



Facility Name & ID Number The Woodbine Nursing Home, LLC

# 0044446 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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>24,156</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>24,156</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>16</u>	<u>19</u>	<u>3,816</u>	<u>3,851</u>	8
9	SNF/PED					9
10	ICF	<u>9,177</u>	<u>1,904</u>	<u>3,153</u>	<u>14,234</u>	10
11	ICF/DD					11
12	SC		<u>392</u>	<u>1,211</u>	<u>1,603</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,193</u>	<u>2,315</u>	<u>8,180</u>	<u>19,688</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.50%

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 3,749

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

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**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
	<b>A. General Services</b>										
1	Dietary	149,417	14,738	8,095	172,250		172,250		172,250		1
2	Food Purchase		97,491		97,491		97,491		97,491		2
3	Housekeeping	88,837	21,127		109,964		109,964		109,964		3
4	Laundry	36,007	9,343		45,350		45,350		45,350		4
5	Heat and Other Utilities			86,906	86,906		86,906	610	87,516		5
6	Maintenance	26,783	6,270	28,337	61,390		61,390		61,390		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>301,044</b>	<b>148,969</b>	<b>123,338</b>	<b>573,351</b>		<b>573,351</b>	<b>610</b>	<b>573,961</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	941,070	79,507	7,725	1,028,302		1,028,302	227	1,028,529		10
10a	Therapy			266,195	266,195		266,195		266,195		10a
11	Activities	57,446	3,295		60,741		60,741		60,741		11
12	Social Services	17,096		1,755	18,851		18,851		18,851		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Emp Benefits Mgmt C</b>							39,525	39,525		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,015,612</b>	<b>82,802</b>	<b>287,675</b>	<b>1,386,089</b>		<b>1,386,089</b>	<b>39,752</b>	<b>1,425,841</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	70,646		108,935	179,581		179,581	(108,935)	70,646		17
18	Directors Fees										18
19	Professional Services			196,218	196,218		196,218	(73,935)	122,283		19
20	Dues, Fees, Subscriptions & Promotions			15,557	15,557		15,557	(1,669)	13,888		20
21	Clerical & General Office Expenses	80,558	12,108	44,705	137,371		137,371	6,810	144,181		21
22	Employee Benefits & Payroll Taxes			289,177	289,177		289,177		289,177		22
23	Inservice Training & Education							1,452	1,452		23
24	Travel and Seminar			1,135	1,135		1,135		1,135		24
25	Other Admin. Staff Transportation			9,227	9,227		9,227	21,441	30,668		25
26	Insurance-Prop.Liab.Malpractice			58,996	58,996		58,996	1,248	60,244		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>151,204</b>	<b>12,108</b>	<b>723,950</b>	<b>887,262</b>		<b>887,262</b>	<b>(153,588)</b>	<b>733,674</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,467,860</b>	<b>243,879</b>	<b>1,134,963</b>	<b>2,846,702</b>		<b>2,846,702</b>	<b>(113,226)</b>	<b>2,733,476</b>		<b>29</b>

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

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 &amp; ID Number

The Woodbine Nursing Home, LLC

#0044446

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	
	<b>D. Ownership</b>											
30	Depreciation			15,423	15,423		15,423	139,172	154,595			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,229	20,229		20,229	367,626	387,855			32
33	Real Estate Taxes			150,000	150,000		150,000		150,000			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(352,864)	7,136			34
35	Rent-Equipment & Vehicles			2,830	2,830		2,830	1,895	4,725			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			548,482	548,482		548,482	155,829	704,311			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131,798		131,798		131,798		131,798			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,234	36,234		36,234		36,234			42
43	Other (specify):* <b>Non-allowable cost</b>		1,676	26,397	28,073		28,073	(28,073)				43
44	<b>TOTAL Special Cost Centers</b>		133,474	62,631	196,105		196,105	(28,073)	168,032			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,467,860	377,353	1,746,076	3,591,289		3,591,289	14,530	3,605,819			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:

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**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	(1,365)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	52,073	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	(13,085)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,677)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,910)	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	(10,403)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 16,633		\$	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)	(2,103)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (2,103)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 14,530		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

The Woodbine Nursing Home, LLC

ID# 0044446

Report Period Beginning: 01/01/2008

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NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Medicare Lab Fees	\$ (7,620)	43	1
2	Medicare Radiology Fees	(93)	43	2
3	Disallow COPE Fees	(2,690)	20	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
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23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(10,403)		49

SEE ACCOUNTANTS' COMPILATION REPORT

**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
<u>Avigdor Horowitz</u>	<u>100</u>	<u>Jackson Heights Nursing Home</u>	<u>Farmer City</u>	<u>Woodbine Realty, LLC</u>	<u>Oak Park</u>	<u>Real Estate</u>

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	<u>30 Depreciation</u>	\$	<u>Woodbine Realty, LLC</u>	<u>100.00%</u>	\$ <u>85,761</u>	\$ <u>85,761</u>	1
2	V	<u>32 Interest Expense</u>		<u>Woodbine Realty, LLC</u>	<u>100.00%</u>	<u>367,626</u>	<u>367,626</u>	2
3	V	<u>34 Rent</u>	<u>360,000</u>	<u>Woodbine Realty, LLC</u>	<u>100.00%</u>		<u>(360,000)</u>	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	<b>Total</b>		\$ <b>360,000</b>			\$ <b>453,387</b>	\$ * <b>93,387</b>	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		\$ 610	\$ 610
16	V	6 Maintenance		SAK Management Services, LLC			
17	V	10 Nursing		SAK Management Services, LLC		227	227
18	V	21 Clerical & General		SAK Management Services, LLC			
19	V	17 Administrative	108,935	SAK Management Services, LLC			(108,935)
20	V	19 Professional Services	108,935	SAK Management Services, LLC		3,915	(105,020)
21	V	20 Dues, Fees & Subscriptions		SAK Management Services, LLC		1,021	1,021
22	V	21 Clerical & General		SAK Management Services, LLC		6,810	6,810
23	V	23 Inservice Training & Education		SAK Management Services, LLC		1,452	1,452
24	V	24 Travel & Seminar		SAK Management Services, LLC		9,720	9,720
25	V	25 Other Admin. Staff Transportation		SAK Management Services, LLC		996	996
26	V	26 Insurance - Property & Liability		SAK Management Services, LLC		1,248	1,248
27	V	27 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC			
28	V	30 Depreciation		SAK Management Services, LLC		1,338	1,338
29	V	34 Rent - Facility & Grounds		SAK Management Services, LLC		7,136	7,136
30	V	35 Rent - Equipment & Vehicles		SAK Management Services, LLC		1,895	1,895
31	V	15 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC		39,525	39,525
32	V	19 Professional Services		SAK Management Services, LLC		35,762	35,762
33	V	24 Travel & Seminar		SAK Management Services, LLC		10,725	10,725
34	V	35 Rent - Equipment & Vehicles		SAK Management Services, LLC			
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 217,870			\$ 122,380	\$ * (95,490)

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

Facility Name &amp; ID Number

The Woodbine Nursing Home, LLC

# 0044446

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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:

01/01/2008

Ending: 2/31/2008

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	1,915,081	8	\$ 5,361	\$ 217,870	\$ 610	1
2	6	Maintenance	SAK Management Fees	1,915,081	8		217,870	0	2
3	10	Nursing	SAK Management Fees	1,915,081	8	1,998	217,870	227	3
4	21	Clerical & General - Salaries	SAK Management Fees	1,915,081	8		217,870	0	4
5	17	Administrative	SAK Management Fees	1,915,081	8		217,870	0	5
6	19	Professional Services	SAK Management Fees	1,915,081	8	34,415	217,870	3,915	6
7	20	Dues, Fees & Subscriptions	SAK Management Fees	1,915,081	8	8,974	217,870	1,021	7
8	21	Clerical & General	SAK Management Fees	1,915,081	8	59,856	217,870	6,810	8
9	21	Clerical & General - Salaries	SAK Management Fees	1,915,081	8		217,870	0	9
10	23	Inservice Training	SAK Management Fees	1,915,081	8	12,762	217,870	1,452	10
11	24	Travel & Seminar	SAK Management Fees	1,915,081	8	85,442	217,870	9,720	11
12	25	Other Admin. Staff Transport.	SAK Management Fees	1,915,081	8	8,757	217,870	996	12
13	26	Insurance - Property & Liability	SAK Management Fees	1,915,081	8	10,969	217,870	1,248	13
14	27	Employee Benefits - Mgmt. Co.	SAK Management Fees	1,915,081	8		217,870	0	14
15	30	Depreciation	SAK Management Fees	1,915,081	8	11,758	217,870	1,338	15
16	34	Rent - Facility & Grounds	SAK Management Fees	1,915,081	8	62,727	217,870	7,136	16
17	35	Rent - Equipment & Vehicles	SAK Management Fees	1,915,081	8	16,653	217,870	1,895	17
18	15	Employee Benefits - Mgmt. Co.	SAK Management Fees	1,915,081	8	347,424	217,870	39,525	18
19	19	Professional Services	Direct Cost			35,762		35,762	19
20	24	Travel & Seminar	Direct Cost			20,014		10,725	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 722,872	\$ 1,998	\$ 122,380	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

The Woodbine Nursing Home, LLC

# 0044446

Report Period Beginning:

01/01/2008

Ending:

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**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	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						
<b>Working Capital</b>																		
6	Cap Mark		X	Line of Credit	Variable	11/01/08	100,000	300,000	11/01/09	0.0923	20,229	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 3,700,000	\$ 3,888,769			\$ 380,229	9						
<b>B. Non-Facility Related*</b>																		
10							Amortization of Loan Costs				7,626	10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 7,626	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 3,700,000	\$ 3,888,769			\$ 387,855	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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.)

**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 2007 report.		\$	<b>146,870</b>	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.)	2007	\$	<b>157,216</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>10,346</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>300,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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.			<b>(160,346)</b>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>150,000</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	<b>140,361</b>	8	
	2004	<b>151,282</b>	9	
	2005	<b>149,265</b>	10	
	2006	<b>153,130</b>	11	
	2007	<b>157,216</b>	12	
<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>Accrual approximated current year real estate bill plus prior year unaccrued amount.</b>				

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>157,215.57</u>	\$ <u>157,215.57</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>157,215.57</u>	\$ <u>157,215.57</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

01/01/2008 Ending:

12/31/2008

**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>1999</u>	<u>\$ 500,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 500,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Woodbine Nursing Home, LLC

# 0044446

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	\$ 481,675	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Boiler		2000	38,072		39	976	976	8,784	9
10	Painting		2001	3,800		27.5	138	138	1,052	10
11	Pantry & Kitchen Remodeling		2008	3,500		10	350	350	350	11
12	Code Alert System Down Payment		2008	992		10	99	99	99	12
13	Rooftop Heating & Cooling Unit over Dining Room		2008	5,851		10	585	585	585	13
14	Hands Free Phone in Elevator Down Payment		2008	1,544		10	154	154	154	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

\*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)	\$	1,485,759	\$	54,375	\$	54,375	\$	492,699	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:

01/01/2008

Ending:

12/31/2008

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	\$ 11,873	\$ 1,257	10	\$ 106,287	71
72	Current Year Purchases	11,556	4,807	1,249	(3,558)	10	1,249	72
73	Fully Depreciated Assets							73
74	Allocation from RE Entity & SAK Management			87,098	87,098			74
75	TOTALS	\$ 114,569	\$ 15,423	\$ 100,220	\$ 84,797		\$ 107,536	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)	\$ 2,100,328	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,423	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 154,595	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 139,172	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 600,235	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			7,136			6
7	TOTAL				\$ 7,136			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: \$ 4,725 Description: Copier- 1,226; Nursing Equip- 1,605; SAK Allocation- \$1,895

(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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$	1,998	\$ 137,894	\$	1,998	\$ 137,894	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		141	9,731		141	9,731	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,718	118,570		1,718	118,570	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 (2)	# of prescrpts				125,766		125,766	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Oxygen</u>	39 (2)					6,032		6,032	13
14	TOTAL			\$	3,857	\$ 266,195	\$ 131,798	3,857	\$ 397,993	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 &amp; ID Number      The Woodbine Nursing Home, LLC

#      0044446

Report Period Beginning:    01/01/2008

Ending:      12/31/2008

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

As of    12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 99,248	\$ 99,248	1
2	Cash-Patient Deposits	15,140	15,140	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u> )	1,614,699	1,614,699	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	79,129	79,129	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	670,223	670,223	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,478,439	\$ 2,478,439	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost	145,913	1,485,759	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,383	114,569	16
17	Accumulated Depreciation (book methods)	(115,367)	(600,235)	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): _____			22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 42,929	\$ 1,500,093	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,521,368	\$ 3,978,532	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 803,511	\$ 803,511	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,140	15,140	28
29	Short-Term Notes Payable	300,000	300,000	29
30	Accrued Salaries Payable	124,637	124,637	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	300,000	300,000	32
33	Accrued Interest Payable	33,784	33,784	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	1,494,508	1,500,609	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,071,580	\$ 3,077,681	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,588,769	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,588,769	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,071,580	\$ 6,666,450	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (550,212)	\$ (2,687,918)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,521,368	\$ 3,978,532	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

The Woodbine Nursing Home, LLC  
Facility ID#: 0044446  
Schedule XV  
12/31/2008

**Schedule 17A**

Schedule XV - Balance Sheet

Line 9 - Other Assets

<u>Description</u>	<u>Operating</u>	<u>Consolidation</u>
Cost report settlement	83,491	83,491
Other assets-current	586,732	586,732
	<u>670,223</u>	<u>670,223</u>

Line 36 - Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Net Loan Costs	-	6,101
Payroll tax withholdings	362,590	362,590
Employee wage assignment	2,033	2,033
Due to WB Realty	1,129,886	1,129,886
	<u>1,494,509</u>	<u>1,500,610</u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(585,177)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Adjustment subsequent to cost report preparation</b>	<b>(4,897)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(590,074)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>39,862</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>39,862</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(550,212)</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,551,550	1
2	Discounts and Allowances for all Levels	289,948	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,841,498	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	660,063	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 660,063	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	116,927	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,645	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 129,572	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<b>Other Income</b>	18	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 18	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,631,151	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	573,351	31
32	Health Care	1,386,089	32
33	General Administration	887,262	33
	<b>B. Capital Expense</b>		
34	Ownership	548,482	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	159,871	35
36	Provider Participation Fee	36,234	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,591,289	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	39,862	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 39,862	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.

\*\*\* 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: 01/01/2008

Ending: 12/31/2008

**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	2,096	2,216	\$ 58,313	\$ 26.31	1
2	Assistant Director of Nursing	2,283	2,487	43,298	17.41	2
3	Registered Nurses	2,426	2,502	56,303	22.50	3
4	Licensed Practical Nurses	14,870	15,834	422,461	26.68	4
5	CNAs & Orderlies	31,786	34,037	360,695	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,365	4,733	57,446	12.14	10
11	Social Service Workers	2,315	2,502	17,096	6.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,678	13,640	149,417	10.95	15
16	Dishwashers					16
17	Maintenance Workers	1,874	2,016	26,783	13.29	17
18	Housekeepers	8,389	8,980	88,837	9.89	18
19	Laundry	3,189	3,530	36,007	10.20	19
20	Administrator	1,912	2,088	70,646	33.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,386	6,704	80,558	12.02	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)	94,569	101,269	\$ 1,467,860 *	\$ 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	\$ 8,095	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant	Monthly	3,072	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,310	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	1,755	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,232		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT



The Woodbine Nursing Home, LLC

Facility ID#: 0044446

Schedule XIX

12/31/2008

Schedule 21A

Schedule XIX (C) - Professional Fees.

Vendor	Services	Amount
Gary A. Weintrab	Legal	1,890
Stahl Cowwen Crowley	Legal	423
Alpha Data Services LLC	Payroll Processing	441
Health Data Systems Inc	A/R Consulting	5,579
Ivans Inc	Medicare Consulting	553
LTC Solutions Inc	Software Consulting	1,500
Midwest Time Recorder Inc	Software Consulting	450
Payday USA	Payroll Processing	2,346
SAK Management Co.	Bookkeeping Fees	108,935
Richard Peelo & Associates	Accounting	4,200
McGladrey & Pullen, LLP	Accounting	4,270
Personnel Planners, Inc	Unemployment Services	940
Sharon Haugh	Medicare Billing Services	3,600
Midwest Renov	Maintenance Consulting	910
SAK Management Co.	Receiver Fees	60,181
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>		<b>196,218</b>
Allocation from SAK Management - Legal		32,190
Allocation from SAK Management - Data Processing		822
Allocation from SAK Management - Other Consulting		1,988
Offset of SAK Bookkeeping Cost		(108,935)
<b>TOTAL (agree to Schedule V, line 19, column 8)</b>		<b>122,283</b>

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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
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: 01/01/2008Ending: 12/31/2008**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 - \$5,412
- (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? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,577 Line L10, C2
- (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. \$ 36,234  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A 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