/2018

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		$ 8,786,470	$ 483,205		$ 263,404	$ (219,801)	$ 3,769,322	1
2	Building Company								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	55,653	9
10	Various	2010	734,652		20	38,859	38,859	360,241	10
11	Various	2011	288,244		20	14,412	14,412	115,297	11
12	Power for ejector and circulating pumps	2012	3,950		20	198	198	1,384	12
13	Water coil for roof	2012	4,301		20	215	215	1,505	13
14	Fire dampners and insulation	2012	3,142		20	157	157	1,100	14
15	Sprinkler system, sprinkler head piping	2012	2,850		20	143	143	999	15
16	Boiler pump, new boiler	2012	5,698		20	285	285	1,995	16
17	Fire alarm door release	2012	3,837		20	192	192	1,343	17
18	Doors for resident rooms and floors and lobby	2012	3,560		20	178	178	1,246	18
19	Ceramic tiling in basement bathrooms	2012	6,767		20	338	338	2,368	19
20	Ceramic tiling in 1st floor bathroom/shower roomo	2012	6,917		20	346	346	2,421	20
21	Shower tub & base installation, valve & wiring	2012	14,821		20	741	741	5,187	21
22	Lighitng for 1st floor resident rooms	2012	11,470		20	574	574	3,996	22
23	Service sink installation	2012	2,513		20	126	126	880	23
24	Condenser Installation	2012	4,675		20	234	234	1,637	24
25	Electrical work for air handler, laundry room, resident rooms	2012	11,666		20	583	583	4,083	25
26	Install condensate pump	2012	3,165		20	158	158	1,107	26
27	Doors for resident rooms and floors and lobby	2012	4,956		20	248	248	1,735	27
28	Camera & pacing system, monitors, lights, alarms	2012	7,875		20	394	394	2,757	28
29	Exit signs, camera outlets, automatic door control	2012	7,410		20	371	371	2,595	29
30	Heat curtin installation	2012	3,365		20	168	168	1,177	30
31	Installed new pipping in the 4th floor ceiling for hot and cold	2012	2,500		20	125	125	875	31
32	All floors shower tub rooms - flooring, wallcovering, lighting	2013	154,632		20	7,732	7,732	54,122	32
33	Installed new ejector pumps in basement	2013	4,900		20	245	245	1,470	33
34	TOTAL (lines 1 thru 33)		$ 10,175,076	$ 483,205		$ 334,964	$ (148,241)	$ 4,396,495	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: 01/01/2018 Ending: 12/31/2018

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		$ 10,175,076	$ 483,205		$ 334,964	$ (148,241)	$ 4,396,495	1
2	Installed new blast rooftop furnace	2013	31,780		20	1,589	1,589	9,534	2
3	Installed nurse station and replaced two doors on 2nd floor	2013	9,832		20	492	492	2,951	3
4	Drop ceiling supplies for 2nd floor remodeling	2013	4,151		20	208	208	1,247	4
5	Remodeled 2nd floor, installed new ceiling tiles, lights, wallpaper	2013	23,750		20	1,188	1,188	7,127	5
6	Purhcased vinyl wallcovering for corridor and dining room	2013	21,037		20	1,052	1,052	6,312	6
7	Installed window treatements and braille signage on 2nd floor	2013	4,992		20	250	250	1,499	7
8	Installed handrails on 2nd floor	2013	3,550		20	178	178	1,067	8
9	Installation on vinyl flooring on 2nd floor	2013	7,333		20	367	367	2,201	9
10	Installed 3 toilet bowls and tanks, 3 faucets and 12 shower rods	2013	2,538		20	127	127	762	10
11	4th floor corridor wall guards and corner guards	2015	14,391		20	720	720	2,880	11
12	3rd and 4th floor dining romm and window treatements	2015	4,358		20	218	218	872	12
13	Installed 4th floor nurses station	2015	10,972		20	549	549	2,196	13
14	Windows/radiator covers/parking lot/guardrails/tuckpointing/ligh	2016	296,150		20	14,808	14,808	44,424	14
15	Wall protection system in corridor	2016	14,391		20	720	720	2,160	15
16	Window treatements	2016	4,358		20	218	218	654	16
17	4th floor nurses station	2016	10,972		20	549	549	1,647	17
18	Elevator rehab	2017	13,643		20	682	682	1,364	18
19	Wall Protection/railings for 4th floor dayroom	2018	10,460		39	134	134	134	19
20	Flooring for 4th floor dayroom	2018	10,041		39	129	129	129	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)		$ 10,673,775	$ 483,205		$ 359,142	$ (124,063)	$ 4,485,655	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: 01/01/2018 Ending: 12/31/2018

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		$ 10,673,775	$ 483,205		$ 359,142	$ (124,063)	$ 4,485,655	1
2									2
3									3
4	Related Party								4
5	Buildings:								5
6	Allocated from dynamic healthcare consulting	1993	104,628	2,683	35	3,989	1,306	75,730	6
7									7
8									8
9									9
10									10
11	Leasehold improvements:								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)		$ 10,778,403	$ 485,888		$ 363,131	$ (122,757)	$ 4,561,385	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: 01/01/2018 Ending: 12/31/2018

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 12E, Carried Forward		$ 10,778,403	$ 485,888		$ 363,131	$ (122,757)	$ 4,561,385	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)		$ 10,778,403	$ 485,888		$ 363,131	$ (122,757)	$ 4,561,385	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: 01/01/2018 Ending: 12/31/2018

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	$ 365,589	$	$ 36,558	$ 36,558	10	$ 287,914	71
72	Current Year Purchases	27,732		1,387	1,387	10	1,387	72
73	Fully Depreciated Assets	1,137,953		63	63	10	1,137,823	73
74	Related Party		1,755		(1,755)			74
75	TOTALS	$ 1,531,274	$ 1,755	$ 38,008	$ 36,253		$ 1,427,124	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 Business		$ 51,639	$	$	$		$ 51,639	76
77		Allocated from Dynamic Healthcare		68,213	790	2,937	2,147		58,527	77
78										78
79										79
80	TOTALS			$ 119,852	$ 790	$ 2,937	$ 2,147		$ 110,166	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)	$ 13,179,529	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 488,433	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 404,076	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (84,357)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,098,675	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	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: 01/01/2018 Ending: 12/31/2018

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								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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 34,074 Description: ATTACHED
(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		$	$ 28,154	17
18	Allocated Dynamic Hc Consultants			22,035	18
19					19
20					20
21	TOTAL		$	$ 50,189	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: 01/01/2018 Ending: 12/31/2018

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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	$ 430,264		$	$		$ 430,264	1
2	Licensed Speech and Language Development Therapist	39-01	hrs	230,445					230,445	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-01	hrs	411,322					411,322	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-03	# of prescrpts				193,022		193,022	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-03					113,823		113,823	13
14	TOTAL			$ 1,072,031		$	$ 306,845		$ 1,378,876	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.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 357,491	$ 531,262	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 941,036)	2,923,047	2,850,166	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	240,775	280,118	6
7	Other Prepaid Expenses	29,208	29,208	7
8	Accounts Receivable (owners or related parties)	4,925,948	5,273,024	8
9	Other(specify): ESCROWS		610,849	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,476,469	$ 9,574,627	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	3,936,009	15
16	Equipment, at Historical Cost	1,679,188	1,879,237	16
17	Accumulated Depreciation (book methods)	(2,568,888)	(6,455,148)	17
18	Deferred Charges		208,242	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):	45,069	45,069	22
23	Other(specify): deposit on fixed assets	27,300	27,300	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,205,302	$ 7,167,469	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,681,771	$ 16,742,096	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 534,405	$ 534,405	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,775,373	2,103,978	29
30	Accrued Salaries Payable	560,708	560,708	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,304	31,304	31
32	Accrued Real Estate Taxes(Sch.IX-B)		383,664	32
33	Accrued Interest Payable	4,274	31,337	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,906,064	$ 3,645,396	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,448,700	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	MORTGAGE PREMIUM		437,798	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,886,498	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,906,064	$ 12,531,894	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,775,707	$ 4,210,202	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,681,771	$ 16,742,096	48

***(See instructions.)**

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,166,653	1
2	Restatements (describe):		2
3		(764,996)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,401,657	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,617,250	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,243,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,374,050	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)**	$ 6,775,707	24 *

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

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 16,468,854	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,468,854	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	570,085	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 570,085	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	275,203	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 275,203	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,314,142	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,931,084	31
32	Health Care	5,106,605	32
33	General Administration	3,835,900	33
	B. Capital Expense		
34	Ownership	1,898,184	34
	C. Ancillary Expense		
35	Special Cost Centers	1,378,876	35
36	Provider Participation Fee	510,594	36
	D. Other Expenses (specify):		
37	**prior year expense adj**	6,649	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,667,892	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,646,250	41
42	**Income Taxes**	(29,000)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,617,250	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 11,549,791	44
45	Private Pay - Net Inpatient Revenue	95,889	45
46	Medicare - Net Inpatient Revenue	4,700,817	46
47	Other-(specify) **HOSPICE/INSURANCE/ETC**	122,357	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,468,854	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** 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: 01/01/2018 Ending: 12/31/2018

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	1,896	2,048	$ 115,280	$ 56.29	1
2	Assistant Director of Nursing	1,872	2,200	87,458	39.75	2
3	Registered Nurses	16,584	17,694	540,080	30.52	3
4	Licensed Practical Nurses	47,741	50,717	1,471,854	29.02	4
5	CNAs & Orderlies	114,784	123,946	1,677,878	13.54	5
6	CNA Trainees					6
7	Licensed Therapist	23,509	25,162	1,072,031	42.61	7
8	Rehab/Therapy Aides	9,014	10,130	147,903	14.60	8
9	Activity Director	1,997	2,245	36,738	16.36	9
10	Activity Assistants	11,310	11,957	150,271	12.57	10
11	Social Service Workers	8,092	8,817	181,211	20.55	11
12	Dietician					12
13	Food Service Supervisor	2,527	2,800	70,558	25.20	13
14	Head Cook	4,432	5,106	74,338	14.56	14
15	Cook Helpers/Assistants	20,785	22,863	292,168	12.78	15
16	Dishwashers					16
17	Maintenance Workers	6,627	7,211	123,137	17.08	17
18	Housekeepers	21,206	22,977	297,247	12.94	18
19	Laundry	13,300	14,270	178,596	12.52	19
20	Administrator	1,824	2,080	130,692	62.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,696	12,540	254,375	20.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,782	4,256	59,406	13.96	31
32	Other Health Care(specify)	5,826	6,258	245,973	39.31	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	328,804	355,277	$ 7,207,194 *	$ 20.29	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	M	$ 18,717	1-3	35
36	Medical Director	O	36,000	9-3	36
37	Medical Records Consultant	N	6,000	10-3	37
38	Nurse Consultant	T	21,159	10-3	38
39	Pharmacist Consultant	H	24,635	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,288	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	MDS CONSULTING		63,156	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 171,955		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Corren	ADMINISTRATOR		$ 130,692
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 130,692

B. Administrative - Other

Description	Amount
MANAGEMENT FEE	$ 28,217
TOTAL (agree to Schedule V, line 17, col. 3)	$ 28,217
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Supplemental Schedule		296,559
See Supplemental Schedule		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 296,559

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 193,078
Unemployment Compensation Insurance	54,873
FICA Taxes	543,194
Employee Health Insurance	304,752
Employee Meals	21,590
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits Other	42,970
	0
	0
	0
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,160,457

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	753
Health Care Worker Background Check	2,889
(Indicate # of checks performed 83)	
Patient Background Checks 211	2,110
Dues and Subscriptions	19,800
Licenses and Fees	9,990
Avertising & Promotion	55,797
Allocated Dynamic Healthcare	4,728
Less: Public Relations Expense	(0)
Non-allowable advertising	(55,797)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,270

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	7,926
Allocated from Dynamic Healthcare	1,170
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,096

* Attach copy of IMRF notifications

**See instructions.

WOODBRIDGE NURSING PAVILION
LEGAL EXPENSES
12/31/2018

DATE	FIRM	INVOICE #	PURPOSE	COST	
2/22/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	3,207.50	
3/21/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	910.00	
3/22/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	8,402.50	
4/17/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	4,193.50	
5/16/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	9,989.50	
6/19/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	2,522.00	
7/16/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	7,376.00	
8/23/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	7,226.50	
9/24/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	13,966.00	
10/19/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	21,324.11	
11/20/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	13,861.79	
11/21/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	379.00	
12/17/18	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	6,968.00	
1/22/19	VON BRIESEN & ROPER,S.C.		LABOR EMPLOYMENT	8,609.50	
1/31/18	STONE POGRUND & KOREY LLC		COMPLETED FACILITY STATUS UPDATE	22.50	
3/31/18	STONE POGRUND & KOREY LLC		GENERAL LITIGATION &COLLECTIONS	22.50	
4/30/18	STONE POGRUND & KOREY LLC		GENERAL LITIGATION &COLLECTIONS	22.50	
5/31/18	STONE POGRUND & KOREY LLC		GENERAL LITIGATION &COLLECTIONS	315.00	
6/30/18	STONE POGRUND & KOREY LLC		GENERAL LITIGATION &COLLECTIONS	1,173.95	
7/31/18	STONE POGRUND & KOREY LLC		GENERAL LITIGATION &COLLECTIONS	325.00	
8/31/18	STONE POGRUND & KOREY LLC		GENERAL LITIGATION &COLLECTIONS	542.50	
9/30/18	STONE POGRUND & KOREY LLC		GENERAL LITIGATION &COLLECTIONS	112.50	
11/1/18	STONE POGRUND & KOREY LLC		COMPLETED FACILITY STATUS UPDATE	45.00	
11/30/18	STONE POGRUND & KOREY LLC		GENERAL LITIGATION &COLLECTIONS	382.50	
12/31/18	STONE POGRUND & KOREY LLC		GENERAL LITIGATION &COLLECTIONS	943.03	3,906.98
4/1/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	2,446.00	
5/1/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	1,201.35	
6/1/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	81.00	
4/1/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	812.00	
8/1/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	1,229.98	
10/1/18	MUCH SHELIST, P.C.		FEDEX AND MESSENGER	13.02	
12/1/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	1,248.00	
1/1/19	MUCH SHELIST, P.C.		GENERAL COUNSELING	129.99	
11/30/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	457.00	
12/31/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	2,068.34	
11/1/18	BANK FINANCIAL		LOAN COUNSEL FEES	205.00	

			TOTAL LEGAL FEES	122,734.56	
				=========	

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.

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

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

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ 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.

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **510,594**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ Has any meal income been offset against
related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe
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:

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

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