

		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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.

<p>I. IDPH Facility ID Number: <u>0043406</u></p> <p>Facility Name: <u>WOODSIDE EXTENDED CARE</u></p> <p>Address: <u>120 WEST 26TH STREET</u> <u>SO. CHICAGO HTS.</u> <u>60411</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u></p> <p>IDPA ID Number: <u>39-4153529</u></p> <p>Date of Initial License for Current Owners: <u>11/01/97</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MORRIS ESFORMES</u></td> </tr> <tr> <td>(Title) <u>MANAGER</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MORRIS ESFORMES</u>	(Title) <u>MANAGER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number WOODSIDE EXTENDED CARE

0043406 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			5,922	5,922	8
9	SNF/PED					9
10	ICF	34,191	359		34,550	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,191	359	5,922	40,472	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.00%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/97 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 20 and days of care provided 5,922

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **WOODSIDE EXTENDED CARE** # **0043406** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	124,275	12,997	11,489	148,761		148,761		148,761		1
2	Food Purchase		137,254		137,254		137,254	(528)	136,726		2
3	Housekeeping	110,708	21,872		132,580		132,580		132,580		3
4	Laundry	34,524	8,613	2,360	45,497		45,497	879	46,376		4
5	Heat and Other Utilities			130,932	130,932		130,932	243	131,175		5
6	Maintenance	123,863	13,079	35,188	172,130		172,130	2,798	174,928		6
7	Other (specify):*			7,050	7,050		7,050	53	7,103		7
8	TOTAL General Services	393,370	193,815	187,019	774,204		774,204	3,445	777,649		8
	B. Health Care and Programs										
9	Medical Director			8,250	8,250		8,250		8,250		9
10	Nursing and Medical Records	1,075,709	46,389	8,767	1,130,865		1,130,865		1,130,865		10
10a	Therapy	93,041	3,080		96,121		96,121		96,121		10a
11	Activities	64,102	9,105	735	73,942		73,942		73,942		11
12	Social Services	18,334		3,780	22,114		22,114		22,114		12
13	CNA Training										13
14	Program Transportation			4,296	4,296		4,296		4,296		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,251,186	58,574	25,828	1,335,588		1,335,588		1,335,588		16
	C. General Administration										
17	Administrative	90,704		595,000	685,704		685,704	(346,997)	338,707		17
18	Directors Fees										18
19	Professional Services			36,583	36,583		36,583	7,063	43,646		19
20	Dues, Fees, Subscriptions & Promotions			10,987	10,987		10,987	(1,118)	9,869		20
21	Clerical & General Office Expenses	55,120	16,834	105,842	177,796		177,796	(68,996)	108,800		21
22	Employee Benefits & Payroll Taxes			252,786	252,786		252,786		252,786		22
23	Inservice Training & Education			1,780	1,780		1,780	17	1,797		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			2,417	2,417		2,417	345	2,762		25
26	Insurance-Prop.Liab.Malpractice			89,071	89,071		89,071	1,657	90,728		26
27	Other (specify):*			334,584	334,584		334,584	(330,077)	4,507		27
28	TOTAL General Administration	145,824	16,834	1,429,050	1,591,708		1,591,708	(738,106)	853,602		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,790,380	269,223	1,641,897	3,701,500		3,701,500	(734,661)	2,966,839		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	11,340
	REPAIRS & MAINTENANCE		149
			0
			11,489
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		2,360
			0
			2,360
5	HEAT & OTHER UTILITIES		
	GAS HEAT		44,282
	ELECTRICITY		46,575
	WATER		39,233
	CABLE TV - LOBBY		842
			0
			130,932
6	MAINTENANCE		
	GROUNDS MAINTENANCE		1,950
	PAINTING & DECORATING		353
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		
	EQUIPMENT MAINTENANCE & REPAIR		21,029
	ELEVATOR MAINTENANCE & REPAIR		1,633
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		1,885
	FIRE SERVICE		8,338
			0
			0
			0
			35,188
7	OTHER		
	SCAVENGER		6,840
	SECURITY SERVICE		210
			7,050
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,250
			8,250

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	5,167
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	DENTAL CONSULTANT	XVIII B 47-2	3,600
			0
			8,767
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	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	735
			0
			735
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	3,780
	SOCIAL WORKER	XVIII B 45-2	0
			0
			3,780
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	4,296 4,296
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	595,000 595,000
18	DIRECTORS FEES	0 0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	13,254
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	23,329
		0 36,583
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	335
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	6,125
	LICENSES & PERMITS XIX F	2,790
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	592
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	550
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	595
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0 10,987
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	516
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	48,500
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,183
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	40,643 105,842

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	134,978
	UNEMPLOYMENT COMPENSATION XIX D	37,435
	WORKERS COMPENSATION INSURANCE XIX D	52,996
	HOSPITALIZATION INSURANCE XIX D	25,688
	EMPLOYEE BENEFITS - OTHER XIX D	1,689
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0 252,786
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,780 1,780
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0 0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,417 2,417
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	89,071 89,071
27	OTHER	
	BAD DEBTS VI 24	334,584
		334,584

GRAND TOTAL COLUMN 3 OTHER

1,641,897

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			224,500	224,500		224,500	(19,460)	205,040			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			230,785	230,785		230,785	80,750	311,535			32
33	Real Estate Taxes			183,681	183,681		183,681	61,195	244,876			33
34	Rent-Facility & Grounds			146,400	146,400		146,400	(146,400)				34
35	Rent-Equipment & Vehicles			39,135	39,135		39,135	3,289	42,424			35
36	Other (specify):* OFFICE RENT			8,736	8,736		8,736	(8,736)				36
37	TOTAL Ownership			833,237	833,237		833,237	(29,362)	803,875			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,211	471,465	617,676		617,676		617,676			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		146,211	532,785	678,996		678,996		678,996			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,790,380	415,434	3,007,919	5,213,733		5,213,733	(764,023)	4,449,710			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(54,377)	30		9
10	Interest and Other Investment Income	(4,326)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(528)	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	(550)	20		17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(595)	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	(334,584)	27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(592)	20		28
29	Other-Attach Schedule	(39,490)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (435,042)		\$	30

OHF 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	2	
		Amount	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)	(328,981)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (328,981)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (764,023)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

WOODSIDE EXTENDED CARE

ID# 0043406

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,153	6	1
2	STAFF DEVELOPMENT	(40,643)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(39,490)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSIDE EXTENDED CARE# 0043406 Report Period Beginning:

01/01/2005

Ending: 12/31/2005

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(528)	0	0	0	0	0	0	0	0	0	0	(528)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	879	0	0	0	0	0	0	0	0	0	879	4
5	Heat and Other Utilities	0	0	243	0	0	0	0	0	0	0	0	243	5
6	Maintenance	1,153	1,164	481	0	0	0	0	0	0	0	0	2,798	6
7	Other (specify):*	0	26	27	0	0	0	0	0	0	0	0	53	7
8	TOTAL General Services	625	2,069	751	0	3,445	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	4,700	(351,697)	0	0	0	0	0	0	0	0	(346,997)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,721	342	0	0	0	0	0	0	0	0	7,063	19
20	Fees, Subscriptions & Promotions	(1,737)	619	0	0	0	0	0	0	0	0	0	(1,118)	20
21	Clerical & General Office Expenses	(40,643)	(32,936)	4,583	0	0	0	0	0	0	0	0	(68,996)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	17	0	0	0	0	0	0	0	0	0	17	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	295	50	0	0	0	0	0	0	0	0	345	25
26	Insurance-Prop.Liab.Malpractice	0	1,387	270	0	0	0	0	0	0	0	0	1,657	26
27	Other (specify):*	(334,584)	3,161	1,346	0	0	0	0	0	0	0	0	(330,077)	27
28	TOTAL General Administration	(376,964)	(16,036)	(345,106)	0	(738,106)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(376,339)	(13,967)	(344,355)	0	(734,661)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSIDE EXTENDED CARE# 0043406

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(54,377)	162	924	33,831	0	0	0	0	0	0	0	(19,460)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,326)	0	1,274	83,802	0	0	0	0	0	0	0	80,750	32
33	Real Estate Taxes	0	0	1,195	60,000	0	0	0	0	0	0	0	61,195	33
34	Rent-Facility & Grounds	0	0	0	(146,400)	0	0	0	0	0	0	0	(146,400)	34
35	Rent-Equipment & Vehicles	0	2,866	423	0	0	0	0	0	0	0	0	3,289	35
36	Other (specify):*	0	0	(8,736)	0	0	0	0	0	0	0	0	(8,736)	36
37	TOTAL Ownership	(58,703)	3,028	(4,920)	31,233	0	(29,362)	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)	(435,042)	(10,939)	(349,275)	31,233	0	(764,023)	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
SEE ATTACHED SCHEDULES				IME REALTY	LINCOLNWOOD	HOME OFFICE
				MST REAL ESTATE	LINCOLNWOOD	RENTAL REAL ESTATE

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	4 HOUSEKEEPING	\$	EKS MANAGEMENT		\$ 879	\$ 879	1
2	V	6 MAINTENANCE		" "		1,164	1,164	2
3	V	7 SCAVENGER		" "		26	26	3
4	V	17 CFO SALARY		" "		4,700	4,700	4
5	V	19 PROFESSIONAL FEES		" "		6,721	6,721	5
6	V	20 WANT ADS/BACKGRD CKS		" "		619	619	6
7	V	21 CLERICAL	48,500	" "		15,564	(32,936)	7
8	V	23 SEMINARS		" "		17	17	8
9	V	25 STAFF TRANSPORTATION		" "		295	295	9
10	V	26 INSURANCE		" "		1,387	1,387	10
11	V	27 EMPLOYEE BENEFITS		" "		3,161	3,161	11
12	V	30 SL DEPRECIATION		" "		162	162	12
13	V	35 EQUIPMENT RENT		" "		2,866	2,866	13
14	Total		\$ 48,500			\$ 37,561	\$ * (10,939)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 360,000	EMI ENTERPRISES		\$	\$ (360,000)
16	V	17 OFFICERS SALARY		" "		8,303	8,303
17	V	19 ACCOUNTING FEES		" "		302	302
18	V	21 CLERICAL		" "		4,390	4,390
19	V	25 STAFF TRANSPORTATION		" "		50	50
20	V	26 INSURANCE		" "		124	124
21	V	27 EMPLOYEE BENEFITS		" "		1,346	1,346
22	V	30 SL DEPRECIATION		" "		155	155
23	V	35 AUTO LEASE		" "		252	252
24	V						
25	V	5 UTILITIES		IME REALTY		243	243
26	V	6 REPAIRS/MAINTENANCE		" "		481	481
27	V	7 ALARM SERVICE		" "		27	27
28	V	19 PROFESSIONAL FEES		" "		40	40
29	V	21 OFFICE EXPENSE		" "		193	193
30	V	26 INSURANCE		" "		146	146
31	V	30 SL DEPRECIATION		" "		769	769
32	V	32 INTEREST		" "		1,274	1,274
33	V	33 REAL ESTATE TAX		" "		1,195	1,195
34	V	35 STORAGE FEES		" "		171	171
35	V	36 OFFICE RENT	8,736	" "			(8,736)
36	V						
37	V						
38	V						
39	Total		\$ 368,736			\$ 19,461	\$ * (349,275)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 146,400	MST REAL ESTATE LLC		\$	\$ (146,400)
16	V	30 SL DEPRECIATION		" "		33,831	33,831
17	V	32 INTEREST		" "		83,802	83,802
18	V	33 REAL ESTATE TAX		" "		60,000	60,000
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 146,400			\$ 177,633	\$ * 31,233

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

Facility Name & ID Number

WOODSIDE EXTENDED CARE

0043406

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATION FROM EMI ENTERPRISES:				SEE ATTACHED				\$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT CONSULT	40.00	SCHEDULE	5	6.25	SALARY	8,303	17-7	2
3											3
4											4
5	PHILIP ESFORMES	MGMT CONSULT	MGMT CONSULT	22.50		5	8.06	MGMT FEE	235,000	17-3	5
6											6
7											7
8	ALLOCATION FROM EKS MANAGEMENT:										8
9	AVRUM WEINFELD		CFO			5	8.62	SALARY	4,700	17-7	9
10											10
11											11
12											12
13								TOTAL	\$ 248,003		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 **WOODSIDE EXTENDED CARE**

0043406

Report Period Beginning:

01/01/2005

Ending: **2/31/2005**

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

Name of Related Organization EKS MANAGEMENT
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING	CENSUS DAYS	15 FACILITIES	\$ 19,581	\$ 19,441	40,472	\$ 879	1
2	6	MAINTENANCE	" "	15 FACILITIES	25,925	25,925	40,472	1,164	2
3	7	SCAVENGER	" "	15 FACILITIES	573		40,472	26	3
4	17	CFO SALARY	" "	15 FACILITIES	104,714	104,714	40,472	4,700	4
5	19	PROFESSIONAL FEES	" "	15 FACILITIES	149,759	119,638	40,472	6,721	5
6	20	WANT ADS	" "	15 FACILITIES	13,787		40,472	619	6
7	21	CLERICAL	" "	15 FACILITIES	346,792	248,929	40,472	15,564	7
8	23	SEMINARS	" "	15 FACILITIES	380		40,472	17	8
9	25	STAFF TRANSPORTATION	" "	15 FACILITIES	6,593		40,472	296	9
10	26	INSURANCE	" "	15 FACILITIES	30,900		40,472	1,387	10
11	27	EMPLOYEE BENEFITS	" "	15 FACILITIES	70,423		40,472	3,161	11
12	30	SL DEPRECIATION	" "	15 FACILITIES	3,617		40,472	162	12
13	35	EQUIPMENT RENT	" "	15 FACILITIES	63,848		40,472	2,866	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				\$ 836,892	\$ 518,647		\$ 37,562	25

Facility Name & ID Number **WOODSIDE EXTENDED CARE**

0043406

Report Period Beginning:

01/01/2005

Ending: **2/31/2005**

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

Name of Related Organization EMI ENTERPRISES
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	901,761	15 FACILITIES	\$ 185,000	\$ 185,000	40,472	\$ 8,303	1
2	19	ACCOUNTING FEES	901,761	15 FACILITIES	6,725		40,472	302	2
3	21	CLERICAL	901,761	15 FACILITIES	97,823	79,576	40,472	4,390	3
4	25	STAFF TRANSPORTATION	901,761	15 FACILITIES	1,114		40,472	50	4
5	26	INSURANCE	901,761	15 FACILITIES	2,768		40,472	124	5
6	27	EMPLOYEE BENEFITS	901,761	15 FACILITIES	29,997		40,472	1,346	6
7	35	DEPRECIATION	901,761	15 FACILITIES	3,451		40,472	155	7
8	35	AUTO LEASE	901,761	15 FACILITIES	5,617		40,472	252	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				\$ 332,495	\$ 264,576		\$ 14,922	25

Facility Name & ID Number **WOODSIDE EXTENDED CARE**

0043406 Report Period Beginning: **01/01/2005**

Ending: **2/31/2005**

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

Name of Related Organization IME REALTY
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	346,361	15 + FACIL	\$ 9,618	\$	8,736	\$ 243	1
2	6	REPAIRS/MAINTENANCE	346,361	15 + FACIL	19,083		8,736	481	2
3	7	ALARM FEES	346,361	15 + FACIL	1,056		8,736	27	3
4	19	PROFESSIONAL FEES	346,361	15 + FACIL	1,575		8,736	40	4
5	21	OFFICE EXPENSE	346,361	15 + FACIL	7,666		8,736	193	5
6	26	INSURANCE	346,361	15 + FACIL	5,806		8,736	146	6
7	30	SL DEPRECIATION	346,361	15 + FACIL	30,446		8,736	769	7
8	32	INTEREST	346,361	15 + FACIL	50,514		8,736	1,274	8
9	33	REAL ESTATE TAX	346,361	15 + FACIL	47,364		8,736	1,195	9
10	35	STORAGE FEES	346,361	15 + FACIL	6,785		8,736	171	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				\$ 179,913	\$		\$ 4,539	25

Facility Name & ID Number

WOODSIDE EXTENDED CARE

0043406

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	US BANK		X	MORTGAGE		04/04	\$ 4,588,000	\$	04/09		\$ 176,623	1						
2	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		04/04	35,360		04/09		30,645	2						
3	RELATED PARTY: MST REAL ESTATE LLC																	
4	CAMBRIDGE REALTY		X	MORTGAGE	\$52,947.11	09/05	4,919,200	4,908,016	09/35	5.3100	81,923	4						
5	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		09/05	172,440	170,561	09/35		1,879	5						
Working Capital																		
6	FIRST BANK		X	WORKING CAPITAL	\$5,000+INTEREST		310,000	250,000		PRIME+	19,003	6						
7	US BANK		X	WORKING CAPITAL-LOC	DEMAND		207,000			PRIME+	4,514	7						
8	RELATED PARTY: IME REALTY		X	MORTGAGE							1,274	8						
9	TOTAL Facility Related				\$52,947.11		\$ 10,232,000	\$ 5,328,577			\$ 315,861	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 10,232,000	\$ 5,328,577			\$ 315,861	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.		\$	236,110	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.)		\$	238,701	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,591	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	241,090	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.		\$	243,681	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	232,727	8
	2001	245,999	9
	2002	253,088	10
	2003	233,772	11
	2004	238,701	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED

ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

INCLUDES RELATED PARTY MST REAL ESTATE LLC

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOODSIDE EXTENDED CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043406

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>32-29-401-011-0000</u>	<u>NURSING HOME</u>	\$ <u>238,700.50</u>	\$ <u>238,700.50</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>238,700.50</u>	\$ <u>238,700.50</u>

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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number WOODSIDE EXTENDED CARE

0043406

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,900 B. General Construction Type: Exterior CONCRETE Frame METAL/CONCRETE Number of Stories 1 + BASEMENT

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>2004</u>	<u>\$ 229,826</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 229,826	3

Facility Name & ID Number **WOODSIDE EXTENDED CARE**# **0043406**

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	112	2004		\$ 4,142,702	\$ 150,629	27.5	\$ 150,629	\$	\$ 257,345	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	CEILING LIGHTING		1997	3,746	96	39	96		780	9
10	WATER SOFTENING SYSTEM		1997	6,926	178	39	178		1,446	10
11	FLOORING		1997	3,910	100	39	100		804	11
12	FLOORING / DOORS / WINDOWS		1998	29,194	748	39	748		5,710	12
13	ROOF		1998	84,450	2,165	39	2,165		17,053	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.		1998	30,915	793	39	793		6,255	14
15	PAINTING / DECORATING		1998	15,111	387	39	387		2,919	15
16	FLOORING / DOORS / BATHROOM FIXTURES		1999	11,198	288	39	288		1,996	16
17	CHAIN LINK FENCE		1999	5,100	131	39	131		846	17
18	FLOOR TILES/COVE BASE		2000	22,766	828	27.5	828		4,933	18
19	PAIR OF ALUMINUM DOORS		2000	2,193	80	27.5	80		463	19
20	PLUMBING		2000	9,913	360	27.5	360		1,845	20
21	PLUMBING / VANITY / SINK / FLOORING		2001	37,788	1,374	27.5	1,374		6,498	21
22	DRAPERIES		2001	7,578	873	10	758	(115)	3,411	22
23	PAVING		2002	18,562	675	27.5	675		2,391	23
24	BATHROOM SINKS		2002	3,888	141	27.5	141		429	24
25	BATHROOM SINKS		2003	7,776	283	27.5	283		837	25
26	FLOORING / CARPETING & TILE		2003	13,887	504	27.5	504		1,125	26
27	ROOF		2003	7,800	284	27.5	284		745	27
28	FENCE		2003	9,500	634	15	634		1,584	28
29	WINDOWS		2004	46,880	1,705	27.5	1,705		2,771	29
30	CUBICLE CURTAINS/FLOORING		2004	33,108	5,297	10	3,311	(1,986)	4,966	30
31	NOTE: ABOVE ITEMS INCLUDE RELATED PARTY SL DEPN									
32	PATIO/FLOORING/TILE/LIGHTING/FIRE PANEL/ROOF AC		2005	30,694	356	27.5	356		356	32
33										33
34	RELATED PARTY ALLOCATION - IME REALTY			25,771	739		739			34
35										35
36										36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			4,611,356		167,547	(2,101)	327,508	

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

Facility Name & ID Number **WOODSIDE EXTENDED CARE**

0043406

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 399,061	\$ 84,794	\$ 36,319	\$ (48,475)	8-15 YRS	\$ 107,031	71
72	Current Year Purchases	23,140	4,628	827	(3,801)	8-10 YRS	827	72
73	Fully Depreciated Assets	3,241					3,241	73
74	RELATED PARTY ALLOC - EKS MGMT 162/EMI ENTERP 155/IME REALTY 30		347	347				74
75	TOTALS	\$ 425,442	\$ 89,769	\$ 37,493	\$ (52,276)		\$ 111,099	75

D. Vehicle Depreciation (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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,266,624	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 259,417	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 205,040	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (54,377)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 438,607	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.

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	FACILITY REAL ESTATE TRANSFERRED TO RELATED PARTY							
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: _____*

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: \$ **21,292** Description: **SEE SCHEDULE 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 USE:	'04 CHRYSLER TOWN&	\$ 699.93	\$ 4,235	17
18	BANKING,MAINT,	05 BMW X53	695.00	5,703	18
19	MARKETING, NSG,	'03 FORD ECOLINE WAGON	658.77	7,905	19
20	ACTIVITIES				20
21	TOTAL		\$ #####	\$ 17,843	21

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. _____/2006 \$ _____

13. _____/2007 \$ _____

14. _____/2008 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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	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	39-3	hrs	\$		\$ 232,658	\$		\$ 232,658	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			359			359	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			238,448			238,448	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 prescripts				129,048		129,048	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES, Other (specify): RADIOLOGY/LAB	39-2					17,163		17,163	13
14	TOTAL			\$		\$ 471,465	\$ 146,211		\$ 617,676	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 WOODSIDE EXTENDED CARE

0043406

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 189,357	\$ 193,980	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,000)	679,033	679,033	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,918	145,497	6
7	Other Prepaid Expenses	153,452	153,452	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>R.E.TAX ESCROW</u>	125,750	286,529	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,254,510	\$ 1,458,491	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		229,826	13
14	Buildings, at Historical Cost		4,142,702	14
15	Leasehold Improvements, at Historical Cost	63,802	435,305	15
16	Equipment, at Historical Cost	433,019	433,019	16
17	Accumulated Depreciation (book methods)	(316,536)	(635,311)	17
18	Deferred Charges		170,561	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>REPLACEMENT RESERVE</u>		173,844	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 180,285	\$ 4,949,946	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,434,795	\$ 6,408,437	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 335,124	\$ 335,124	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,094	4,094	28
29	Short-Term Notes Payable	250,000	250,000	29
30	Accrued Salaries Payable	63,415	63,415	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,480	26,480	31
32	Accrued Real Estate Taxes(Sch.IX-B)	181,090	241,090	32
33	Accrued Interest Payable		21,718	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MEMBERS' LOANS</u>	465,723	465,723	36
37	<u>DUE TO MST REAL ESTATE LLC</u>	9,365		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,335,291	\$ 1,407,644	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,908,016	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)	\$	\$ 4,908,016	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,335,291	\$ 6,315,660	46
47	TOTAL EQUITY(page 18, line 24)	\$ 99,504	\$ 92,777	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,434,795	\$ 6,408,437	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 263,019	1
2	Restatements (describe):		2
3			3
4	ROUNDING	4	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 263,023	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	706,481	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	(870,000)	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)	\$ (163,519)	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)	\$ 99,504	24 *

* This must agree with page 17, line 47.

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,677,120	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,677,120	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	240,321	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 240,321	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***	4,326	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,326	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)	\$ 5,921,767	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	774,204	31
32	Health Care	1,335,588	32
33	General Administration	1,591,708	33
	B. Capital Expense		
34	Ownership	833,237	34
	C. Ancillary Expense		
35	Special Cost Centers	617,676	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,213,733	40
41	Income before Income Taxes (line 30 minus line 40)**	708,034	41
42	Income Taxes	(1,553)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 706,481	43

* 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.

TAX RETURN PREPARED ON CASH BASIS

*** 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 WOODSIDE EXTENDED CARE

0043406

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,814	1,820	\$ 52,698	\$ 28.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,832	4,918	97,160	19.76	3
4	Licensed Practical Nurses	15,453	15,903	295,850	18.60	4
5	CNAs & Orderlies	52,788	56,558	477,994	8.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,848	6,415	93,041	14.50	8
9	Activity Director					9
10	Activity Assistants	7,619	8,125	64,102	7.89	10
11	Social Service Workers	2,094	2,229	18,334	8.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,877	15,774	124,275	7.88	15
16	Dishwashers					16
17	Maintenance Workers	8,319	8,421	72,098	8.56	17
18	Housekeepers	14,506	15,063	110,708	7.35	18
19	Laundry	4,963	5,222	34,524	6.61	19
20	Administrator	2,080	2,080	90,704	43.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,303	5,717	55,120	9.64	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	1,674	1,762	13,756	7.81	31
32	Other Health C: <u>MDS/QA/ADMISS</u>	9,870	10,073	138,251	13.72	32
33	Other(specify) <u>TRANSPRT/SECU</u>	6,495	6,691	51,765	7.74	33
34	TOTAL (lines 1 - 33)	158,535	166,771	\$ 1,790,380 *	\$ 10.74	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 11,340	1-3	35
36	Medical Director	8,250	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,167	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	735	11-3	44
45	Social Service Consultant	3,780	12-3	45
46	Other(specify)			46
47	<u>DENTAL CONSULTANT</u>	3,600	10-3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 32,872		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DEBBIE MASSEY	ADMIN		\$ 90,704	Workers' Compensation Insurance	\$ 52,996	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	37,435	Advertising: Employee Recruitment	335	
				FICA Taxes	134,978	Health Care Worker Background Check	0	
				Employee Health Insurance	25,688	(Indicate # of checks performed)		
				Employee Meals	0	MARKETING/ADV/PROMO	592	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,145	
				EMPLOYEE BENEFITS - OTHER	1,689	LICENSES & PERMITS	800	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	6,125	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	619	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,145)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(0)	
						Yellow page advertising	(592)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,704	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 252,786		\$ 9,869		
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
EMI ENTERPRISES			\$ 360,000				Out-of-State Travel	\$
PHILIP ESFORMES			235,000					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 595,000				Seminar Expense	0
C. Professional Services			TOTAL			Entertainment Expense		
Vendor/Payee	Type		Amount			Amount	()	
ALPHA DATA	DATA PROCESSING		\$ 4,174					
HDSI	DATA PROCESSING		6,211					
LTC SOLUTION	DATA PROCESSING		1,320					
MAXX SOURCE	DATA PROCESSING		805					
MUTUAL OF OMAHA	DATA PROCESSING		744					
KBKB	ACCOUNTING FEES		15,900					
ADDUCCI,DORF,ET AL	LEGAL FEES		936					
LAWRENCE SCHWARTZ	LEGAL FEES		846					
PERSONNEL PLANNERS	EMPLOYMENT CONSULT		1,147					
RICHARD PEELO	MEDICARE COST REPORT		4,500					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 36,583	\$			TOTAL (agree to Sch. V, line 24, col. 8)	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATING	2004	\$ 3,458	3	\$	\$	\$ 576	\$ 1,153	\$ 1,153	\$ 576	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
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12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 3,458		\$	\$	\$ 576	\$ 1,153	\$ 1,153	\$ 576	\$	\$								

Facility Name & ID Number WOODSIDE EXTENDED CARE# 0043406Report Period Beginning: 01/01/2005Ending: 12/31/2005**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. IL COUNCIL LONG TERM CARE \$ 6,125
- (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. \$ 1,578 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,320
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. \$ 0 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? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees