



Facility Name & ID Number WOODSIDE EXTENDED CARE

# 0043406 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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			3,890	3,890	8
9	SNF/PED					9
10	ICF	36,254	300		36,554	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,254	300	3,890	40,444	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.93%

D. How many bed-hold days during this year were paid by the Department? 76 (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 \_\_\_\_\_

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **WOODSIDE EXTENDED CARE** # **0043406** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

**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
	<b>A. General Services</b>										
1	Dietary	132,605	14,730	11,835	159,170		159,170	0	159,170		1
2	Food Purchase		138,174		138,174	(14,746)	123,428	(443)	122,985		2
3	Housekeeping	98,440	16,504	0	114,944		114,944	0	114,944		3
4	Laundry	37,665	11,649	7,148	56,462		56,462	913	57,375		4
5	Heat and Other Utilities			110,293	110,293		110,293	264	110,557		5
6	Maintenance	69,303	11,549	27,764	108,616		108,616	4,355	112,971		6
7	Other (specify):* <b>TRANSP/SECURITY</b>	44,751		6,693	51,444		51,444	66	51,510		7
8	<b>TOTAL General Services</b>	<b>382,764</b>	<b>192,606</b>	<b>163,733</b>	<b>739,103</b>	<b>(14,746)</b>	<b>724,357</b>	<b>5,155</b>	<b>729,512</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		9,000	9,000		9,000	0	9,000		9
10	Nursing and Medical Records	1,103,206	53,294	6,955	1,163,455		1,163,455	0	1,163,455		10
10a	Therapy	104,159		57	104,216		104,216	0	104,216		10a
11	Activities	56,060	10,292	0	66,352		66,352	0	66,352		11
12	Social Services	17,500		4,482	21,982		21,982	0	21,982		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			4,460	4,460		4,460	0	4,460		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,280,925</b>	<b>63,586</b>	<b>24,954</b>	<b>1,369,465</b>	<b>0</b>	<b>1,369,465</b>	<b>0</b>	<b>1,369,465</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	91,256		344,000	435,256		435,256	(188,678)	246,578		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			40,185	40,185		40,185	18,456	58,641		19
20	Dues, Fees, Subscriptions & Promotions			8,621	8,621		8,621	(30)	8,591		20
21	Clerical & General Office Expenses	88,786	18,419	96,513	203,718		203,718	(86,429)	117,289		21
22	Employee Benefits & Payroll Taxes			255,465	255,465	14,746	270,211	0	270,211		22
23	Inservice Training & Education			1,695	1,695		1,695	0	1,695		23
24	Travel and Seminar			0	0		0	5	5		24
25	Other Admin. Staff Transportation			6,863	6,863		6,863	536	7,399		25
26	Insurance-Prop.Liab.Malpractice			137,572	137,572		137,572	434	138,006		26
27	Other (specify):*			161,029	161,029		161,029	(155,507)	5,522		27
28	<b>TOTAL General Administration</b>	<b>180,042</b>	<b>18,419</b>	<b>1,051,943</b>	<b>1,250,404</b>	<b>14,746</b>	<b>1,265,150</b>	<b>(411,213)</b>	<b>853,937</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,843,731</b>	<b>274,611</b>	<b>1,240,630</b>	<b>3,358,972</b>	<b>0</b>	<b>3,358,972</b>	<b>(406,058)</b>	<b>2,952,914</b>		<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	11,835
	REPAIRS & MAINTENANCE	0
		0
		11,835
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	7,148
		0
		7,148
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	27,987
	ELECTRICITY	40,092
	WATER	41,238
	CABLE TV - LOBBY	976
		0
		110,293
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	1,870
	PAINTING & DECORATING	683
	BUILDING REPAIRS	575
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	10,967
	ELEVATOR MAINTENANCE & REPAIR	1,598
	OUTSIDE LABOR	207
	EXTERMINATING SERVICE	2,209
	FIRE SERVICE	9,655
		0
		0
		0
		0
		27,764
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	6,525
	SECURITY SERVICE	168
		0
		0
		6,693
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	223
	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	5,232
	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	1,500
		0
		6,955
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	57
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		57
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	4,482
	SOCIAL WORKER XVIII B 45-2	0
		0
		4,482
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	4,460
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	344,000
<b>18</b>	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	13,871
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	26,314
		0
		40,185
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	604
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	3,895
	LICENSES & PERMITS XIX F	1,357
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	500
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,265
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		8,621
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	54,500
	PENALTIES / OVERDRAFT CHARGES VI 18	90
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,117
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	25,806
		96,513

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	138,988
	UNEMPLOYMENT COMPENSATION XIX D	37,454
	WORKERS COMPENSATION INSURANC XIX D	55,626
	HOSPITALIZATION INSURANCE XIX D	23,397
	EMPLOYEE BENEFITS - OTHER XIX D	0
	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
		0
		255,465
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,695
		1,695
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	6,863
		6,863
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	137,572
		137,572
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	161,029
		161,029

GRAND TOTAL COLUMN 3 OTHER

1,240,630

**EQUIPMENT RENTAL**  
**PAGE 14 XII. B. LINE 16**

KREG THERAPEUTIC	THERAPUTIC BED	2,457
PRO-CARE	THERAPUTIC BED	1,860
GREAT AMERICA LEASING	COPIER	2,355
ILLINOIS BUSINESS SYSTEM	COPIER	958
MEIKEM	DISHWASHER	1,430
PI SURVEILLANCE	TV SECURITY MONITOR	9,000
PITNEY BOWES	POSTAGE METER	546
PUBLIC STORAGE	STORAGE	1,899
	<b>EQUIPMENT RENTAL</b>	<b>20,505</b>

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

TOTAL FOOD PURCHASE	138,174
LESS SALES TAX	(443)
NET FOOD	137,731
TOTAL PATIENT CENSUS	40,444
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	121332
ADD # EMPLOYEE MEALS/DAY	40
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	14600
PATIENT MEALS	121332
ADD EMPLOYEE MEALS	14600
TOTAL MEALS/YEAR	135932
NET FOOD	137731
DIVIDE TOTAL MEALS/YEAR	135932
COST PER MEAL	1.01
TIME EMPLOYEE MEALS	14600
EMPLOYEE MEAL RECLASSIFIC	14746

**STAFF TRANSPORTATION**  
**PAGE 3 V. LINE 25**

	NAME	DESCRIPTION	DEPARTMENT	AMOUNT
JAN	DONALD CANTELO	EMPLOYEE REIMBURSEMNT	MAINTENANCE	128
JAN	SEBASTIAN BUJAK	PAYROLL REIMBURSEMNT	PAINTERS	30
JAN	PAWEL WAISILOWSKI	PAYROLL REIMBURSEMNT	PAINTERS	30
FEB	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation	266
FEB	DONALD CANTELO	EMPLOYEE REIMBURSEMNT	MAINTENANCE	119
FEB	SEBASTIAN BUJAK	PAYROLL REIMBURSEMNT	PAINTERS	30
FEB	STANISLAW, OLECH	PAYROLL REIMBURSEMNT	PAINTERS	30
JAN	PAWEL WAISILOWSKI	PAYROLL REIMBURSEMNT	PAINTERS	30
MAR	DONALD CANTELO	EMPLOYEE REIMBURSEMNT	MAINTENANCE	128
MAR	FLEET SERVICES	GASOLINE	FACILITY VAN	3,866
MAR	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation	306
APR	DONALD CANTELO	EMPLOYEE REIMBURSEMNT	MAINTENANCE	129
MAY	DONALD CANTELO	EMPLOYEE REIMBURSEMNT	MAINTENANCE	112
MAY	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation	349
JUNE	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation	355
JULY	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation	215
AUG	DONALD CANTELO	EMPLOYEE REPAYMENT	MAINTENANCE	(455)
SEPT	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation	397
NOV	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation	352
DEC	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation	135
DEC	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation	311
		<b>TOTAL FACILITY STAFF TRANSPORTATION</b>		<b>6,863</b>
		MGMT CO ALLOCATION		536
		<b>TOTAL STAFF TRANSPORTATION</b>		<b>7,399</b>

Facility Name &amp; ID Number

WOODSIDE EXTENDED CARE

#0043406

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	
	<b>D. Ownership</b>											
30	Depreciation			65,445	65,445		65,445	142,769	208,214			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			35,124	35,124		35,124	325,341	360,465			32
33	Real Estate Taxes			(9,997)	(9,997)		(9,997)	275,085	265,088			33
34	Rent-Facility & Grounds			621,900	621,900		621,900	(621,900)	0			34
35	Rent-Equipment & Vehicles			48,820	48,820		48,820	2,747	51,567			35
36	Other (specify):* OFFICE RENT			8,736	8,736		8,736	(8,736)	0			36
37	<b>TOTAL Ownership</b>			770,028	770,028	0	770,028	115,306	885,334			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		69,247	258,111	327,358		327,358	0	327,358			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			61,320	61,320		61,320	0	61,320			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	69,247	319,431	388,678	0	388,678	0	388,678			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,843,731	343,858	2,330,089	4,517,678	0	4,517,678	(290,752)	4,226,926			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	(20,747)	30		9
10	Interest and Other Investment Income	(123)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(443)	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	(500)	20		17
18	Fines and Penalties	(90)	21		18
19	Entertainment				19
20	Contributions	(2,265)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(161,029)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(54,653)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (239,850)		\$ 0	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(50,902)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (50,902)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (290,752)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

WOODSIDE EXTENDED CARE

ID# 0043406

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,153	6	1
2	STAFF DEVELOPMENT	(25,806)	21	2
3	MARKETING SALARIES	(30,000)	21	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	<b>Total</b>	(54,653)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSIDE EXTENDED CARE# 0043406

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	(443)	0	0	0	0	0	0	0	0	0	0	(443)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	913	0	0	0	0	0	0	0	0	0	913	4
5	Heat and Other Utilities	0	0	264	0	0	0	0	0	0	0	0	264	5
6	Maintenance	1,153	1,215	1,987	0	0	0	0	0	0	0	0	4,355	6
7	Other (specify):*	0	39	27	0	0	0	0	0	0	0	0	66	7
8	<b>TOTAL General Services</b>	<b>710</b>	<b>2,167</b>	<b>2,278</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,155</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	5,705	(194,383)	0	0	0	0	0	0	0	0	(188,678)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,056	900	11,500	0	0	0	0	0	0	0	18,456	19
20	Fees, Subscriptions & Promotions	(2,765)	2,735	0	0	0	0	0	0	0	0	0	(30)	20
21	Clerical & General Office Expenses	(55,896)	(39,305)	8,772	0	0	0	0	0	0	0	0	(86,429)	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	5	0	0	0	0	0	0	0	0	0	5	24
25	Other Admin. Staff Transportation	0	299	237	0	0	0	0	0	0	0	0	536	25
26	Insurance-Prop.Liab.Malpractice	0	185	249	0	0	0	0	0	0	0	0	434	26
27	Other (specify):*	(161,029)	4,329	1,193	0	0	0	0	0	0	0	0	(155,507)	27
28	<b>TOTAL General Administration</b>	<b>(219,690)</b>	<b>(19,991)</b>	<b>(183,032)</b>	<b>11,500</b>	<b>0</b>	<b>(411,213)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(218,980)</b>	<b>(17,824)</b>	<b>(180,754)</b>	<b>11,500</b>	<b>0</b>	<b>(406,058)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSIDE EXTENDED CARE# 0043406

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	(20,747)	181	952	162,383	0	0	0	0	0	0	0	142,769	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(123)	0	1,553	323,911	0	0	0	0	0	0	0	325,341	32
33	Real Estate Taxes	0	0	1,114	273,971	0	0	0	0	0	0	0	275,085	33
34	Rent-Facility & Grounds	0	0	0	(621,900)	0	0	0	0	0	0	0	(621,900)	34
35	Rent-Equipment & Vehicles	0	2,151	596	0	0	0	0	0	0	0	0	2,747	35
36	Other (specify):*	0	0	(8,736)	0	0	0	0	0	0	0	0	(8,736)	36
37	<b>TOTAL Ownership</b>	<b>(20,870)</b>	<b>2,332</b>	<b>(4,521)</b>	<b>138,365</b>	<b>0</b>	<b>115,306</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(239,850)</b>	<b>(15,492)</b>	<b>(185,275)</b>	<b>149,865</b>	<b>0</b>	<b>(290,752)</b>	<b>45</b>						

**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 LLC		RENTAL REAL
					LINCOLNWOOD	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	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)	
1	V	4 HOUSEKEEPING	\$	EKS MANAGEMENT		\$ 913	\$ 913	1
2	V	6 MAINTENANCE		" "		1,215	1,215	2
3	V	7 SCAVENGER		" "		39	39	3
4	V	17 CFO SALARY		" "		5,705	5,705	4
5	V	19 PROFESSIONAL FEES		" "		6,056	6,056	5
6	V	20 WANT ADS/BACKGRD CKS		" "		2,735	2,735	6
7	V	21 CLERICAL	54,500	" "		15,195	(39,305)	7
8	V	24 IN-STATE TRAVEL		" "		5	5	8
9	V	25 STAFF TRANSPORTATION		" "		299	299	9
10	V	26 INSURANCE		" "		185	185	10
11	V	27 EMPLOYEE BENEFITS		" "		4,329	4,329	11
12	V	30 SL DEPRECIATION		" "		181	181	12
13	V	35 EQUIPMENT RENT		" "		2,151	2,151	13
14	Total		\$ 54,500			\$ 39,008	\$ * (15,492)	14

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

Facility Name &amp; ID Number

WOODSIDE EXTENDED CARE

# 0043406

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	\$ 204,000	EMI ENTERPRISES		\$	\$ (204,000)
16	V	17 OFFICERS SALARY		" "		9,617	9,617
17	V	19 ACCOUNTING FEES		" "		860	860
18	V	21 CLERICAL		" "		8,723	8,723
19	V	25 STAFF TRANSPORTATION		" "		237	237
20	V	26 INSURANCE		" "		138	138
21	V	27 EMPLOYEE BENEFITS		" "		1,193	1,193
22	V	30 SL DEPRECIATION		" "		179	179
23	V	35 AUTO LEASE		" "		340	340
24	V	6 DRIVERS SALARY		" "		1,506	1,506
25	V			IME REALTY			
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		" "		49	49
30	V	26 INSURANCE		" "		111	111
31	V	30 SL DEPRECIATION		" "		773	773
32	V	32 INTEREST		" "		1,553	1,553
33	V	33 REAL ESTATE TAX		" "		1,114	1,114
34	V	35 STORAGE FEES		" "		256	256
35	V	36 OFFICE RENT	8,736	" "			(8,736)
36	V	5 UTILITIES		" "		264	264
37	V						
38	V						
39	Total		\$ 212,736			\$ 27,461	\$ * (185,275)

\* 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	\$ 621,900	MST REAL ESTATE LLC		\$	\$(621,900)
16	V	30 SL DEPRECIATION		" "		162,383	162,383
17	V	32 INTEREST		" "		261,273	261,273
18	V	32 MIP INSURANCE		" "		62,638	62,638
19	V	33 REAL ESTATE TAX		" "		273,971	273,971
20	V	19 ACCOUNTING FEES		" "		11,500	11,500
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		\$ 621,900			\$ 771,765	\$ * 149,865

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

Facility Name &amp; ID Number

WOODSIDE EXTENDED CARE

# 0043406

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	<b>ALLOCATION FROM EMI ENTERPRISES:</b>				<b>SEE ATTACHED</b>				\$		1
2	<b>MORRIS ESFORMES</b>	<b>PRESIDENT</b>	<b>MGMT CONSULT</b>	<b>40.00</b>	<b>SCHEDULE</b>	<b>5</b>	<b>6.25</b>	<b>SALARY</b>	<b>9,617</b>	<b>17-7</b>	2
3											3
4											4
5	<b>PHILIP ESFORMES</b>	<b>MGMT CONSULT</b>	<b>MGMT CONSULT</b>	<b>22.50</b>		<b>5</b>	<b>8.06</b>	<b>MGMT FEE</b>	<b>140,000</b>	<b>17-3</b>	5
6											6
7											7
8	<b>ALLOCATION FROM EKS MANAGEMENT:</b>										8
9	<b>AVRUM WEINFELD</b>		<b>CFO</b>	<b>0.00</b>		<b>5</b>	<b>8.62</b>	<b>SALARY</b>	<b>5,705</b>	<b>17-7</b>	9
10											10
11											11
12											12
13								<b>TOTAL</b>	<b>\$ 155,322</b>		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:

**01/01/2006**

Ending: **2/31/2006**

**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	863,827	14 FACILITIES	\$ 19,500	\$ 19,500	40,444	\$ 913	1
2	6	MAINTENANCE	863,827	14 FACILITIES	25,953	25,953	40,444	1,215	2
3	7	SCAVENGER	863,827	14 FACILITIES	825		40,444	39	3
4	17	CFO SALARY	863,827	14 FACILITIES	121,844	121,844	40,444	5,705	4
5	19	PROFESSIONAL FEES	863,827	14 FACILITIES	129,352	110,503	40,444	6,056	5
6	20	WANT ADS/BACKGRND CHKS	863,827	14 FACILITIES	58,423		40,444	2,735	6
7	21	CLERICAL	863,827	14 FACILITIES	324,544	218,865	40,444	15,195	7
8	24	IN-STATE TRAVEL	863,827	14 FACILITIES	112		40,444	5	8
9	25	STAFF TRANSPORTATION	863,827	14 FACILITIES	6,388		40,444	299	9
10	26	INSURANCE	863,827	14 FACILITIES	3,958		40,444	185	10
11	27	EMPLOYEE BENEFITS	863,827	14 FACILITIES	92,462		40,444	4,329	11
12	30	SL DEPRECIATION	863,827	14 FACILITIES	3,880		40,444	181	12
13	35	EQUIPMENT RENT	863,827	14 FACILITIES	45,937		40,444	2,151	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				\$ 833,178	\$ 496,665		\$ 39,008	25

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

# **0043406** Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

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	778,042	14 FACILITIES	\$ 185,000	\$ 185,000	40,444	\$ 9,617	1
2	19	ACCOUNTING FEES	778,042	14 FACILITIES	16,537		40,444	860	2
3	21	CLERICAL	778,042	14 FACILITIES	167,811	132,028	40,444	8,723	3
4	25	STAFF TRANSPORTATION	778,042	14 FACILITIES	4,565		40,444	237	4
5	26	INSURANCE	778,042	14 FACILITIES	2,648		40,444	138	5
6	27	EMPLOYEE BENEFITS	778,042	14 FACILITIES	80,669		40,444	4,193	6
7	35	DEPRECIATION	778,042	14 FACILITIES	3,451		40,444	179	7
8	35	AUTO LEASE	778,042	14 FACILITIES	6,544		40,444	340	8
9	6	DRIVERS SALARY	778,042	14 FACILITIES	28,965	28,965	40,444	1,506	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				\$ 496,190	\$ 345,993		\$ 25,793	25

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

# **0043406** Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

**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	344,402	14+FACILITIE	\$ 10,404	\$	8,736	\$ 264	1
2	6	REPAIRS/MAINTENANCE	344,402	14+FACILITIES	18,957		8,736	481	2
3	7	ALARM FEES	344,402	14+FACILITIES	1,056		8,736	27	3
4	19	PROFESSIONAL FEES	344,402	14+FACILITIES	1,575		8,736	40	4
5	21	OFFICE EXPENSE	344,402	14+FACILITIES	1,942		8,736	49	5
6	26	INSURANCE	344,402	14+FACILITIES	4,387		8,736	111	6
7	30	SL DEPRECIATION	344,402	14+FACILITIES	30,446		8,736	773	7
8	32	INTEREST	344,402	14+FACILITIES	61,229		8,736	1,553	8
9	33	REAL ESTATE TAX	344,402	14+FACILITIES	43,904		8,736	1,114	9
10	35	STORAGE FEES	344,402	14+FACILITIES	10,073		8,736	256	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				\$ 183,973	\$		\$ 4,668	25

Facility Name & ID Number

**WOODSIDE EXTENDED CARE**

# **0043406**

Report Period Beginning:

**01/01/2006**

Ending:

**12/31/2006**

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	RELATED PARTY: MST REAL ESTATE LLC						\$	\$			\$	1						
2	CAMBRIDGE REALTY		X	MORTGAGE	\$52,947.11	09/05	4,919,200		09/35	5.3100	258,641	2						
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		09/05	172,440	167,929	09/35		2,632	3						
4	MIP INSURANCE										62,638	4						
5	RELATED PARTY: IME REALTY	X		MORTGAGE							1,553	5						
<b>Working Capital</b>																		
6	FIRST BANK		X	WORKING CAPITAL	\$5,000+INTEREST		310,000	189,991		PRIME+	16,881	6						
7	US BANK		X	WORKING CAPITAL-LOC	DEMAND		207,000	0		PRIME+	17,025	7						
8	HEALTHCAP RRG		X	INSURANCE FINANCING							1,218	8						
9	TOTAL Facility Related				\$52,947.11		\$ 5,608,640	\$ 357,920			\$ 360,588	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12											261,273	12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$	14						
15	TOTALS (line 9+line14)						\$ 5,608,640	\$ 357,920			\$ 360,588	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 62,638      Line # 32-7

\* 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 2005 report.		\$	<b>241,090</b>	<b>1</b>
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.)		\$	<b>248,800</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>7,710</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>256,264</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>263,974</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2001</b>	<b>245,999</b>	<b>8</b>
	<b>2002</b>	<b>253,088</b>	<b>9</b>
	<b>2003</b>	<b>233,772</b>	<b>10</b>
	<b>2004</b>	<b>238,701</b>	<b>11</b>
	<b>2005</b>	<b>248,800</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2005 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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.

**2005 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 2005 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 2005.

(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>248,800.19</u>	\$ <u>248,800.19</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>248,800.19</u>	\$ <u>248,800.19</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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 WOODSIDE EXTENDED CARE

# 0043406

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

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

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>RELATED PARTY-MST REAL ESTATE LLC:</u>			\$	<u>1</u>
2	<u>NURSING HOME</u>		<u>2004</u>	<u>229,826</u>	<u>2</u>
3	<b>TOTALS</b>			\$ <u>229,826</u>	<u>3</u>

Facility Name &amp; ID Number WOODSIDE EXTENDED CARE

# 0043406

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	RELATED PARTY-MST REAL ESTATE LLC:			\$	\$		\$	\$	\$	4
5	112	2004		4,142,702	150,629	27.5	150,629		407,974	5
6										6
7										7
8	RELATED PARTY-MST REAL ESTATE LLC-SL DEPN:									8
	<b>Improvement Type**</b>									
9	CEILING LIGHTING		1997	3,746	96	39	96		876	9
10	WATER SOFTENING SYSTEM		1997	6,926	178	39	178		1,624	10
11	FLOORING		1997	3,910	100	39	100		904	11
12	FLOORING / DOORS / WINDOWS		1998	29,194	748	39	748		6,458	12
13	ROOF		1998	84,450	2,165	39	2,165		19,218	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.		1998	30,915	793	39	793		7,048	14
15	PAINTING / DECORATING		1998	15,111	387	39	387		3,306	15
16	FLOORING / DOORS / BATHROOM FIXTURES		1999	11,198	288	39	288		2,284	16
17	CHAIN LINK FENCE		1999	5,100	131	39	131		977	17
18	FLOOR TILES/COVE BASE		2000	22,766	828	27.5	828		5,761	18
19	PAIR OF ALUMINUM DOORS		2000	2,193	80	27.5	80		543	19
20	PLUMBING		2000	9,913	360	27.5	360		2,205	20
21	PLUMBING / VANITY / SINK / FLOORING		2001	37,788	1,374	27.5	1,374		7,872	21
22	PAVING		2002	18,562	675	27.5	675		3,066	22
23	BATHROOM SINKS		2002	3,888	141	27.5	141		570	23
24	BATHROOM SINKS		2003	7,776	283	27.5	283		1,120	24
25	FLOORING / CARPETING & TILE		2003	13,887	504	27.5	504		1,629	25
26	ROOF		2003	7,800	284	27.5	284		1,029	26
27	FENCE		2003	9,500	634	15	634		2,218	27
28	WINDOWS		2004	46,880	1,705	27.5	1,705		4,476	28
29	WOODSIDE EXTENDED CARE:									29
30	DRAPERIES		2001	7,578	436	10	758	322	4,169	30
31	CUBICLE CURTAINS/FLOORING		2004	33,108	3,178	10	3,311	133	8,277	31
32	PATIO/FLOORING/TILE/LIGHTING/FIRE PANEL/ROOF AC		2005	30,694	1,116	27.5	1,116		1,472	32
33	WALL TILE / EXIT SIGNS / PLUMBING / DOORS		2006	51,197	1,190	27.5	1,190		1,190	33
34										34
35										35
36	RELATED PARTY ALLOCATION - IME REALTY			25,771	743	39	743			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.

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

# **0043406**

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**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	<b>TOTAL (lines 4 thru 69)</b>		\$ 4,662,553	\$ 169,046		\$ 169,501	\$ 455	\$ 496,266	70

\*\*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:

**01/01/2006**

Ending:

**12/31/2006**

**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	\$ 422,201	\$ 58,130	\$ 37,974	\$ (20,156)	8-15 YRS	\$ 145,832	71
72	Current Year Purchases	6,976	1,395	349	(1,046)	10 YRS	349	72
73	Fully Depreciated Assets	3,241			0		3,241	73
74	<b>RELATED PARTY ALLOC - EKS MGMT 181/EMI ENTERP 179/IME REALTY 30</b>		390	390	0			74
75	<b>TOTALS</b>	\$ 432,418	\$ 59,915	\$ 38,713	\$ (21,202)		\$ 149,422	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	<b>TOTALS</b>			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 5,324,797	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 228,961	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 208,214	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,747)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 645,688	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92	<b>SPRINKLER SYSTEM</b>	\$ 94,060	92
93	<b>GENERATOR PROJECT</b>	2,400	93
94			94
95		\$ 96,460	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								5
6								6
7	<b>TOTAL</b>				\$			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: \$ **20,505** 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	<b>FACILITY USE:</b>	<b>'04 CHRYSLER TOWN&amp;</b>	\$ <b>699.93</b>	\$ <b>9,197</b>	17
18	<b>BANKING,MAINT,</b>	<b>'05 BMW X53</b>	<b>695.00</b>	<b>8,340</b>	18
19	<b>MARKETING, NSG,</b>	<b>'03 FORD ECOLINE WAGON</b>	<b>658.77</b>	<b>5,270</b>	19
20	<b>ACTIVITIES</b>	<b>'06 FORD E350 VAN</b>	<b>690.00</b>	<b>5,508</b>	20
21	<b>TOTAL</b>		\$ <b>#####</b>	\$ <b>28,315</b>	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.	<b>/2007</b>	\$ _____
13.	<b>/2008</b>	\$ _____
14.	<b>/2009</b>	\$ _____

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 116,559	\$		\$ 116,559	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			464			464	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			141,088			141,088	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				61,002		61,002	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>RADIOLOGY/LAB</b>	39-2					8,245		8,245	13
14	<b>TOTAL</b>			\$		\$ 258,111	\$ 69,247		\$ 327,358	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: **01/01/2006**

Ending:

**12/31/2006**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2006**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 216,783	\$ 223,241	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>150,000</u> )	629,165	629,165	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,714	106,235	6
7	Other Prepaid Expenses	2,132	72,980	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>R.E.TAX ESCROW</u>	125,750	211,925	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,072,544	\$ 1,243,546	10
	<b>B. Long-Term Assets</b>			
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	209,341	580,844	15
16	Equipment, at Historical Cost	439,996	439,996	16
17	Accumulated Depreciation (book methods)	(381,981)	(862,866)	17
18	Deferred Charges		164,493	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>		208,570	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 267,356	\$ 4,903,565	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,339,900	\$ 6,147,111	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 233,409	\$ 233,409	26
27	Officer's Accounts Payable	469,268	469,268	27
28	Accounts Payable-Patient Deposits	4,030	4,030	28
29	Short-Term Notes Payable	60,000	132,984	29
30	Accrued Salaries Payable	62,039	62,039	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,332	27,332	31
32	Accrued Real Estate Taxes(Sch.IX-B)		256,264	32
33	Accrued Interest Payable	267	21,679	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 856,345	\$ 1,207,005	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	129,991	129,991	39
40	Mortgage Payable		4,765,814	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>DUE TO LLC</u>	146,858		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 276,849	\$ 4,895,805	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,133,194	\$ 6,102,810	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 206,706	\$ 44,301	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,339,900	\$ 6,147,111	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>99,504</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>ROUNDING</b>	<b>7</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>99,511</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>787,195</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(680,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>107,195</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>206,706</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,151,188	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,151,188	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	170,436	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 170,436	8
	<b>C. Other Operating Revenue</b>		
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	123	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 123	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,321,747	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	739,103	31
32	Health Care	1,369,465	32
33	General Administration	1,250,404	33
	<b>B. Capital Expense</b>		
34	Ownership	770,028	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	327,358	35
36	Provider Participation Fee	61,320	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,517,678	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	804,069	41
42	<b>Income Taxes</b>	(16,874)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 787,195	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: 01/01/2006

Ending: 12/31/2006

**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	1,617	1,617	\$ 49,603	\$ 30.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,490	6,607	137,320	20.78	3
4	Licensed Practical Nurses	15,218	15,965	322,608	20.21	4
5	CNAs & Orderlies	50,099	53,885	474,360	8.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,903	6,448	104,159	16.15	8
9	Activity Director					9
10	Activity Assistants	6,218	6,761	56,060	8.29	10
11	Social Service Workers	1,918	2,088	17,500	8.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,490	16,173	132,605	8.20	15
16	Dishwashers					16
17	Maintenance Workers	7,165	7,467	69,303	9.28	17
18	Housekeepers	12,655	13,389	98,440	7.35	18
19	Laundry	5,154	5,418	37,665	6.95	19
20	Administrator	2,104	2,137	91,256	42.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,824	10,313	88,786	8.61	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	1,539	1,555	15,649	10.06	31
32	Other Health C: <u>MDS/ADMISSION</u>	5,947	6,093	103,666	17.01	32
33	Other(specify) <u>TRANSP/SECURI</u>	5,771	5,835	44,751	7.67	33
34	TOTAL (lines 1 - 33)	153,112	161,751	\$ 1,843,731 *	\$ 11.40	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	M	\$ 11,835	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,232	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	0	11-3	44
45	Social Service Consultant	E	4,482	12-3	45
46	Other(specify)	S			46
47	<u>DENTAL CONSULTANT</u>		1,500	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,049		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	ADMINISTRATOR	0.00%	\$ 91,256	Workers' Compensation Insurance	\$ 55,626	IDPH License Fee	\$	
				Unemployment Compensation Insurance	37,454	Advertising: Employee Recruitment	604	
				FICA Taxes	138,988	Health Care Worker Background Check	0	
				Employee Health Insurance	23,397	(Indicate # of checks performed <u>60</u> )		
				Employee Meals	14,746	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	2,765	
				EMPLOYEE BENEFITS - OTHER	0	MARKETING/ADV/PROMO	0	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	5,252	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	2,735	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(2,765)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	( 0 )	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 91,256	TOTAL (agree to Schedule V, line 22, col.8)	\$ 270,211	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,591	
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 - MANAGEMENT FEES			\$ 204,000			\$	Out-of-State Travel	\$
PHILIP ESFORMES - MANAGEMENT FEES			140,000					
							In-State Travel	
							MGMT CO ALLOCATION	5
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 344,000				Seminar Expense	0
C. Professional Services								
Vendor/Payee	Type		Amount					
ALPHA DATA	DATA PROCESSING		\$ 4,465				Entertainment Expense	( )
HDSI	DATA PROCESSING		6,114				(agree to Sch. V, line 24, col. 8)	
LTC SOLUTION	DATA PROCESSING		1,320				TOTAL	\$ 5
MAXX SOURCE	DATA PROCESSING		1,149					
MUTUAL OF OMAHA	DATA PROCESSING		823					
KBKB	ACCOUNTING FEES		15,900					
ADDUCCI,DORF,ET AL	LEGAL FEES		1,542					
SACHNOFF & WEAVER	LEGAL FEES		3,360					
PERSONNEL PLANNERS	EMPLOYMENT CONSULT		1,012					
RICHARD PEELO	MEDICARE COST REPORT		4,500					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 40,185	TOTAL		\$		

\* 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	FY2003	FY2004	FY2005	FY2006
1	<b>PAINT/DECORATING</b>	<b>2004</b>	<b>\$ 3,458</b>	<b>3</b>	<b>\$</b>	<b>\$ 576</b>	<b>\$ 1,153</b>	<b>\$ 1,153</b>	<b>\$ 576</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>							
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20	<b>TOTALS</b>		<b>\$ 3,458</b>		<b>\$</b>	<b>\$ 576</b>	<b>\$ 1,153</b>	<b>\$ 1,153</b>	<b>\$ 576</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>							

Facility Name & ID Number WOODSIDE EXTENDED CARE# 0043406Report Period Beginning: 01/01/2006Ending: 12/31/2006**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. \$ \_\_\_\_\_ 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. \$ 14,746 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