FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

I. IDPH License ID Number: 0034157

Facility Name: WOODBRIDGE NURSING PAVILION

Address: 2242 NORTH KEDZIE (Number) CHICAGO (City) 60647 (Zip Code)

County: COOK

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 1/1/2020 to 12/31/2020 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, 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-3585

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: 1/1/2020 Ending: 12/31/2020

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	81,252	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	222	TOTALS	222	81,252	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	53,184	579	10,470	64,233	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,184	579	10,470	64,233	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.05%

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 10,470

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	520,268	33,309	19,100	572,677		572,677		572,677			1
2	Food Purchase		349,934		349,934	(21,777)	328,157	(633)	327,524			2
3	Housekeeping	382,810	59,335		442,145		442,145		442,145			3
4	Laundry	233,478	26,006	11,113	270,597		270,597		270,597			4
5	Heat and Other Utilities			228,230	228,230		228,230	2,323	230,553			5
6	Maintenance	126,518	127,041	39,053	292,612		292,612	31,182	323,794			6
7	Other (specify):*			29,642	29,642		29,642		29,642			7
8	TOTAL General Services	1,263,074	595,625	327,138	2,185,837	(21,777)	2,164,060	32,872	2,196,932			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	4,571,960	428,669	193,268	5,193,897		5,193,897	25,186	5,219,083			10
10a	Therapy	1,155,211	1,387		1,156,598		1,156,598		1,156,598			10a
11	Activities	181,457	8,137	1,699	191,293		191,293		191,293			11
12	Social Services	167,791		3,608	171,399		171,399		171,399			12
13	CNA Training											13
14	Program Transportation			21	21		21		21			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,076,419	438,193	234,596	6,749,208		6,749,208	25,186	6,774,394			16
	C. General Administration											
17	Administrative	241,151			241,151		241,151	340,460	581,611			17
18	Directors Fees											18
19	Professional Services			308,287	308,287		308,287	17,851	326,138			19
20	Dues, Fees, Subscriptions & Promotions			194,156	194,156		194,156	(147,247)	46,909			20
21	Clerical & General Office Expenses	269,906	22,494	699,891	992,291		992,291	(372,053)	620,238			21
22	Employee Benefits & Payroll Taxes			1,287,599	1,287,599	21,777	1,309,376		1,309,376			22
23	Inservice Training & Education			715	715		715		715			23
24	Travel and Seminar			14,286	14,286		14,286	547	14,833			24
25	Other Admin. Staff Transportation							5,433	5,433			25
26	Insurance-Prop.Liab.Malpractice			862,670	862,670		862,670	28,198	890,868			26
27	Other (specify):*			430,587	430,587		430,587	(301,370)	129,217			27
28	TOTAL General Administration	511,057	22,494	3,798,191	4,331,742	21,777	4,353,519	(428,181)	3,925,338			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,850,550	1,056,312	4,359,925	13,266,787		13,266,787	(370,123)	12,896,664			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: 1/1/2020** **Ending: 12/31/2020**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	19,100	
	REPAIRS & MAINTENANCE		0	
	CONTRACTED DIETARY SERVICES		0	
				19,100
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		11,113	
	CONTRACTED LAUNDRY SERVICES		0	
				11,113
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		59,044	
	ELECTRICITY		69,243	
	WATER		93,390	
	CABLE TV - LOBBY		6,553	
				228,230
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,750	
	PAINTING & DECORATING		2,035	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		23,806	
	ELEVATOR MAINTENANCE & REPAIR		4,562	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,900	
	FIRE SERVICE		0	
				39,053
7	**OTHER**			
	SCAVENGER		29,642	
	SECURITY SERVICE		0	
				29,642
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		36,000	36,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	26,294	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	152,616	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	14,358	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2		
				193,268
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,699	
				1,699
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,608	
				3,608
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID# WOODBRIDGE NURSING PAVILION **#0034157 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		21	
				21
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	138,182	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	170,105	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0	
				308,287
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	124,362	
	EMPLOYEE WANT ADS	XIX F	11,408	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	13,565	
	LICENSES & PERMITS	XIX F	15,464	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	27,062	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	292	
	PATIENT BACKGROUND CHECKS	XIX F	2,003	
				194,156
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		15,041	
	EQUIPMENT REPAIR & MAINTENANCE		29,733	
	OUTSIDE CLERICAL SERVICES		626,024	
	PENALTIES / OVERDRAFT CHARGES	VI 18	7,296	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		21,797	
	MESSENGER SERVICE		0	
				699,891

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	588,893	
	UNEMPLOYMENT COMPENSATION	XIX D	29,756	
	WORKERS COMPENSATION INSURANCE	XIX D	257,749	
	HOSPITALIZATION INSURANCE	XIX D	335,598	
	EMPLOYEE BENEFITS - OTHER	XIX D	75,603	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				1,287,599
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		715	
				715
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	14,286	
				14,286
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		0	
				0
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		862,670	
				862,670
27	**OTHER**			
	BAD DEBTS	VI 24	430,587	
				430,587

GRAND TOTAL COLUMN 3 OTHER **4,359,925**

WOODBRIDGE NURSING PAVILION
SCHEDULES
12/31/2020

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

TOTAL FOOD PURCHASE	349,934
LESS SALES TAX	(633)
NET FOOD	349,301
TOTAL PATIENT CENSUS	64,233
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	192,699
ADD # EMPLOYEE MEALS/DAY	35
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	12,810
PATIENT MEALS	192,699
ADD EMPLOYEE MEALS	12,810
TOTAL MEALS/YEAR	205,509
NET FOOD	349,301
DIVIDE TOTAL MEALS/YEAR	205,509
COST PER MEAL	2
TIMES EMPLOYEE MEALS	12,810
EMPLOYEE MEAL RECLASSIFICATION	**21,777**

Facility Name & ID Number WOODBRIDGE NURSING PAVILION #0034157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			99,365	99,365		99,365	285,020	384,385			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,437	17,437		17,437	141,963	159,400			32
33	Real Estate Taxes							442,680	442,680			33
34	Rent-Facility & Grounds			1,592,527	1,592,527		1,592,527	(1,592,527)				34
35	Rent-Equipment & Vehicles			67,324	67,324		67,324	20,889	88,213			35
36	Other (specify):*							42,616	42,616			36
37	**TOTAL Ownership**			1,776,653	1,776,653		1,776,653	(659,359)	1,117,294			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		261,266		261,266		261,266		261,266			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			447,763	447,763		447,763		447,763			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		261,266	447,763	709,029		709,029		709,029			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,850,550	1,317,578	6,584,341	15,752,469		15,752,469	(1,029,482)	14,722,987			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: 1/1/2020 Ending: 12/31/2020

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 Reference	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	(13,989)	30		9
10	Interest and Other Investment Income	(179,774)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(633)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(7,296)	21		18
19	Entertainment		20		19
20	Contributions	(27,062)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(430,587)	27		24
25	Fund Raising, Advertising and Promotional	(124,362)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A		22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (783,703)		$	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)	(245,779)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (245,779)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,029,482)		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: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(633)	0	0	0	0	0	0	0	0	0	0	(633)	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	2,323	0	0	0	0	0	0	0	0	2,323	5
6	Maintenance	0	0	14,445	16,737	0	0	0	0	0	0	0	31,182	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(633)	0	16,768	16,737	0	0	0	0	0	0	0	32,872	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	25,186	0	0	0	0	0	0	0	0	25,186	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	25,186	0	0	0	0	0	0	0	0	25,186	16
	C. General Administration													
17	Administrative	0	0	0	340,460	0	0	0	0	0	0	0	340,460	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,000	6,851	0	0	0	0	0	0	0	0	17,851	19
20	Fees, Subscriptions & Promotions	(151,424)	0	4,177	0	0	0	0	0	0	0	0	(147,247)	20
21	Clerical & General Office Expenses	(7,296)	0	(401,805)	37,048	0	0	0	0	0	0	0	(372,053)	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	547	0	0	0	0	0	0	0	0	547	24
25	Other Admin. Staff Transportation	0	0	5,433	0	0	0	0	0	0	0	0	5,433	25
26	Insurance-Prop.Liab.Malpractice	0	21,410	6,788	0	0	0	0	0	0	0	0	28,198	26
27	Other (specify):*	(430,587)	0	129,217	0	0	0	0	0	0	0	0	(301,370)	27
28	**TOTAL General Administration**	(589,307)	32,410	(248,792)	377,508	0	0	0	0	0	0	0	(428,181)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(589,940)	32,410	(206,838)	394,245	0	0	0	0	0	0	0	(370,123)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(13,989)	296,541	2,468	0	0	0	0	0	0	0	0	285,020	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(179,774)	317,163	4,574	0	0	0	0	0	0	0	0	141,963	32
33	Real Estate Taxes	0	434,084	8,596	0	0	0	0	0	0	0	0	442,680	33
34	Rent-Facility & Grounds	0	(1,592,527)	0	0	0	0	0	0	0	0	0	(1,592,527)	34
35	Rent-Equipment & Vehicles	0	0	20,889	0	0	0	0	0	0	0	0	20,889	35
36	Other (specify):*	0	42,616	0	0	0	0	0	0	0	0	0	42,616	36
37	TOTAL Ownership	(193,763)	(502,123)	36,527	0	0	0	0	0	0	0	0	(659,359)	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)	(783,703)	(469,713)	(170,311)	394,245	0	0	0	0	0	0	0	(1,029,482)	45

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	RENT	$ 1,592,527	WOODBRIDGE BUILDING LLC	100.00%	$	$ (1,592,527)	1
2	V								2
3	V	19	PROFESSIONAL FEES				11,000	11,000	3
4	V	30	DEPRECIATION				296,541	296,541	4
5	V	32	AMORTIZATION				11,106	11,106	5
6	V	33	REAL ESTATE TAXES				434,084	434,084	6
7	V	32	INTEREST EXPENSE				306,057	306,057	7
8	V	26	INSURANCE				21,410	21,410	8
9	V	36	MORTGAGE INSURANCE				42,616	42,616	9
10	V	6	REPAIR & MAINTENANCE						10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,592,527			$ 1,122,814	$ * (469,713)	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: 1/1/2020 Ending: 12/31/2020

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	BOOKKEEPING SERVICES	$ 626,024	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$ (626,024)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V	5	UTILITIES				2,323	2,323	20
21	V	6	REPAIR & MAINT.-OTHER EXPENSE				14,445	14,445	21
22	V	10	NURSE CONSULTANT				25,186	25,186	22
23	V	19	PROFESSIONAL FEES				6,851	6,851	23
24	V	20	DUES AND SUBSCRIPTION				4,177	4,177	24
25	V	21	CLERICAL & GENERAL - SALARIES				171,731	171,731	25
26	V	21	CLERICAL & GENERAL-OTHER EXPENSE				52,488	52,488	26
27	V	24	SEMINARS AND TRAVEL				547	547	27
28	V	25	AUTO EXPENSE				5,433	5,433	28
29	V	26	INSURANCE				6,788	6,788	29
30	V	27	EMP. BEN. - GEN, ADMIN.				129,217	129,217	30
31	V	30	DEPRECIATION				2,468	2,468	31
32	V	32	INTEREST				4,574	4,574	32
33	V	33	REAL ESTATE TAXES				8,596	8,596	33
34	V	35	AUTO RENTAL				20,324	20,324	34
35	V	35	EQUIPMENT RENTAL				565	565	35
36	V								36
37	V								37
38	V								38
39	Total			$ 626,024			$ 455,713	$ * (170,311)	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: 1/1/2020 Ending: 12/31/2020

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%	$ 16,737	$ 16,737	15
16	V	17	ADMIN COMP - M MAUER				54,438	54,438	16
17	V	17	ADMIN COMP - M AARON				71,063	71,063	17
18	V	17	ADMIN COMP - F AARON						18
19	V	17	ADMIN COMP - D AARON				2,154	2,154	19
20	V	17	ADMIN COMP - S GOLDSTEIN				86,250	86,250	20
21	V	17	ADMIN COMP - R AARON						21
22	V	17	ADMIN COMP - S HARAMARAS				34,506	34,506	22
23	V	17	ADMIN COMP - D KUFTA				29,152	29,152	23
24	V	17	ADMIN COMP - HOWARD ALTER						24
25	V	17	ADMIN COMP - NON OWNER - V DAVIS				36,007	36,007	25
26	V	17	ADMIN COMP - CONTROLLER-NON OWNER				26,890	26,890	26
27	V	21	CLERICAL COMP - S AARON				22,434	22,434	27
28	V	21	CLERICAL COMP - E MARYLES				14,614	14,614	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			$			$ 394,245	$ * 394,245	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: 1/1/2020 Ending: 12/31/2020

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				4
5	Miriam Latinik	4.51%	Waterfront Terrace Inc	Chicago				5
6	Joseph Mauer	4.51%	Willow Crest Nursing Pavilion Ltd	Sandwich				6
7	Sharon Aaron	0.59%	Woodbridge Nursing Pavilion Ltd	Chicago				7
8	Dennis Nehmer	0.59%						8
9	Diania Kufta	0.59%						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: 1/1/2020 Ending: 12/31/2020

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	ADMINISTRATIV	24.87	SEE ATTACHED	11.37	22.74	SALARY	$ 71,063	17-07	1
2	DANIEL AARON	RELATIVE	ADMINISTRATIVE			0.5	0.91	SALARY	2,154	17-07	2
3	MARSHALL MAUER	OWNER	ADMINISTRATIV	6.76		8.71	21.78	SALARY	54,438	17-07	3
4	SHARON AARON	OWNER	CLERICAL	0.59		9.36	23.40	SALARY	22,434	21-07	4
5	STEVEN GOLDSTEIN	RELATIVE	ADMINISTRATIVE			15		SALARY	20,000	17-01	5
6	DENNIS NEHMER	OWNER	MAINTENANCE	0.59		11.42	28.55	SALARY	16,737	06-01	6
7	DIANA KUFTA	OWNER	ADMINISTRATIV	0.59		6.94	17.35	SALARY	29,152	17-07	7
8	SUE KOPLIN-HARAMARAS	OWNER	ADMINISTRATIV	0.59		15		SALARY	34,506	17-07	8
9	ROBERT AARON	RELATIVE	ADMINISTRATIVE			2		SALARY	7,180	17-07	9
10	STEVEN GOLDSTEIN	RELATIVE	ADMINISTRATIVE			15		SALARY	86,250	17-07	10
11	ESTHER MARYLES	RELATIVE	CLERICAL			8.11	20.28	SALARY	14,614	21-07	11
12											12
13								TOTAL	$ 358,528		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: 1/1/2020 Ending: 2/31/2020

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	296,074	9	$ 10,707	$	64,233	$ 2,323	1
2	6	REPAIR & MAINT.-OTHER EXPEI	PATIENT DAYS	296,074	9	66,584		64,233	14,445	2
3	10	NURSE CONSULTANT	PATIENT DAYS	296,074	9	116,092		64,233	25,186	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	296,074	9	31,579		64,233	6,851	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	296,074	9	19,254		64,233	4,177	5
6	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	296,074	9	791,573	791,573	64,233	171,731	6
7	21	CLERICAL & GENERAL-OTHER I	PATIENT DAYS	296,074	9	241,939		64,233	52,488	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	296,074	9	2,520		64,233	547	8
9	25	AUTO EXPENSE	PATIENT DAYS	296,074	9	25,044		64,233	5,433	9
10	26	INSURANCE	PATIENT DAYS	296,074	9	31,289		64,233	6,788	10
11	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	296,074	9	595,611		64,233	129,217	11
12	30	DEPRECIATION	PATIENT DAYS	296,074	9	11,374		64,233	2,468	12
13	32	INTEREST	PATIENT DAYS	296,074	9	21,081		64,233	4,574	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	296,074	9	39,621		64,233	8,596	14
15	35	AUTO RENTAL	PATIENT DAYS	296,074	9	93,680		64,233	20,324	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	296,074	9	2,605		64,233	565	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,100,553	$ 791,573		$ 455,713	25

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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	5	$ 58,624	$ 58,624	11	$ 16,737	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	9	250,000	250,000	9	54,438	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	5	250,000	250,000	11	71,063	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	3	127,500	127,500			4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	5	9	21,541	21,541	1	2,154	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	230,000	230,000	15	86,250	6
7	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	6	3	21,541	21,541			7
8	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	1	69,011	69,011	15	34,506	8
9	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	5	168,022	168,022	7	29,152	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	5	132,015	132,015	11	36,007	11
12	17	ADMIN COMP - CONTROLLER-N	WGHTD AVG HOURS	40	9	114,916	114,916	9	26,890	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	95,871	95,871	9	22,434	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	40	9	72,080	72,080	8	14,614	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,623,121	$ 1,623,121		$ 394,245	25

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	MIDLAND STATES BANK		X	MORTGAGE	$53,985.77	9/21/10	$ 10,880,000	$ 8,107,728	10/01/37	3.7000	$ 306,057	1
2												2
3		X		LOAN COSTS	W/O OVER LOAN		299,868	186,029			11,106	3
4												4
5												5
	Working Capital											
6	MB FINANCIAL	X		WORKING CAPITAL						PRIME+	17,437	6
7												7
8	RELATED PARTY ALLOCATION										4,574	8
9	TOTAL Facility Related				$53,985.77		$ 11,179,868	$ 8,293,757			$ 339,174	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 11,179,868	$ 8,293,757			$ 339,174	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 42,616 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: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 425,000	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.)		$ 432,680	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,680	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 435,000	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.)**		$	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.		$ 442,680	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	326,590	8
	2016	356,958	9
	2017	383,664	10
	2018	415,445	11
	2019	432,680	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOODBRIDGE NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-35-217-015-0000	NURSING HOME	$ 128,191.51	$ 128,191.51
2.	13-35-217-016-0000	NURSING HOME	$ 167,701.34	$ 167,701.34
3.	13-35-217-017-0000	NURSING HOME	$ 128,191.51	$ 128,191.51
4.			$	$
5.	10-23-404-059-0000	DYNAMIC HEALTHCARE	$ 36,915.77	$ 8,596.00
6.		ALLOCATION	$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 461,000.13	$ 432,680.36

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 X 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 1/1/2020 Ending: 12/31/2020

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 [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: 1/1/2020 Ending: 12/31/2020

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	$	35	$ 193,622	$ 193,622	$ 2,922,739	4
5											5
6											6
7											7
8	RELATED PARTY ALLOCATION				104,628		35	2,989	2,989		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			6,790	16
17	Various			1998	50,252		20			50,252	17
18	Various			1999	68,242		20			68,242	18
19	Various			2000	57,506		20			57,506	19
20	Various			2001	62,933		20	3,147	3,147	61,435	20
21	Various			2002	83,062		20	2,058	2,058	40,434	21
22	Various			2003	16,347		20	70	70	16,169	22
23	Various			2004	116,859		20			116,859	23
24	Various			2005	112,439		20	2,046	2,046	106,205	24
25	Various			2006	70,102		20			70,102	25
26	Various			2007	205,027		20	10,036	10,036	149,903	26
27	Various			2008	99,839		20			99,839	27
28	Various			2009	563,904		20	15,734	15,734	177,726	28
29	Various			2010	5,192		20	260	260	2,857	29
30	Various			2011	15,685		20	402	402	3,819	30
31	Various			2012	27,813		20	1,974	1,974	16,768	31
32	Various			2013	29,666		20	3,000	3,000	23,199	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: 1/1/2020 Ending: 12/31/2020

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									67
68									68
69	Financial Statement Depreciation			398,374			(398,374)		69
70	TOTAL (lines 4 thru 69)		$ 8,673,715	$ 398,374		$ 235,338	$ (163,036)	$ 4,191,499	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: 1/1/2020 Ending: 12/31/2020

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		$ 8,673,715	$ 398,374		$ 235,338	$ (163,036)	$ 4,191,499	1
2	Installed 2 new 60 series pump pipes	2014	4,324		20	216	216	1,359	2
3	Remote annunciator for fire pump; Tie kitchen to fire	2014	5,255		20	263	263	1,774	3
4	3rd floor - lights, walls, doors, nurses station	2014	6,152		20	308	308	1,872	4
5	Water pump	2015	3,617		20	181	181	1,055	5
6	Water valve work in therapy room	2015	7,100		20	355	355	1,982	6
7	Installed hose, restricted feeder & water feed pump for chiller	2015	2,722		20	136	136	771	7
8	Installed 3 security cameras & monitor	2015	2,910		20	146	146	765	8
9	3rd floor - lights, walls, doors, nurses station	2015	55,427		20	2,771	2,771	15,703	9
10	Lobby - flooring, replace door, wallcovering, ceiling panels	2015	10,681		20	534	534	2,982	10
11	Resident room & evacuation Interior Signage	2016	2,849		20	570	570	2,850	11
12	4th floor nurse call system	2016	3,575		20	715	715	3,456	12
13	4th floor - vinyl tile flooring 2232 sq ft	2016	26,099		20	5,220	5,220	25,230	13
14	Installed new pump & relay for air handler	2016	3,100		20	89	89	422	14
15	Install new fittings & sections to leaking 2" copper pipe in kit	2016	2,875		20	82	82	383	15
16	Install new 2" ball valve &7 ft new piping/fittings	2016	2,850		20	81	81	372	16
17	Install new section of 4" cast iron pipe with new couplings	2016	3,200		20	91	91	395	17
18	Install 2x di-electric unions/pipings/ball valves	2016	2,850		20	81	81	379	18
19	Wireless Equipment	2016	9,354		20	1,871	1,871	7,796	19
20	Firewall, switches, wireless network/cabinet	2016	3,677		20	105	105	438	20
21	Signage - 2nd floor corridor	2017	2,893		20	76	76	304	21
22	Protection system - 2nd floor corridor	2017	6,213		20	163	163	652	22
23	Water pressure restoration	2017	6,350		20	151	151	604	23
24	Installed new lighting sinks, faucets - room 101	2017	13,850		20	297	297	1,188	24
25	Wall - ac unit	2017	2,950		20	344	344	1,376	25
26	Plumbing parts - bathroom	2017	2,841		20	47	47	188	26
27	Installed new pumps - boiler room	2017	6,400		20	107	107	428	27
28	Installed new call light system - 2nd floor	2017	7,166		20	102	102	408	28
29	Installed new piping - kithcen sewer	2017	3,800		20	45	45	180	29
30	Installed mirrors - therapy room	2017	2,860		20	27	27	108	30
31	Boiler upgrade	2017	3,443		20	16	16	64	31
32	Sprinkler System - install new RPZ valve and new fittings	2019	3,500		39	90	90	180	32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,894,598	$ 398,374		$ 250,618	$ (147,756)	$ 4,267,163	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: 1/1/2020 Ending: 12/31/2020

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		$ 8,894,598	$ 398,374		$ 250,618	$ (147,756)	$ 4,267,163	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	64,729	9
10	Various	2010	734,652		20	38,859	38,859	437,959	10
11	Various	2011	288,244		20	14,412	14,412	144,121	11
12	Power for ejector and circulating pumps	2012	3,950		20	198	198	1,780	12
13	Water coil for roof	2012	4,301		20	215	215	1,935	13
14	Fire dampners and insulation	2012	3,142		20	157	157	1,414	14
15	Sprinkler system, sprinkler head piping	2012	2,850		20	143	143	1,285	15
16	Boiler pump, new boiler	2012	5,698		20	285	285	2,565	16
17	Fire alarm door release	2012	3,837		20	192	192	1,727	17
18	Doors for resident rooms and floors and lobby	2012	3,560		20	178	178	1,602	18
19	Ceramic tiling in basement bathrooms	2012	6,767		20	338	338	3,044	19
20	Ceramic tiling in 1st floor bathroom/shower roomo	2012	6,917		20	346	346	3,113	20
21	Shower tub & base installation, valve & wiring	2012	14,821		20	741	741	6,669	21
22	Lighitng for 1st floor resident rooms	2012	11,470		20	574	574	5,144	22
23	Service sink installation	2012	2,513		20	126	126	1,132	23
24	Condenser Installation	2012	4,675		20	234	234	2,105	24
25	Electrical work for air handler, laundry room, resident rooms	2012	11,666		20	583	583	5,249	25
26	Install condensate pump	2012	3,165		20	158	158	1,423	26
27	Doors for resident rooms and floors and lobby	2012	4,956		20	248	248	2,231	27
28	Camera & pacing system, monitors, lights, alarms	2012	7,875		20	394	394	3,545	28
29	Exit signs, camera outlets, automatic door control	2012	7,410		20	371	371	3,337	29
30	Heat curtin installation	2012	3,365		20	168	168	1,513	30
31	Installed new pipping in the 4th floor ceiling for hot and cold	2012	2,500		20	125	125	1,125	31
32	All floors shower tub rooms - flooring, wallcovering, lighting	2013	154,632		20	7,732	7,732	69,586	32
33	Installed new ejector pumps in basement	2013	4,900		20	245	245	1,960	33
34	TOTAL (lines 1 thru 33)		$ 10,283,204	$ 398,374		$ 322,178	$ (76,196)	$ 5,037,456	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: 1/1/2020 Ending: 12/31/2020

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		$ 10,283,204	$ 398,374		$ 322,178	$ (76,196)	$ 5,037,456	1
2	Installed new blast rooftop furnace	2013	31,780		20	1,589	1,589	12,712	2
3	Installed nurse station and replaced two doors on 2nd floor	2013	9,832		20	492	492	3,935	3
4	Drop ceiling supplies for 2nd floor remodeling	2013	4,151		20	208	208	1,663	4
5	Remodeled 2nd floor, installed new ceiling tiles, lights, wallpaper	2013	23,750		20	1,188	1,188	9,503	5
6	Purhcased vinyl wallcovering for corridor and dining room	2013	21,037		20	1,052	1,052	8,416	6
7	Installed window treatements and braille signage on 2nd floor	2013	4,992		20	250	250	1,999	7
8	Installed handrails on 2nd floor	2013	3,550		20	178	178	1,423	8
9	Installation on vinyl flooring on 2nd floor	2013	7,333		20	367	367	2,935	9
10	Installed 3 toilet bowls and tanks, 3 faucets and 12 shower rods	2013	2,538		20	127	127	1,016	10
11	4th floor corridor wall guards and corner guards	2015	14,391		20	720	720	3,720	11
12	3rd and 4th floor dining romm and window treatements	2015	4,358		20	218	218	1,308	12
13	Installed 4th floor nurses station	2015	10,972		20	549	549	3,294	13
14	Windows/radiator covers/parking lot/guardrails/tuckpointing/ligh	2016	296,150		20	14,808	14,808	74,040	14
15	Wall protection system in corridor	2016	14,391		20	720	720	3,600	15
16	Window treatements	2016	4,358		20	218	218	1,090	16
17	4th floor nurses station	2016	10,972		20	549	549	2,745	17
18	Elevator rehab	2017	13,643		20	682	682	2,728	18
19	Wall Protection/railings for 4th floor dayroom	2018	10,460		39	134	134	402	19
20	Flooring for 4th floor dayroom	2018	10,041		39	129	129	387	20
21	Flooring, Drywall, Painting - 3rd floor dayroom	2019	10,500		39	525	525	1,050	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)		$ 10,792,403	$ 398,374		$ 346,881	$ (51,493)	$ 5,175,422	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: 1/1/2020 Ending: 12/31/2020

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	$ 403,904	$	$ 36,263	$ 36,263	10	$ 299,990	71
72	Current Year Purchases	9,606		480	480	10	480	72
73	Fully Depreciated Assets	1,137,953					1,137,953	73
74	RELATED PARTY			761	761			74
75	TOTALS	$ 1,551,463	$	$ 37,504	$ 37,504		$ 1,438,423	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		$ 51,639	$	$	$		$ 51,639	76
77										77
78										78
79										79
80	TOTALS			$ 51,639	$	$	$		$ 51,639	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)	$ 13,145,505	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 398,374	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 384,385	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,989)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,665,484	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: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

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.		$
13.		$
14.		$

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

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

16. Rental Amount for movable equipment: $ 37,088 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	2017 FORD STARCRAFT	$ 658.00	$ 7,896	17
18	ADMINISTRATIVE	LEXUS	699.34	15,394	18
19		TOYOTA TACOMA	557.20	6,946	19
20					20
21	TOTAL		$ #######	$ 30,236	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: 1/1/2020 Ending: 12/31/2020

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 ____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				125,474		125,474	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): RENTALS	39-2 39-2					124,276 11,516		124,276 11,516	13
14	TOTAL			$		$	$ 261,266		$ 261,266	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: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (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	$ 4,840,505	$ 5,014,224	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 582,093)	5,511,994	5,511,994	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	218,440	257,588	6
7	Other Prepaid Expenses	94,892	94,892	7
8	Accounts Receivable (owners or related parties)	3,536,769	3,883,845	8
9	Other(specify): ESCROWS		787,545	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 14,202,600	$ 15,550,088	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	2,039,736	3,792,849	15
16	Equipment, at Historical Cost	1,699,377	2,644,000	16
17	Accumulated Depreciation (book methods)	(2,787,328)	(8,242,241)	17
18	Deferred Charges	58,366	58,366	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Security Deposits**	43,908	43,908	22
23	Other(specify): LOAN COSTS		186,029	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,054,059	$ 6,009,671	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,256,659	$ 21,559,759	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,405,247	$ 1,405,247	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,575,815	1,942,933	29
30	Accrued Salaries Payable	699,601	699,601	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,793	35,793	31
32	Accrued Real Estate Taxes(Sch.IX-B)		434,999	32
33	Accrued Interest Payable		24,999	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)**	$ 3,716,456	$ 4,543,572	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,098,344	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,098,344	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,716,456	$ 12,641,916	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,540,203	$ 8,917,843	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,256,659	$ 21,559,759	48

***(See instructions.)**

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,084,942	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,084,942	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,788,261	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	(333,000)	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)**	$ 2,455,261	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)**	$ 11,540,203	24 *

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

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 16,499,897	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,499,897	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	315,293	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 315,293	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***	179,774	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 179,774	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STIMULUS PAYMENT	1,545,766	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,545,766	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,540,730	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,185,837	31
32	Health Care	6,749,208	32
33	General Administration	4,331,742	33
	B. Capital Expense		
34	Ownership	1,776,653	34
	C. Ancillary Expense		
35	Special Cost Centers	261,266	35
36	Provider Participation Fee	447,763	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,752,469	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,788,261	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,788,261	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,272,080	44
45	Private Pay - Net Inpatient Revenue	131,196	45
46	Medicare - Net Inpatient Revenue	7,096,621	46
47	Other-(specify) HOSPICE/INSURANCE/ETC		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,499,897	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: 1/1/2020 Ending: 12/31/2020

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	1,901	2,112	$ 128,940	$ 61.05	1
2	Assistant Director of Nursing	624	640	33,662	52.60	2
3	Registered Nurses	12,427	13,248	466,439	35.21	3
4	Licensed Practical Nurses	47,991	51,970	1,675,069	32.23	4
5	CNAs & Orderlies	109,375	118,129	2,004,618	16.97	5
6	CNA Trainees					6
7	Licensed Therapist	19,720	20,963	917,490	43.77	7
8	Rehab/Therapy Aides	9,294	10,610	237,721	22.41	8
9	Activity Director	1,888	2,200	43,480	19.76	9
10	Activity Assistants	8,661	9,135	137,977	15.10	10
11	Social Service Workers	7,514	8,144	167,791	20.60	11
12	Dietician					12
13	Food Service Supervisor	2,207	2,639	72,442	27.45	13
14	Head Cook	4,376	4,928	83,564	16.96	14
15	Cook Helpers/Assistants	19,558	22,411	364,262	16.25	15
16	Dishwashers					16
17	Maintenance Workers	5,832	6,416	126,518	19.72	17
18	Housekeepers	21,249	23,851	382,810	16.05	18
19	Laundry	13,244	14,695	233,478	15.89	19
20	Administrator	1,880	2,080	157,710	75.82	20
21	Assistant Administrator	1,816	2,080	83,441	40.12	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,339	11,440	269,906	23.59	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	2,039	2,287	40,757	17.82	31
32	Other Health C: Care Plan Coord	5,876	6,212	222,475	35.81	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	307,811	336,190	$ 7,850,550 *	$ 23.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 19,100	1-3	35
36	Medical Director	O	36,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	152,616	10-3	38
39	Pharmacist Consultant	H	14,358	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	1,699	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 223,773		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	26	$ 1,459	10-3	50
51	Licensed Practical Nurses	37	2,821	10-3	51
52	Certified Nurse Assistants/Aides	847	22,014	10-3	52
53	TOTAL (lines 50 - 52)	910	$ 26,294		53

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PATRICIA CORREA	ADMINISTRATOR	0	$ 157,710
SARAH SANCHEZ	ASST ADMIN	0	83,441
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 241,151

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 SCHEDULE ATTACHED		308,287
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 308,287

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 257,749
Unemployment Compensation Insurance	29,756
FICA Taxes	588,893
Employee Health Insurance	335,598
Employee Meals	21,777
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	75,603
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,309,376

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	$ 1,990
Advertising: Employee Recruitment	11,408
Health Care Worker Background Check	292
(Indicate # of checks performed 8)	
Patient Background Checks 200	2,003
TRUST/FRANCHISE/CONTRIB/ETC	27,062
MARKETING/ADV/PROMO	124,362
LICENSES/DUES/SUBSCRIPTIONS	27,039
MGMT CO ALLOC	4,177
TRUST/FRANCHISE/CONTRIB/ETC	(27,062)
Less: Public Relations Expense	(0)
Non-allowable advertising	(124,362)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,909

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	14,286
MGMT CO ALLOC	547
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,833

* Attach copy of IMRF notifications

**See instructions.

WOODBRIDGE NURSING PAVILION
SCHEDULE - LEGAL
12/31/2020

DATE	VENDOR	DESCRITPION	AMOUNT
1/31/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	1,378.50
2/29/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	1,416.45
3/31/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	765.00
4/30/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	149.70
5/31/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	194.70
6/30/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	1,745.68
7/31/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	3,594.00
8/31/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	1,084.61
9/30/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	1,760.60
10/31/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	687.50
11/30/2020	DI MONTE & LIZAK, LLC ATTORNEYS AT LAW	CAROL BORG MEDICAID APPEAL	232.50
1/1/2020	MUCH SHELIST, P.C.	General Counseling	1,170.00
4/27/2020	MUCH SHELIST, P.C.	Annual Illinois Corporation Report	350.00
1/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	90.00
2/29/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	262.92
3/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	22.50
4/30/2020	STONE POGRUND & KOREY LLC	Carol Borg Medical Appeal	37.92
7/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	22.50
9/30/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	1,222.08
11/30/2020	STONE POGRUND & KOREY LLC	General Litigation and Collections	517.50
12/3/2020	STONE POGRUND & KOREY LLC	General Litigation and Collections	697.50
4/1/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	507.40
4/21/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	98.00
5/17/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	1,198.60
5/17/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	315.00
5/17/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	1,085.00
6/17/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	252.00
7/27/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	133.00
9/16/2020	VON BRIESEN & ROPER, S.C.	2020 DOL Compliance Review	2,898.00
9/16/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	403.00
9/16/2020	VON BRIESEN & ROPER, S.C.	Robin Thompson IDHR Complaint	3,572.00
9/30/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	280.00
10/20/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	461.00
10/20/2020	VON BRIESEN & ROPER, S.C.	Robin Thompson IDHR Complaint	6,665.00
10/20/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	310.00
10/31/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	365.63
10/31/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	4,887.00
10/31/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	2,420.00
10/31/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	186.00
11/23/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	365.63
11/30/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	3,150.00
11/30/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	9,815.00
12/31/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	1,080.00
12/31/2020	VON BRIESEN & ROPER, S.C.	2020 DOL Compliance Review	13,611.00
12/31/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	93.00
	TOTAL		**71,553.42**

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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-$ 11,522**

(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?

(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. $ **16,253** Line **10-2**

(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 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. $ **447,763**
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. $ **21,777** Has any meal income been offset against related costs? **N/A** 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 for 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? **5%**
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:

(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.