

Facility Name & ID Number WOODSIDE EXTENDED CARE

0043406 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 _____

	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			2,048	2,048	8
9	SNF/PED					9
10	ICF	37,585	695		38,280	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,585	695	2,048	40,328	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.65%

D. How many bed-hold days during this year were paid by the Department?
229 (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 _____ and days of care provided 2,048

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **WOODSIDE EXTENDED CARE** # **0043406** 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	141,782	16,924	11,340	170,046		170,046		170,046		1
2	Food Purchase		153,721		153,721		153,721	(733)	152,988		2
3	Housekeeping	104,730	21,794		126,524		126,524		126,524		3
4	Laundry	42,127	11,890	4,508	58,525		58,525	917	59,442		4
5	Heat and Other Utilities			148,245	148,245		148,245	241	148,486		5
6	Maintenance	85,670	33,734	31,997	151,401		151,401	4,026	155,427		6
7	Other (specify):* TRANSP/SECURITY	53,381		7,608	60,989		60,989	51	61,040		7
8	TOTAL General Services	427,690	238,063	203,698	869,451		869,451	4,502	873,953		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,167,105	49,793	10,632	1,227,530		1,227,530	891	1,228,421		10
10a	Therapy	107,658	4,965		112,623		112,623		112,623		10a
11	Activities	66,961	12,380		79,341		79,341		79,341		11
12	Social Services	27,790		2,841	30,631		30,631		30,631		12
13	CNA Training										13
14	Program Transportation			6,280	6,280		6,280		6,280		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,369,514	67,138	28,753	1,465,405		1,465,405	891	1,466,296		16
	C. General Administration										
17	Administrative	90,704		221,000	311,704		311,704	(101,436)	210,268		17
18	Directors Fees										18
19	Professional Services			46,120	46,120		46,120	17,618	63,738		19
20	Dues, Fees, Subscriptions & Promotions			14,341	14,341		14,341	(2,435)	11,906		20
21	Clerical & General Office Expenses	75,568	19,964	82,533	178,065		178,065	(78,496)	99,569		21
22	Employee Benefits & Payroll Taxes			255,624	255,624		255,624		255,624		22
23	Inservice Training & Education			1,350	1,350		1,350	31	1,381		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			5,977	5,977		5,977	658	6,635		25
26	Insurance-Prop.Liab.Malpractice			128,839	128,839		128,839	776	129,615		26
27	Other (specify):*			154,937	154,937		154,937	(147,283)	7,654		27
28	TOTAL General Administration	166,272	19,964	910,721	1,096,957		1,096,957	(310,567)	786,390		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,963,476	325,165	1,143,172	3,431,813		3,431,813	(305,174)	3,126,639		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	11,340
	REPAIRS & MAINTENANCE	0
		0
		11,340
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	4,508
		0
		4,508
5	HEAT & OTHER UTILITIES	
	GAS HEAT	52,394
	ELECTRICITY	55,302
	WATER	39,499
	CABLE TV - LOBBY	1,050
		0
		148,245
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,690
	PAINTING & DECORATING	758
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	16,903
	ELEVATOR MAINTENANCE & REPAIR	1,690
	OUTSIDE LABOR	738
	EXTERMINATING SERVICE	2,193
	FIRE SERVICE	7,025
		0
		0
		0
		0
		31,997
7	OTHER	
	SCAVENGER	7,440
	SECURITY SERVICE	168
		0
		0
		7,608
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	2,115
	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	4,917
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL CONSULTANT XVIII B 47-2	3,600
		0
		10,632
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	2,841
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,841
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	6,280
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	221,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	19,981
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	26,139
		0
		46,120
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,322
	EMPLOYEE WANT ADS XIX F	1,136
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,134
	LICENSES & PERMITS XIX F	3,913
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	250
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,586
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		14,341
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	11
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	46,000
	PENALTIES / OVERDRAFT CHARGES VI 18	155
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	10,600
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	25,767
		82,533

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	148,015
	UNEMPLOYMENT COMPENSATION XIX D	40,739
	WORKERS COMPENSATION INSURANC XIX D	41,030
	HOSPITALIZATION INSURANCE XIX D	25,112
	EMPLOYEE BENEFITS - OTHER XIX D	728
	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
		255,624
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,350
		1,350
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	5,977
		5,977
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	128,839
		128,839
27	OTHER	
	BAD DEBTS VI 24	154,937
		154,937

GRAND TOTAL COLUMN 3 OTHER

1,143,172

**WOODSIDE EXTENDED CARE
SCHEDULES
12/31/2007**

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

KREG THERAPEUTIC	THERAPEUTIC BED	3168
PRO-CARE	THERAPEUTIC BED	1860
GREAT AMERICA LEASING	COPIER	2624
MEIKEM	DISHWASHER	1100
PI SURVEILLANCE	TV SECURITY MONITOR	9000
PITNEY BOWES	POSTAGE METER	546
PUBLIC STORAGE	STORAGE	1812
	EQUIPMENT RENTAL	20110

MST/WOODSIDE			
STAFF TRANSPORTATION		ACCT #18370	
12/31/07			
	NAME	DESCRIPTION	DEPARTMENT
	AMOUNT		
02/28	FLEET SERVICES	GASOLINE	FACILITY VAN
			2,846
03/31	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation
			104
04/30	STEVE FOLEY CHEVROLET	AUTO MAINTENANCE	banking, maintenance, & activities, transportation
			166
06/30	SECRETARY OF STATE	AUTO LICENSE RENEWAL	FACILITY VAN
			98
06/30	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation
			251
08/31	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation
			352
09/30	FLEET SERVICES	GASOLINE	FACILITY VAN
			389
09/30	OLECH, STANISLAW	PAYROLL REIMBURSEMENT	PAINTERS
			50
09/30	REJENT, WITOLD	PAYROLL REIMBURSEMENT	PAINTERS
			200
09/30	STECHNIJ, HENRYK	PAYROLL REIMBURSEMENT	PAINTERS
			200
09/30	WAI SILOWSKI, PAWEL	PAYROLL REIMBURSEMENT	PAINTERS
			50
10/31	FLEET SERVICES	GASOLINE	FACILITY VAN
			342
11/30	PETTY CASH	EMPLOYEE REIMBURSEMNT	banking, maintenance, & activities, transportation
			176
11/30	FLEET SERVICES	GASOLINE	FACILITY VAN
			372
12/31	FLEET SERVICES	GASOLINE	FACILITY VAN
			379
TOTAL			5,977

Facility Name & ID Number

WOODSIDE EXTENDED CARE

#0043406

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			41,723	41,723		41,723	176,839	218,562			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,641	14,641		14,641	274,768	289,409			32
33	Real Estate Taxes							250,560	250,560			33
34	Rent-Facility & Grounds			678,000	678,000		678,000	(678,000)				34
35	Rent-Equipment & Vehicles			46,112	46,112		46,112	2,669	48,781			35
36	Other (specify):* OFFICE RENT			8,736	8,736		8,736	(8,736)				36
37	TOTAL Ownership			789,212	789,212		789,212	18,100	807,312			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,967	169,097	234,064		234,064		234,064			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		64,967	230,417	295,384		295,384		295,384			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,963,476	390,132	2,162,801	4,516,409		4,516,409	(287,074)	4,229,335			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	3,864	30		9
10	Interest and Other Investment Income	(8,162)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(733)	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	(250)	20		17
18	Fines and Penalties	(155)	21		18
19	Entertainment				19
20	Contributions	(1,586)	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	(154,937)	27		24
25	Fund Raising, Advertising and Promotional	(2,322)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(55,191)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (219,472)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(67,602)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (67,602)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (287,074)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

WOODSIDE EXTENDED CARE

ID# 0043406

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 576	6	1
2	STAFF DEVELOPMENT	(25,767)	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	Total	(55,191)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSIDE EXTENDED CARE# 0043406 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	(733)	0	0	0	0	0	0	0	0	0	0	(733)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	917	0	0	0	0	0	0	0	0	0	917	4
5	Heat and Other Utilities	0	0	241	0	0	0	0	0	0	0	0	241	5
6	Maintenance	576	1,220	2,230	0	0	0	0	0	0	0	0	4,026	6
7	Other (specify):*	0	24	27	0	0	0	0	0	0	0	0	51	7
8	TOTAL General Services	(157)	2,161	2,498	0	0	0	0	0	0	0	0	4,502	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	891	0	0	0	0	0	0	0	0	891	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	891	0	0	0	0	0	0	0	0	891	16
	C. General Administration													
17	Administrative	0	5,854	(107,290)	0	0	0	0	0	0	0	0	(101,436)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,676	442	11,500	0	0	0	0	0	0	0	17,618	19
20	Fees, Subscriptions & Promotions	(4,158)	1,723	0	0	0	0	0	0	0	0	0	(2,435)	20
21	Clerical & General Office Expenses	(55,922)	(29,451)	6,877	0	0	0	0	0	0	0	0	(78,496)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	31	0	0	0	0	0	0	0	0	0	31	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	370	288	0	0	0	0	0	0	0	0	658	25
26	Insurance-Prop.Liab.Malpractice	0	320	456	0	0	0	0	0	0	0	0	776	26
27	Other (specify):*	(154,937)	3,299	4,355	0	0	0	0	0	0	0	0	(147,283)	27
28	TOTAL General Administration	(215,017)	(12,178)	(94,872)	11,500	0	(310,567)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(215,174)	(10,017)	(91,483)	11,500	0	(305,174)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSIDE EXTENDED CARE# 0043406

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	3,864	193	936	171,846	0	0	0	0	0	0	0	176,839	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,162)	0	1,456	281,474	0	0	0	0	0	0	0	274,768	32
33	Real Estate Taxes	0	0	1,084	249,476	0	0	0	0	0	0	0	250,560	33
34	Rent-Facility & Grounds	0	0	0	(678,000)	0	0	0	0	0	0	0	(678,000)	34
35	Rent-Equipment & Vehicles	0	1,759	910	0	0	0	0	0	0	0	0	2,669	35
36	Other (specify):*	0	0	(8,736)	0	0	0	0	0	0	0	0	(8,736)	36
37	TOTAL Ownership	(4,298)	1,952	(4,350)	24,796	0	18,100	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(219,472)	(8,065)	(95,833)	36,296	0	(287,074)	45						

Facility Name & ID Number

WOODSIDE EXTENDED CARE

0043406

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	LINCOLNWOOD	RENTAL REAL ESTATE

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

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

1	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	4 HOUSEKEEPING	\$	EKS MANAGEMENT		\$ 917	\$ 917	1
2	V	6 MAINTENANCE		" "		1,220	1,220	2
3	V	7 SCAVENGER		" "		24	24	3
4	V	17 CFO SALARY		" "		5,854	5,854	4
5	V	19 PROFESSIONAL FEES		" "		5,676	5,676	5
6	V	20 WANT ADS/BACKGRD CKS		" "		1,723	1,723	6
7	V	21 CLERICAL	46,000	" "		16,549	(29,451)	7
8	V	23 SEMINARS		" "		31	31	8
9	V	25 STAFF TRANSPORTATION		" "		370	370	9
10	V	26 INSURANCE		" "		320	320	10
11	V	27 EMPLOYEE BENEFITS		" "		3,299	3,299	11
12	V	30 SL DEPRECIATION		" "		193	193	12
13	V	35 EQUIPMENT RENT		" "		1,759	1,759	13
14	Total		\$ 46,000			\$ 37,935	\$ * (8,065)	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	6 DRIVERS SALARY	\$	EMI ENTERPRISES		\$ 1,305	\$ 1,305	15
16	V	17 MANAGEMENT FEES	116,000	" "			(116,000)	16
17	V	17 OFFICERS SALARY		" "		8,710	8,710	17
18	V	19 ACCOUNTING FEES		" "		398	398	18
19	V	21 CLERICAL		" "		6,838	6,838	19
20	V	25 STAFF TRANSPORTATION		" "		288	288	20
21	V	26 INSURANCE		" "		402	402	21
22	V	27 EMPLOYEE BENEFITS		" "		4,355	4,355	22
23	V	30 SL DEPRECIATION		" "		162	162	23
24	V	35 AUTO LEASE		" "		652	652	24
25	V	10 NURSING CONSULTANTS		" "		891	891	25
26	V							26
27	V	5 UTILITIES		IME REALTY		241	241	27
28	V	6 REPAIRS/MAINTENANCE		" "		925	925	28
29	V	7 ALARM SERVICE		" "		27	27	29
30	V	19 PROFESSIONAL FEES		" "		44	44	30
31	V	21 OFFICE EXPENSE		" "		39	39	31
32	V	26 INSURANCE		" "		54	54	32
33	V	30 SL DEPRECIATION		" "		774	774	33
34	V	32 INTEREST		" "		1,456	1,456	34
35	V	33 REAL ESTATE TAX		" "		1,084	1,084	35
36	V	35 STORAGE FEES		" "		258	258	36
37	V	36 OFFICE RENT	8,736	" "			(8,736)	37
38	V							38
39	Total		\$ 124,736			\$ 28,903	\$ * (95,833)	39

* 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	19 ACCOUNTING FEES	\$	MST REAL ESTATE LLC		\$ 11,500	\$ 11,500	15
16	V	34 RENT	678,000	" "			(678,000)	16
17	V	30 SL DEPRECIATION		" "		171,846	171,846	17
18	V	32 INTEREST		" "		257,490	257,490	18
19	V	32 MIP INSURANCE		" "		23,984	23,984	19
20	V	33 REAL ESTATE TAX		" "		249,476	249,476	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 678,000			\$ 714,296	\$ * 36,296	39

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

Facility Name & ID Number

WOODSIDE EXTENDED CARE

0043406

Report Period Beginning:

01/01/2007

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	ALLOCATION FROM EMI ENTERPRISES:				SEE ATTACHED				\$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT CONSULT	40.00	SCHEDULE	5	6.25	SALARY	8,710	17-7	2
3											3
4											4
5	PHILIP ESFORMES	MGMT CONSULT	MGMT CONSULT	22.50		5	7.14	MGMT FEE	105,000	17-3	5
6											6
7											7
8	ALLOCATION FROM EKS MANAGEMENT:										8
9	AVRUM WEINFELD		CFO	0.00		5	8.93	SALARY	5,854	17-7	9
10											10
11											11
12											12
13								TOTAL	\$ 119,564		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:

01/01/2007

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 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	857,979	14 FACILITIES	\$ 19,500	\$ 19,500	40,328	\$ 917	1
2	6	MAINTENANCE	857,979	14 FACILITIES	25,953	25,953	40,328	1,220	2
3	7	SCAVENGER	857,979	14 FACILITIES	512		40,328	24	3
4	17	CFO SALARY-A. WEINFELD	857,979	14 FACILITIES	124,552	124,552	40,328	5,854	4
5	19	PROFESSIONAL FEES	857,979	14 FACILITIES	120,756	100,571	40,328	5,676	5
6	20	WANT ADS/BACKGRND CHKS	857,979	14 FACILITIES	36,665		40,328	1,723	6
7	21	CLERICAL	857,979	14 FACILITIES	352,089	246,687	40,328	16,549	7
8	23	SEMINARS	857,979	14 FACILITIES	659		40,328	31	8
9	25	STAFF TRANSPORTATION	857,979	14 FACILITIES	7,865		40,328	370	9
10	26	INSURANCE	857,979	14 FACILITIES	6,798		40,328	320	10
11	27	EMPLOYEE BENEFITS	857,979	14 FACILITIES	70,186		40,328	3,299	11
12	30	SL DEPRECIATION	857,979	14 FACILITIES	4,096		40,328	193	12
13	35	EQUIPMENT RENT	857,979	14 FACILITIES	37,419		40,328	1,759	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				\$ 807,050	\$ 517,263		\$ 37,935	25

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

0043406 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 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	DRIVERS SALARY	342,637	4 FACILITIES	\$ 11,091	\$ 3,587	40,328	\$ 1,305	1
2	17	OFFICERS SALARY-M.ESFORMES " "	342,637	4 FACILITIES	74,000	74,000	40,328	8,710	2
3	19	ACCOUNTING FEES	342,637	4 FACILITIES	3,380		40,328	398	3
4	21	CLERICAL	342,637	4 FACILITIES	58,095	43,765	40,328	6,838	4
5	25	STAFF TRANSPORTATION	342,637	4 FACILITIES	2,444		40,328	288	5
6	26	INSURANCE	342,637	4 FACILITIES	3,417		40,328	402	6
7	27	EMPLOYEE BENEFITS	342,637	4 FACILITIES	37,000		40,328	4,355	7
8	30	DEPRECIATION	342,637	4 FACILITIES	1,380		40,328	162	8
9	35	AUTO LEASE	342,637	4 FACILITIES	5,543		40,328	652	9
10	10	NURSING CONSULTANTS	342,637	4 FACILITIES	7,567	7,567	40,328	891	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				\$ 203,917	\$ 128,919		\$ 24,001	25

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

0043406

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 IME REALTY
 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	5	UTILITIES	187,059	14 FACILITIES	\$ 5,162	\$	8,736	\$ 241	1
2	6	REPAIRS/MAINTENANCE	187,059	14 FACILITIES	19,803	6,152	8,736	925	2
3	7	ALARM FEES	187,059	14 FACILITIES	575		8,736	27	3
4	19	PROFESSIONAL FEES	187,059	14 FACILITIES	952		8,736	44	4
5	21	OFFICE EXPENSE	187,059	14 FACILITIES	831		8,736	39	5
6	26	INSURANCE	187,059	14 FACILITIES	1,150		8,736	54	6
7	30	SL DEPRECIATION	187,059	14 FACILITIES	16,570		8,736	774	7
8	32	INTEREST	187,059	14 FACILITIES	31,178		8,736	1,456	8
9	33	REAL ESTATE TAX	187,059	14 FACILITIES	23,213		8,736	1,084	9
10	35	STORAGE FEES	187,059	14 FACILITIES	5,519		8,736	258	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				\$ 104,953	\$ 6,152		\$ 4,902	25

Facility Name & ID Number

WOODSIDE EXTENDED CARE

0043406

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	RELATED PARTY: MST REAL ESTATE LLC						\$	\$			\$	1						
2	CAMBRIDGE REALTY		X	MORTGAGE	\$52,947.11	09/05	4,919,200	4,765,813	09/35	5.3100	254,858	2						
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		09/05	172,440	165,297	09/35		2,632	3						
4	MIP INSURANCE										23,984	4						
5	RELATED PARTY: IME REALTY	X		MORTGAGE							1,456	5						
Working Capital																		
6	FIRST BANK		X	WORKING CAPITAL	\$5,000+INTEREST		310,000			PRIME+	12,280	6						
7	US BANK		X	WORKING CAPITAL-LOC	DEMAND		207,000			PRIME+	229	7						
8	HEALTHCAP RRG		X	INSURANCE FINANCING							2,132	8						
9	TOTAL Facility Related				\$52,947.11		\$ 5,608,640	\$ 4,931,110			\$ 297,571	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 5,608,640	\$ 4,931,110			\$ 297,571	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 23,984 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 2006 report.		\$	256,264	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	249,133	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(7,131)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	256,607	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	249,476	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	253,088	8
	2003	233,772	9
	2004	238,701	10
	2005	248,800	11
	2006	249,133	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2006 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:** 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 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 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>32-29-401-011-0000</u>	<u>NURSING HOME</u>	\$ <u>249,132.72</u>	\$ <u>249,132.72</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>249,132.72</u>	\$ <u>249,132.72</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.

Facility Name & ID Number WOODSIDE EXTENDED CARE

0043406

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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>			\$	1
2	<u>NURSING HOME</u>		<u>2004</u>	<u>229,826</u>	2
3	TOTALS			\$ 229,826	3

Facility Name & ID Number WOODSIDE EXTENDED CARE

0043406

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	RELATED PARTY-MST REAL ESTATE LLC:			\$	\$		\$	\$	\$	4
5	112	2004		4,142,702	150,629	27.5	150,629		558,603	5
6										6
7										7
8	RELATED PARTY-MST REAL ESTATE LLC-SL DEPN:									8
	Improvement Type**									
9	CEILING LIGHTING		1997	3,746	96	39	96		972	9
10	WATER SOFTENING SYSTEM		1997	6,926	178	39	178		1,802	10
11	FLOORING		1997	3,910	100	39	100		1,004	11
12	FLOORING / DOORS / WINDOWS		1998	29,194	748	39	748		7,206	12
13	ROOF		1998	84,450	2,165	39	2,165		21,383	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.		1998	30,915	793	39	793		7,841	14
15	PAINTING / DECORATING		1998	15,111	387	39	387		3,693	15
16	FLOORING / DOORS / BATHROOM FIXTURES		1999	11,198	288	39	288		2,572	16
17	CHAIN LINK FENCE		1999	5,100	131	39	131		1,108	17
18	FLOOR TILES/COVE BASE		2000	22,766	828	27.5	828		6,589	18
19	PAIR OF ALUMINUM DOORS		2000	2,193	80	27.5	80		623	19
20	PLUMBING		2000	9,913	360	27.5	360		2,565	20
21	PLUMBING / VANITY / SINK / FLOORING		2001	37,788	1,374	27.5	1,374		9,246	21
22	PAVING		2002	18,562	675	27.5	675		3,741	22
23	BATHROOM SINKS		2002	3,888	141	27.5	141		711	23
24	BATHROOM SINKS		2003	7,776	283	27.5	283		1,403	24
25	FLOORING / CARPETING & TILE		2003	13,887	504	27.5	504		2,133	25
26	ROOF		2003	7,800	284	27.5	284		1,313	26
27	FENCE		2003	9,500	634	15	634		2,852	27
28	WINDOWS		2004	46,880	1,705	27.5	1,705		6,181	28
29	SPRINKLER SYSTEM / ELECTRICAL / ROOF AC / TILING		2007	298,345	9,463	27.5	9,463		9,463	29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

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

0043406

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	\$ 429,177	\$ 36,763	\$ 38,465	\$ 1,702	8-15 YRS	\$ 184,646	71
72	Current Year Purchases	3,052	153	153		10 YRS	153	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC - EKS MGMT 193/EMI ENTERP 162/IME REALTY 30		385	385				74
75	TOTALS	\$ 432,229	\$ 37,301	\$ 39,003	\$ 1,702		\$ 184,799	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,620,835	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 214,698	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,562	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,864	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 859,880	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ **20,110** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE:	'04 CHRYSLER TOWN&	\$ 699.93	\$ 3,512	17
18	BANKING,MAINT,	'05 BMW X53	695.00	8,340	18
19	MARKETING, NSG,	'07 NISSAN MURANO	699.14	5,870	19
20	ACTIVITIES	'06 FORD E350 VAN	690.00	8,280	20
21	TOTAL		\$ #####	\$ 26,002	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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 87,776	\$		\$ 87,776	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			380			380	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			80,941			80,941	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				59,510		59,510	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RADIOL/LAB/SUPPL	39-2					5,457		5,457	13
14	TOTAL			\$		\$ 169,097	\$ 64,967		\$ 234,064	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: **01/01/2007**

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	\$ 28,524	\$ 99,434	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>200,000</u>)	851,704	851,704	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,068	120,970	6
7	Other Prepaid Expenses		1,476	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>R.E.TAX ESCROW</u>	125,750	222,361	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,100,046	\$ 1,295,945	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		229,826	13
14	Buildings, at Historical Cost		4,142,702	14
15	Leasehold Improvements, at Historical Cost	112,881	782,730	15
16	Equipment, at Historical Cost	439,807	439,807	16
17	Accumulated Depreciation (book methods)	(420,463)	(1,072,895)	17
18	Deferred Charges		158,425	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>DUE FROM LLC</u>	92,324		22
23	Other(specify): <u>REPLACEMENT RESERVE</u>		199,492	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 224,549	\$ 4,880,087	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,324,595	\$ 6,176,032	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 179,823	\$ 179,823	26
27	Officer's Accounts Payable	598,555	598,555	27
28	Accounts Payable-Patient Deposits	4,030	4,030	28
29	Short-Term Notes Payable	160,000	236,955	29
30	Accrued Salaries Payable	66,287	66,287	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,482	30,482	31
32	Accrued Real Estate Taxes(Sch.IX-B)		256,607	32
33	Accrued Interest Payable	78	21,167	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,039,255	\$ 1,393,906	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	69,991	69,991	39
40	Mortgage Payable		4,688,858	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)	\$ 69,991	\$ 4,758,849	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,109,246	\$ 6,152,755	46
47	TOTAL EQUITY(page 18, line 24)	\$ 215,349	\$ 23,277	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,324,595	\$ 6,176,032	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 206,706	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 206,706	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	459,643	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	(451,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 8,643	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)	\$ 215,349	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,788,467	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,788,467	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	187,720	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 187,720	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,162	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,162	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)	\$ 4,984,349	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	869,451	31
32	Health Care	1,465,405	32
33	General Administration	1,096,957	33
	B. Capital Expense		
34	Ownership	789,212	34
	C. Ancillary Expense		
35	Special Cost Centers	234,064	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,516,409	40
41	Income before Income Taxes (line 30 minus line 40)**	467,940	41
42	Income Taxes	(8,297)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 459,643	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: 01/01/2007

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	2,271	2,271	\$ 57,136	\$ 25.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,581	6,746	144,990	21.49	3
4	Licensed Practical Nurses	14,637	15,141	327,292	21.62	4
5	CNAs & Orderlies	50,992	53,636	513,760	9.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,020	6,460	107,658	16.67	8
9	Activity Director					9
10	Activity Assistants	6,908	7,458	66,961	8.98	10
11	Social Service Workers	1,925	1,974	27,790	14.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,450	16,133	141,782	8.79	15
16	Dishwashers					16
17	Maintenance Workers	7,014	7,129	85,670	12.02	17
18	Housekeepers	12,265	12,883	104,730	8.13	18
19	Laundry	5,294	5,696	42,127	7.40	19
20	Administrator	2,080	2,080	90,704	43.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,375	8,675	75,568	8.71	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	1,350	1,372	12,368	9.01	31
32	Other Health C: <u>MDS/ADMISSION</u>	6,245	6,469	111,559	17.25	32
33	Other(specify) <u>TRANSP/SECURI</u>	6,128	6,147	53,381	8.68	33
34	TOTAL (lines 1 - 33)	153,535	160,270	\$ 1,963,476 *	\$ 12.25	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	\$ 11,340	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	4,917	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	0	12-3	45
46	Other(specify)	S			46
47	<u>DENTAL CONSULTANT</u>		3,600	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,857		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	\$ 90,704	Workers' Compensation Insurance	\$ 41,030	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	40,739	Advertising: Employee Recruitment	1,136	
				FICA Taxes	148,015	Health Care Worker Background Check	0	
				Employee Health Insurance	25,112	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,836	
				EMPLOYEE BENEFITS - OTHER	728	MARKETING/ADV/PROMO	2,322	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	7,057	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,723	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,836)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(2,322)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,704	TOTAL (agree to Schedule V, line 22, col.8)	\$ 255,624	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,906	
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			\$ 116,000				Out-of-State Travel	\$
PHILIP ESFORMES - MANAGEMENT FEES			105,000					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 221,000				Seminar Expense	0
C. Professional Services								
Vendor/Payee	Type		Amount					
ALPHA DATA	DATA PROCESSING		\$ 4,302					
E-HEALTH DATA SOLUTIONS	DATA PROCESSING		6,364					
HDSI	DATA PROCESSING		6,033					
LTC SOLUTION	DATA PROCESSING		1,500					
MAXX SOURCE	DATA PROCESSING		1,264					
MUTUAL OF OMAHA	DATA PROCESSING		519					
KBKB	ACCOUNTING FEES		15,900					
SACHNOFF & WEAVER	LEGAL FEES		2,223					
LAWRENCE SCHWARTZ	LEGAL FEES		1,237					
PERSONNEL PLANNERS	EMPLOYMENT CONSULT		1,473					
MICHIGAN PEER REVIEW	EMPL QUALITY REVIEW		805					
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.)			\$ 46,120	TOTAL			Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							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	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	2004	\$ 3,458	3	\$ 576	\$ 1,153	\$ 1,153	\$ 576												
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 3,458		\$ 576	\$ 1,153	\$ 1,153	\$ 576												

Facility Name & ID Number WOODSIDE EXTENDED CARE

0043406

Report Period Beginning: 01/01/2007

Ending: 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 LONG TERM CARE \$ 5,134
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,238 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,320
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$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