

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0044446

Facility Name: The Woodbine Nursing Home, LLC

Address: 6909 West North Avenue Oak Park 60302
 Number City Zip Code

County: Cook

Telephone Number: (708) 386-1112 Fax # _____

HFS ID Number: 364309374

Date of Initial License for Current Owners: 10/01/99

Type of Ownership:

<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 _____	

In the event there are further questions about this report, please contact:
 Name: Michael W. Martin Telephone Number: (217) 789-7700
 Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2007 to 12/31/2007 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Suzanne A. Koenig</u>	
	(Title) <u>Receiver</u>	
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>15 S. Old State Capitol Pz-Ste 200-Springfield, IL 62701</u>	
	(Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Woodbine Nursing Home, LLC

0044446 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	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	<u>66</u>	Skilled (SNF)	<u>66</u>	<u>24,090</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>66</u>	TOTALS	<u>66</u>	<u>24,090</u>	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	<u>4,916</u>	<u>45</u>	<u>3,336</u>	<u>8,297</u>	8
9	SNF/PED					9
10	ICF	<u>7,134</u>	<u>2,293</u>	<u>368</u>	<u>9,795</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,050</u>	<u>2,338</u>	<u>3,704</u>	<u>18,092</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.10%

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 Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 10/01/99

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 10/01/99 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 26 and days of care provided 3,298

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number The Woodbine Nursing Home, LLC # 0044446 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	154,092	12,945	7,743	174,780		174,780		174,780		1
2	Food Purchase		70,755		70,755		70,755		70,755		2
3	Housekeeping	88,058	17,250		105,308		105,308		105,308		3
4	Laundry	25,883	20,587	1,167	47,637		47,637		47,637		4
5	Heat and Other Utilities			71,478	71,478		71,478	551	72,029		5
6	Maintenance	28,215	4,406	19,069	51,690		51,690	21	51,711		6
7	Other (specify):*										7
8	TOTAL General Services	296,248	125,943	99,457	521,648		521,648	572	522,220		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	901,895	39,250	3,515	944,660		944,660	10,378	955,038		10
10a	Therapy			255,740	255,740		255,740		255,740		10a
11	Activities	63,326	3,612	1,210	68,148		68,148		68,148		11
12	Social Services	17,172	52	2,186	19,410		19,410		19,410		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Benefits - Mgmt. Co.							1,548	1,548		15
16	TOTAL Health Care and Programs	982,393	42,914	262,651	1,287,958		1,287,958	11,926	1,299,884		16
	C. General Administration										
17	Administrative	78,008		93,063	171,071		171,071	(26,236)	144,835		17
18	Directors Fees										18
19	Professional Services			322,506	322,506		322,506	29,881	352,387		19
20	Dues, Fees, Subscriptions & Promotions			10,078	10,078		10,078	57	10,135		20
21	Clerical & General Office Expenses	63,242	11,154	12,563	86,959		86,959	26,580	113,539		21
22	Employee Benefits & Payroll Taxes			289,349	289,349		289,349		289,349		22
23	Inservice Training & Education							482	482		23
24	Travel and Seminar			774	774		774		774		24
25	Other Admin. Staff Transportation			4,292	4,292		4,292	7,042	11,334		25
26	Insurance-Prop.Liab.Malpractice			63,835	63,835		63,835	1,106	64,941		26
27	Other (specify):* Benefits - Mgmt. Co.							10,357	10,357		27
28	TOTAL General Administration	141,250	11,154	796,460	948,864		948,864	49,269	998,133		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,419,891	180,011	1,158,568	2,758,470		2,758,470	61,767	2,820,237		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

The Woodbine Nursing Home, LLC

#0044446

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			10,616	10,616		10,616	87,947	98,563			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,181	14,181		14,181	367,626	381,807			32
33	Real Estate Taxes			150,000	150,000		150,000		150,000			33
34	Rent-Facility & Grounds			420,000	420,000		420,000	(414,397)	5,603			34
35	Rent-Equipment & Vehicles			1,628	1,628		1,628	1,964	3,592			35
36	Other (specify):*											36
37	TOTAL Ownership			596,425	596,425		596,425	43,140	639,565			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,812		90,812		90,812		90,812			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,135	36,135		36,135		36,135			42
43	Other (specify):* Non-allowable Cos		122	45,769	45,891		45,891	(44,858)	1,033			43
44	TOTAL Special Cost Centers		90,934	81,904	172,838		172,838	(44,858)	127,980			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,419,891	270,945	1,836,897	3,527,733		3,527,733	60,049	3,587,782			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Woodbine Nursing Home, LLC

0044446

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	789	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(36,193)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,887)	43		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 See Pg. 5A	(10,213)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,504)		\$	30

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)	107,553		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 107,553		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 60,049		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		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

The Woodbine Nursing Home, LLC

ID# 0044446

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Medicare Lab Fees	\$ (6,668)	43	1
2	Medicare Radiology Fees	(110)	43	2
3	Disallow out of period legal fees	(2,500)	19	3
4	Disallow COPE dues	(935)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,213)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Woodbine Nursing Home, LLC# 0044446

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	551	0	0	0	0	0	0	0	0	551	5
6	Maintenance	0	0	21	0	0	0	0	0	0	0	0	21	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	572	0	572	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	10,378	0	0	0	0	0	0	0	0	10,378	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	1,548	0	0	0	0	0	0	0	0	1,548	15
16	TOTAL Health Care and Programs	0	0	11,926	0	11,926	16							
	C. General Administration													
17	Administrative	0	0	(75,314)	0	0	0	0	0	0	0	0	(75,314)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,500)	0	32,381	0	0	0	0	0	0	0	0	29,881	19
20	Fees, Subscriptions & Promotions	(935)	0	992	0	0	0	0	0	0	0	0	57	20
21	Clerical & General Office Expenses	0	0	75,658	0	0	0	0	0	0	0	0	75,658	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	482	0	0	0	0	0	0	0	0	482	23
24	Travel and Seminar	0	0	6,087	0	0	0	0	0	0	0	0	6,087	24
25	Other Admin. Staff Transportation	0	0	955	0	0	0	0	0	0	0	0	955	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,106	0	0	0	0	0	0	0	0	1,106	26
27	Other (specify):*	0	0	10,357	0	0	0	0	0	0	0	0	10,357	27
28	TOTAL General Administration	(3,435)	0	52,704	0	49,269	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,435)	0	65,202	0	61,767	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Woodbine Nursing Home, LLC# 0044446

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	789	85,761	1,397	0	0	0	0	0	0	0	0	87,947	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	367,626	0	0	0	0	0	0	0	0	0	367,626	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(420,000)	5,603	0	0	0	0	0	0	0	0	(414,397)	34
35	Rent-Equipment & Vehicles	0	0	1,964	0	0	0	0	0	0	0	0	1,964	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	789	33,387	8,964	0	43,140	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):*	(44,858)	0	0	0	0	0	0	0	0	0	0	(44,858)	43
44	TOTAL Special Cost Centers	(44,858)	0	0	0	0	0	0	0	0	0	0	(44,858)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(47,504)	33,387	74,166	0	60,049	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
Avigdor Horowitz	100	Jackson Heights Nursing Home	Farmer City	Woodbine Realty, LLC	Oak Park	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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	30 Depreciation	\$	Woodbine Realty, LLC	100.00%	\$ 85,761	\$	85,761	1
2	V	32 Interest expense		Woodbine Realty, LLC	100.00%	367,626		367,626	2
3	V	34 Rent	420,000	Woodbine Realty, LLC	100.00%			(420,000)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 420,000			\$ 453,387	\$ *	33,387	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	5 Utilities	\$	SAK Management Services, LLC		\$ 551	\$	551	15
16	V	6 Maintenance		SAK Management Services, LLC		21		21	16
17	V	10 Nursing		SAK Management Services, LLC		10,378		10,378	17
18	V	21 Clerical & General		SAK Management Services, LLC		49,078		49,078	18
19	V	17 Administrative	93,063	SAK Management Services, LLC		17,749		(75,314)	19
20	V	19 Professional Services	93,063	SAK Management Services, LLC		5,853		(87,210)	20
21	V	20 Dues, Fees & Subscriptions		SAK Management Services, LLC		992		992	21
22	V	21 Clerical & General		SAK Management Services, LLC		5,090		5,090	22
23	V	21 Clerical & General - Salaries		SAK Management Services, LLC		21,490		21,490	23
24	V	23 Inservice Training & Education		SAK Management Services, LLC		482		482	24
25	V	24 Travel & Seminar		SAK Management Services, LLC		4,994		4,994	25
26	V	25 Other Admin. Staff Transportation		SAK Management Services, LLC		955		955	26
27	V	26 Insurance - Property & Liability		SAK Management Services, LLC		1,106		1,106	27
28	V	27 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC		10,357		10,357	28
29	V	30 Depreciation		SAK Management Services, LLC		1,397		1,397	29
30	V	34 Rent - Facility & Grounds		SAK Management Services, LLC		5,603		5,603	30
31	V	35 Rent - Equipment & Vehicles		SAK Management Services, LLC		1,492		1,492	31
32	V	15 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC		1,548		1,548	32
33	V	19 Professional Services		SAK Management Services, LLC		119,591		119,591	33
34	V	24 Travel & Seminar		SAK Management Services, LLC		1,093		1,093	34
35	V	35 Rent - Equipment & Vehicles		SAK Management Services, LLC		472		472	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 186,126			\$ 260,292	\$ *	74,166	39

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

Facility Name & ID Number The Woodbine Nursing Home, LLC # 0044446 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Woodbine Nursing Home, LLC

0044446

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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 SAK Management Services, LLC
 Street Address 4055 W. Peterson, Suite 101
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 202-0000
 Fax Number (773) 267-0111

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	SAK Management Fees	1,890,235	8	\$ 5,596	\$ 186,126	\$ 551	1
2	6	Maintenance	SAK Management Fees	1,890,235	8	211	186,126	21	2
3	10	Nursing	SAK Management Fees	1,890,235	8	105,396	186,126	10,378	3
4	21	Clerical & General - Salaries	SAK Management Fees	1,890,235	8	498,418	186,126	49,078	4
5	17	Administrative	SAK Management Fees	1,890,235	8	180,250	186,126	17,749	5
6	19	Professional Services	SAK Management Fees	1,890,235	8	59,442	186,126	5,853	6
7	20	Dues, Fees & Subscriptions	SAK Management Fees	1,890,235	8	10,072	186,126	992	7
8	21	Clerical & General	SAK Management Fees	1,890,235	8	51,688	186,126	5,090	8
9	21	Clerical & General - Salaries	SAK Management Fees	1,890,235	8	218,250	186,126	21,490	9
10	23	Inservice Training	SAK Management Fees	1,890,235	8	4,891	186,126	482	10
11	24	Travel & Seminar	SAK Management Fees	1,890,235	8	50,720	186,126	4,994	11
12	25	Other Admin. Staff Transport.	SAK Management Fees	1,890,235	8	9,694	186,126	955	12
13	26	Insurance - Property & Liability	SAK Management Fees	1,890,235	8	11,235	186,126	1,106	13
14	27	Employee Benefits - Mgmt. Co.	SAK Management Fees	1,890,235	8	105,185	186,126	10,357	14
15	30	Depreciation	SAK Management Fees	1,890,235	8	14,188	186,126	1,397	15
16	34	Rent - Facility & Grounds	SAK Management Fees	1,890,235	8	56,907	186,126	5,603	16
17	35	Rent - Equipment & Vehicles	SAK Management Fees	1,890,235	8	15,154	186,126	1,492	17
18	15	Clerical & General	SAK Management Fees	1,890,235	8	15,717	186,126	1,548	18
19	19	Professional Services	Direct Cost			122,091		119,591	19
20	24	Travel & Seminar	Direct Cost			18,959		1,093	20
21	35	Rent - Equipment & Vehicles	Direct Cost			966		472	21
22									22
23									23
24									24
25	TOTALS					\$ 1,555,030	\$ 822,064	\$ 260,292	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Woodbine Nursing Home, LLC

0044446 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

1	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								\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

The Woodbine Nursing Home, LLC

0044446

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	Cap Mark		X	Mortgage	Variable	07/01/05	\$ 3,600,000	\$ 3,588,769	07/01/35	0.0650	\$ 360,000	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Cap Mark		X	Line of Credit	Variable	11/01/06	100,000	200,000	11/01/08	0.0923	14,181	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 3,700,000	\$ 3,788,769			\$ 374,181	9						
B. Non-Facility Related*																		
10												10						
11									Amortization of loan costs		7,626	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 7,626	14						
15	TOTALS (line 9+line14)						\$ 3,700,000	\$ 3,788,769			\$ 381,807	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Woodbine Nursing Home, LLC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044446

CONTACT PERSON REGARDING THIS REPORT Suzanne A Koenig

TELEPHONE (773) 202-0000 FAX #: (773) 267-0111

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>16-06-104-029-0000</u>	<u>Nursing Home</u>	\$ <u>153,130.34</u>	\$ <u>153,130.34</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>153,130.34</u>	\$ <u>153,130.34</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Woodbine Nursing Home, LLC

0044446

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: Not Available B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

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).

NONE

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
 (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>Nursing Home</u>	<u>Not Available</u>	<u>1999</u>	<u>\$ 500,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 500,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Woodbine Nursing Home, LLC

0044446

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	66	1999		\$ 1,432,000	\$	27.5	\$ 52,073	\$ 52,073	\$ 429,602
5									
6									
7									
8									
Improvement Type**									
9	Boiler		2000	38,072		39	976	976	7,808
10	Painting		2001	3,800		27.5	138	138	914
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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)	\$	1,473,872	\$	53,187	\$	53,187	\$	438,324	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Woodbine Nursing Home, LLC

0044446

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 103,013	\$ 10,616	\$ 10,291	\$ (325)	10	\$ 94,415	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocation from RE Entity & SAK Management			35,085	35,085			74
75	TOTALS	\$ 103,013	\$ 10,616	\$ 45,376	\$ 34,760		\$ 94,415	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	N/A			\$	\$	\$	\$		\$	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)	\$ 2,076,885	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,616	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 98,563	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 87,947	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 532,739	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions				N/A			4
5								5
6		Allocation from SAK Mgmt. Services			5,603			6
7	TOTAL				\$ 5,603			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: \$ 3,592 Description: Copier - 1,522; Nursing equipment - 106; SAK Allocation - \$1,964

(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			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	10A(3)	hrs	\$	1,862	\$ 111,745	\$	1,862	\$ 111,745	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		252	15,110		252	15,110	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,148	128,885		2,148	128,885	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				88,484		88,484	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Oxygen</u>	39(2)					2,328		2,328	13
14	TOTAL			\$	4,262	\$ 255,740	\$ 90,812	4,262	\$ 346,552	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Woodbine Nursing Home, LLC

0044446

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 24,887	\$ 24,887	1
2	Cash-Patient Deposits	5,753	5,753	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,196,547	1,196,547	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	74,526	74,526	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	559,113	559,113	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,860,826	\$ 1,860,826	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost	134,026	1,473,872	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	827	103,013	16
17	Accumulated Depreciation (book methods)	(95,358)	(532,739)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>Net loan costs</u>)		1,525	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 39,495	\$ 1,545,671	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,900,321	\$ 3,406,497	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,006,465	\$ 1,006,465	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,753	5,753	28
29	Short-Term Notes Payable	200,000	200,000	29
30	Accrued Salaries Payable	122,669	122,669	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,176	11,176	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	1,139,435	1,139,435	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,485,498	\$ 2,485,498	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,588,769	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)	\$	\$ 3,588,769	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,485,498	\$ 6,074,267	46
47	TOTAL EQUITY (page 18, line 24)	\$ (585,177)	\$ (2,667,770)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,900,321	\$ 3,406,497	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

The Woodbine Nursing Home, LLC
Facility ID#: 0044446
Schedule XV
12/31/2007

Schedule 17A

Schedule XV - Balance Sheet

Line 9 - Other Assets

<u>Description</u>	<u>Operating</u>	<u>Consolidation</u>
Cost report settlement	11,004	11,004
Other assets-current	548,109	548,109
	<u>559,113</u>	<u>559,113</u>

Line 36 - Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Payroll tax withholdings	320,926	320,926
Employee wage assignment	2,033	2,033
Accrued payroll taxes	46,590	46,590
Due to WB Realty	769,886	769,886
	<u>1,139,435</u>	<u>1,139,435</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (162,078)	1
2	Restatements (describe):		2
3			3
4	Adjustment subsequent to cost report preparation	2,529	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (159,549)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(425,628)	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	()	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)	\$ (425,628)	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)	\$ (585,177)	24 *

**OPERATING ENTITY ONLY

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 2,161,334	1
2	Discounts and Allowances for all Levels	181,794	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,343,128	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	639,460	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 639,460	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	106,620	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,897	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 119,517	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 3,102,105	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	521,648	31
32	Health Care	1,287,958	32
33	General Administration	948,864	33
	B. Capital Expense		
34	Ownership	596,425	34
	C. Ancillary Expense		
35	Special Cost Centers	136,703	35
36	Provider Participation Fee	36,135	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,527,733	40
41	Income before Income Taxes (line 30 minus line 40)**	(425,628)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (425,628)	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 the 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. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number The Woodbine Nursing Home, LLC

0044446

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	1,626	1,786	\$ 50,914	\$ 28.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,700	2,724	76,135	27.95	3
4	Licensed Practical Nurses	15,502	16,593	397,330	23.95	4
5	CNAs & Orderlies	31,169	34,545	377,516	10.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,919	5,434	63,326	11.65	10
11	Social Service Workers	1,875	1,913	17,172	8.98	11
12	Dietician					12
13	Food Service Supervisor	1,288	1,382	23,909	17.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,247	13,071	130,183	9.96	15
16	Dishwashers					16
17	Maintenance Workers	1,891	2,197	28,215	12.84	17
18	Housekeepers	7,918	8,553	88,058	10.30	18
19	Laundry	1,751	2,118	25,883	12.22	19
20	Administrator	2,040	2,280	78,008	34.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,174	5,418	63,242	11.67	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,100	98,014	\$ 1,419,891 *	\$ 14.49	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	Monthly	\$ 7,743	1(3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,974	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	Monthly	1,210	11(3)	44
45	Social Service Consultant	Monthly	2,186	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,113		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	N/A			52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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		
Gerald Parker	Administrator	0	30,737	Workers' Compensation Insurance	\$ 35,301	IDPH License Fee	\$		
Judy Pitzele	Administrator	0	19,340	Unemployment Compensation Insurance	70,810	Advertising: Employee Recruitment	3,046		
Jill Satterfield	Administrator	0	27,931	FICA Taxes	106,728	Health Care Worker Background Check (Indicate # of checks performed <u>29</u>)	290		
				Employee Health Insurance	47,985	Resident Background Checks			
				Employee Meals		Licenses & Permits	1,924		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on Long Term Care	4,818		
				Pension Plan	25,641	Allocation from SAK Mgmt. Co.	992		
				Employee Morale	2,884	Less: COPE dues	(935)		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,008	TOTAL (agree to Schedule V, line 22, col.8)		\$ 10,135			
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	
SAK Management Co.	Management Fees		\$ 93,063				Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	774	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 93,063	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 774
C. Professional Services									
Vendor/Payee	Type		Amount						
See Schedule 21A	Various		\$ 322,506						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 322,506						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

The Woodbine Nursing Home, LLC
 Facility ID#: 0044446
 Schedule XIX
 12/31/2007

Schedule 21A

Schedule XIX (C) - Professional Fees.

<u>Vendor</u>	<u>Services</u>	<u>Amount</u>
Sachnoff & Weaver	Legal	2,500
Stahl Cowwen Crowley	Legal	14,374
Alpha Data Services	Payroll processing	3,296
Health Data Systems	A/R consulting	6,013
Health Care Braning Grooup	Webhosting	1,583
Ivans, Inc.	Medicare consulting	84
LTC Solutions	Software consulting	3,470
Midwest Time Recorder	Software consulting	2,123
Omnicare of Northern IL	Professional consulting	4,229
SAK Management co.	Bookkeeping Fees	93,063
Richard Peelo & Assoc	Accounting	3,850
Daniel Malone	Accounting	342
Personnel Planners, Inc	Unemployment services	930
SAK Management co.	Receiver fees	182,826
Pinnacle Consulting	Medicare consulting	350
Sharon Haugh	Medicare billing services	<u>3,473</u>
TOTAL (agree to Schedule V, line 19, column 3)		322,506
Less: Disallowed out of period legal fees		(2,500)
Allocation from SAK Management - Legal		122,751
Allocation from SAK Management - Data Processing		826
Allocation from SAK Management - Other Consulting		1,867
Offset of SAK Bookkeeping Cost		<u>(93,063)</u>
TOTAL (agree to Schedule V, line 19, column 8)		<u><u>352,387</u></u>

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	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6					N/A															
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Woodbine Nursing Home, LLC# 0044446Report Period Beginning: 01/01/2007Ending: 12/31/2007**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 on Long Term Care - \$3,883
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,716 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,135
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. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, 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

SEE ACCOUNTANTS' COMPILATION REPORT