

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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

I. IDPH License ID Number: 0043406

Facility Name: WOODSIDE EXTENDED CARE

Address: 120 WEST 26TH STREET SO CHICAGO HTS 60411
 Number City Zip Code

County: COOK

Telephone Number: (847) 674-5795 Fax # (847) 674-5794

HFS ID Number: 39-4153529

Date of Initial License for Current Owners: 11/01/97

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
 Name: BOB KAGDA Telephone Number: (847) 675-3585
 Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2008 to 12/31/2008 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____ (Date) _____
	(Type or Print Name) <u>MORRIS ESFORMES</u> (Title) <u>MANAGER</u>
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____
	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>
	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WOODSIDE EXTENDED CARE

0043406 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 _____

	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	23,424	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,992	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			2,375	2,375	8
9	SNF/PED					9
10	ICF	37,690	318		38,008	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,690	318	2,375	40,383	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.51%

D. How many bed-hold days during this year were paid by the Department? 267 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 20 and days of care provided 2,331

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number

WOODSIDE EXTENDED CARE

0043406

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	147,979	15,280	11,340	174,599		174,599		174,599		1
2	Food Purchase		167,500		167,500		167,500	(319)	167,181		2
3	Housekeeping	97,692	20,410		118,102		118,102		118,102		3
4	Laundry	45,833	12,299	975	59,107		59,107	930	60,037		4
5	Heat and Other Utilities			164,381	164,381		164,381	261	164,642		5
6	Maintenance	92,979	22,197	51,539	166,715		166,715	4,191	170,906		6
7	Other (specify):* TRANSP/SECURITY	54,260		8,077	62,337		62,337	55	62,392		7
8	TOTAL General Services	438,743	237,686	236,312	912,741		912,741	5,118	917,859		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,194,517	57,647	12,842	1,265,006		1,265,006		1,265,006		10
10a	Therapy	101,374			101,374		101,374		101,374		10a
11	Activities	78,057	14,988		93,045		93,045		93,045		11
12	Social Services	27,725		3,066	30,791		30,791		30,791		12
13	CNA Training										13
14	Program Transportation			4,276	4,276		4,276		4,276		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,401,673	72,635	29,184	1,503,492		1,503,492		1,503,492		16
	C. General Administration										
17	Administrative	94,192		180,000	274,192		274,192	(73,133)	201,059		17
18	Directors Fees										18
19	Professional Services			44,799	44,799		44,799	17,936	62,735		19
20	Dues, Fees, Subscriptions & Promotions			17,117	17,117		17,117	(7,061)	10,056		20
21	Clerical & General Office Expenses	82,268	16,950	104,822	204,040		204,040	(97,311)	106,729		21
22	Employee Benefits & Payroll Taxes			279,837	279,837		279,837		279,837		22
23	Inservice Training & Education			1,905	1,905		1,905	5	1,910		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			7,044	7,044		7,044	667	7,711		25
26	Insurance-Prop.Liab.Malpractice			124,935	124,935		124,935	11,194	136,129		26
27	Other (specify):*			362,084	362,084		362,084	(353,280)	8,804		27
28	TOTAL General Administration	176,460	16,950	1,122,543	1,315,953		1,315,953	(500,983)	814,970		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,016,876	327,271	1,388,039	3,732,186		3,732,186	(495,865)	3,236,321		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	975
		0
		975
5	HEAT & OTHER UTILITIES	
	GAS HEAT	55,132
	ELECTRICITY	67,969
	WATER	40,165
	CABLE TV - LOBBY	1,115
		0
		164,381
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,228
	PAINTING & DECORATING	496
	BUILDING REPAIRS	577
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	16,773
	ELEVATOR MAINTENANCE & REPAIR	1,740
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,494
	FIRE SERVICE	26,231
		0
		0
		0
		0
		51,539
7	OTHER	
	SCAVENGER	7,909
	SECURITY SERVICE	168
		0
		0
		8,077
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	2,416
	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	6,826
	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
		12,842
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	3,066
	SOCIAL WORKER XVIII B 45-2	0
		0
		3,066
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

**WOODSIDE EXTENDED CARE
SCHEDULES
12/31/2008**

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

KREG THERAPEUTIC	THERAPEUTIC BED	1091
PRO-CARE	THERAPEUTIC BED	1705
GREAT AMERICA LEASING	COPIER	2417
MEIKEM	DISHWASHER	1430
PI SURVEILLANCE	TV SECURITY MONITOR	9000
PITNEY BOWES	POSTAGE METER	688
PUBLIC STORAGE	STORAGE	<u>2123</u>
	EQUIPMENT RENTAL	18454

Facility Name & ID Number

WOODSIDE EXTENDED CARE

#0043406

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			40,047	40,047		40,047	182,605	222,652		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			20,182	20,182		20,182	277,970	298,152		32
33	Real Estate Taxes							244,729	244,729		33
34	Rent-Facility & Grounds			678,000	678,000		678,000	(678,000)			34
35	Rent-Equipment & Vehicles			46,002	46,002		46,002	2,150	48,152		35
36	Other (specify):* OFFICE RENT			8,736	8,736		8,736	(8,736)			36
37	TOTAL Ownership			792,967	792,967		792,967	20,718	813,685		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		60,267	179,266	239,533		239,533		239,533		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			61,488	61,488		61,488		61,488		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		60,267	240,754	301,021		301,021		301,021		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,016,876	387,538	2,421,760	4,826,174		4,826,174	(475,147)	4,351,027		45

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

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

0043406

Report Period Beginning: **01/01/2008**

Ending: **12/31/2008**

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	5,496	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	(319)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(550)	20		17
18	Fines and Penalties	(16,028)	21		18
19	Entertainment				19
20	Contributions	(5,402)	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	(362,084)	27		24
25	Fund Raising, Advertising and Promotional	(2,604)	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	(49,725)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (431,216)		\$	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)	(43,931)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (43,931)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (475,147)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

WOODSIDE EXTENDED CARE

ID# 0043406

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (30,000)	21	1
2	STAFF DEVELOPMENT	(19,725)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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	(49,725)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSIDE EXTENDED CARE# 0043406

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(319)	0	0	0	0	0	0	0	0	0	0	(319)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	930	0	0	0	0	0	0	0	0	0	930	4
5	Heat and Other Utilities	0	0	261	0	0	0	0	0	0	0	0	261	5
6	Maintenance	0	1,238	2,953	0	0	0	0	0	0	0	0	4,191	6
7	Other (specify):*	0	41	14	0	0	0	0	0	0	0	0	55	7
8	TOTAL General Services	(319)	2,209	3,228	0	0	0	0	0	0	0	0	5,118	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	5,893	(79,026)	0	0	0	0	0	0	0	0	(73,133)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,651	285	12,000	0	0	0	0	0	0	0	17,936	19
20	Fees, Subscriptions & Promotions	(8,556)	1,495	0	0	0	0	0	0	0	0	0	(7,061)	20
21	Clerical & General Office Expenses	(65,753)	(36,355)	4,797	0	0	0	0	0	0	0	0	(97,311)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	5	0	0	0	0	0	0	0	0	0	5	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	387	280	0	0	0	0	0	0	0	0	667	25
26	Insurance-Prop.Liab.Malpractice	0	290	428	10,476	0	0	0	0	0	0	0	11,194	26
27	Other (specify):*	(362,084)	3,664	5,140	0	0	0	0	0	0	0	0	(353,280)	27
28	TOTAL General Administration	(436,393)	(18,970)	(68,096)	22,476	0	(500,983)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(436,712)	(16,761)	(64,868)	22,476	0	(495,865)	29						

STATE OF ILLINOIS

Summary B

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

0043406

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,496	140	874	176,095	0	0	0	0	0	0	0	182,605	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,486	276,484	0	0	0	0	0	0	0	277,970	32
33	Real Estate Taxes	0	0	1,129	243,600	0	0	0	0	0	0	0	244,729	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	1,543	607	0	0	0	0	0	0	0	0	2,150	35
36	Other (specify):*	0	0	(8,736)	0	0	0	0	0	0	0	0	(8,736)	36
37	TOTAL Ownership	5,496	1,683	(4,640)	18,179	0	20,718	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)	(431,216)	(15,078)	(69,508)	40,655	0	(475,147)	45						

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

0043406

Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	4 HOUSEKEEPING	\$	EKS MANAGEMENT		\$ 930	\$ 930	1
2	V	6 MAINTENANCE		" "		1,238	1,238	2
3	V	7 SCAVENGER		" "		41	41	3
4	V	17 CFO SALARY		" "		5,893	5,893	4
5	V	19 PROFESSIONAL FEES		" "		5,651	5,651	5
6	V	20 WANT ADS/BACKGRD CKS		" "		1,495	1,495	6
7	V	21 CLERICAL	54,000	" "		17,645	(36,355)	7
8	V	23 SEMINARS		" "		5	5	8
9	V	25 STAFF TRANSPORTATION		" "		387	387	9
10	V	26 INSURANCE		" "		290	290	10
11	V	27 EMPLOYEE BENEFITS		" "		3,664	3,664	11
12	V	30 SL DEPRECIATION		" "		140	140	12
13	V	35 EQUIPMENT RENT		" "		1,543	1,543	13
14	Total		\$ 54,000			\$ 38,922	\$ * (15,078)	14

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

Facility Name & ID Number

WOODSIDE EXTENDED CARE

0043406

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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 Schedule V	2 Line	3	4	5	6	7	8		
		Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)		
15	V	6	DRIVERS SALARY	\$	EMI ENTERPRISES		\$ 1,786	\$ 1,786	15
16	V	17	REGIONAL DIRECTOR		" "		4,173	4,173	16
17	V	17	MANAGEMENT FEES	92,500	" "			(92,500)	17
18	V	17	OFFICERS SALARY		" "		9,301	9,301	18
19	V	19	ACCOUNTING FEES		" "		185	185	19
20	V	21	CLERICAL		" "		4,774	4,774	20
21	V	25	STAFF TRANSPORTATION		" "		280	280	21
22	V	26	INSURANCE		" "		368	368	22
23	V	27	EMPLOYEE BENEFITS		" "		5,140	5,140	23
24	V	30	SL DEPRECIATION		" "		64	64	24
25	V	35	AUTO LEASE		" "		332	332	25
26	V								26
27	V	5	UTILITIES		IME REALTY		261	261	27
28	V	6	REPAIRS/MAINTENANCE		" "		1,167	1,167	28
29	V	7	ALARM SERVICE		" "		14	14	29
30	V	19	ACCOUNTING FEES		" "		100	100	30
31	V	21	OFFICE EXPENSE		" "		23	23	31
32	V	26	INSURANCE		" "		60	60	32
33	V	30	SL DEPRECIATION		" "		810	810	33
34	V	32	INTEREST		" "		1,486	1,486	34
35	V	33	REAL ESTATE TAX		" "		1,129	1,129	35
36	V	35	STORAGE FEES		" "		275	275	36
37	V	36	OFFICE RENT	8,736	" "			(8,736)	37
38	V								38
39	Total		\$ 101,236				\$ 31,728	\$ * (69,508)	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: 01/01/2008 Ending: 12/31/2008

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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization						
15	V	19	ACCOUNTING FEES	\$	MST REAL ESTATE LLC		\$ 12,000	\$ 12,000	15	
16	V	26	HAZARD INSURANCE		" "		10,476	10,476	16	
17	V	34	RENT	678,000	" "			(678,000)	17	
18	V	30	SL DEPRECIATION		" "		176,095	176,095	18	
19	V	32	INTEREST	733	" "		250,870	250,137	19	
20	V	32	MIP INSURANCE		" "		23,715	23,715	20	
21	V	32	AMORT LOAN COST		" "		2,632	2,632	21	
22	V	33	REAL ESTATE TAX		" "		243,600	243,600	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		\$ 678,733				\$ 719,388	\$ * 40,655	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:

01/01/2008

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	ALLOCATION FROM EMI ENTERPRISES:				SEE ATTACHED				\$	1	
2	MORRIS ESFORMES	PRESIDENT	MGMT CONSUL	40.00	SCHEDULE	5	6.25	SALARY	9,301	17-7	2
3											3
4											4
5	PHILIP ESFORMES	MGMT CONSULT	MGMT CONSUL	22.50		5	7.14	MGMT FEE	87,500	17-3	5
6											6
7											7
8	ALLOCATION FROM EKS MANAGEMENT:										8
9	AVRUM WEINFELD		CFO	0.00		3	5.17	SALARY	5,893	17-7	9
10											10
11											11
12											12
13								TOTAL	\$ 102,694		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:

01/01/2008

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING	CENSUS DAYS	859,462	14 FACILITIES	\$ 19,500	\$ 40,992	\$ 930	1
2	6	MAINTENANCE	" "	859,462	14 FACILITIES	25,953	40,992	1,238	2
3	7	SCAVENGER	" "	859,462	14 FACILITIES	866	40,992	41	3
4	17	CFO SALARY-A. WEINFELD	" "	859,462	14 FACILITIES	123,563	40,992	5,893	4
5	19	PROFESSIONAL FEES	" "	859,462	14 FACILITIES	118,475	40,992	5,651	5
6	20	WANT ADS/BACKGRND CHKS	" "	859,462	14 FACILITIES	31,349	40,992	1,495	6
7	21	CLERICAL	" "	859,462	14 FACILITIES	369,953	40,992	17,645	7
8	23	SEMINARS	" "	859,462	14 FACILITIES	95	40,992	5	8
9	25	STAFF TRANSPORTATION	" "	859,462	14 FACILITIES	8,106	40,992	387	9
10	26	INSURANCE	" "	859,462	14 FACILITIES	6,085	40,992	290	10
11	27	EMPLOYEE BENEFITS	" "	859,462	14 FACILITIES	76,819	40,992	3,664	11
12	30	SL DEPRECIATION	" "	859,462	14 FACILITIES	2,943	40,992	140	12
13	35	EQUIPMENT RENT	" "	859,462	14 FACILITIES	32,345	40,992	1,543	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					\$ 816,052	\$ 521,578	\$ 38,922	25

Facility Name & ID Number WOODSIDE EXTENDED CARE

0043406 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

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	CENSUS DAYS	859,462	14 FACILITIES	\$ 37,451	\$ 40,992	\$ 1,786	1
2	17	REGIONAL DIRECTOR	" "	859,462	14 FACILITIES	87,500	40,992	4,173	2
3	17	OFFICERS SALARY-MESFOR	" "	859,462	14 FACILITIES	195,000	40,992	9,301	3
4	19	ACCOUNTING FEES	" "	859,462	14 FACILITIES	3,885	40,992	185	4
5	21	CLERICAL	" "	859,462	14 FACILITIES	100,089	40,992	4,774	5
6	25	STAFF TRANSPORTATION	" "	859,462	14 FACILITIES	5,861	40,992	280	6
7	26	INSURANCE	" "	859,462	14 FACILITIES	7,710	40,992	368	7
8	27	EMPLOYEE BENEFITS	" "	859,462	14 FACILITIES	107,763	40,992	5,140	8
9	30	DEPRECIATION	" "	859,462	14 FACILITIES	1,340	40,992	64	9
10	35	AUTO LEASE	" "	859,462	14 FACILITIES	6,960	40,992	332	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					\$ 553,559	\$ 377,654	\$ 26,403	25

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

0043406

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

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	\$ 5,588		8,736	\$ 261	1
2	6	REPAIRS/MAINTENANCE	187,059	14 FACILITIES	24,974	12,303	8,736	1,167	2
3	7	ALARM FEES	187,059	14 FACILITIES	301		8,736	14	3
4	19	ACCOUNTING FEES	187,059	14 FACILITIES	2,135		8,736	100	4
5	21	OFFICE EXPENSE	187,059	14 FACILITIES	489		8,736	23	5
6	26	INSURANCE	187,059	14 FACILITIES	1,275		8,736	60	6
7	30	SL DEPRECIATION	187,059	14 FACILITIES	17,336		8,736	810	7
8	32	INTEREST	187,059	14 FACILITIES	31,829		8,736	1,486	8
9	33	REAL ESTATE TAX	187,059	14 FACILITIES	24,171		8,736	1,129	9
10	35	STORAGE FEES	187,059	14 FACILITIES	5,882		8,736	275	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				\$ 113,980	\$ 12,303		\$ 5,325	25

Facility Name & ID Number WOODSIDE EXTENDED CARE

0043406

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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		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						\$	\$			\$						
2	CAMBRIDGE REALTY		X	MORTGAGE	\$52,947.11	09/05	4,919,200	4,688,858	09/35	5.3100	250,869						
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		09/05	172,440	20,083	09/35		2,632						
4	MIP INSURANCE										23,715						
5	RELATED PARTY: IME REALTY	X		MORTGAGE							1,486						
Working Capital																	
6	FIRST BANK		X	WORKING CAPITAL	\$5,000+INTEREST		310,000	69,991		PRIME+	7,735						
7	US BANK		X	WORKING CAPITAL-LOC	DEMAND		207,000	655,000		PRIME+	12,447						
8																	
9	TOTAL Facility Related				\$52,947.11		\$ 5,608,640	\$ 5,433,932			\$ 298,884						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 5,608,640	\$ 5,433,932			\$ 298,884						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 23,715 Line # 32

* 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.)

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

0043406 Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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.		\$	256,607	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.)		\$	244,003	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(12,604)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	256,204	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	243,600	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	233,772	8	
	2004	238,701	9	
	2005	248,800	10	
	2006	249,133	11	
	2007	244,003	12	
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 2007 TAX BILL.				
		FOR BHF USE ONLY		
	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

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.

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:

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

Facility Name & ID Number WOODSIDE EXTENDED CARE# 0043406

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		
	Bed* ^s	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		709,232	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		1,068	9
10		WATER SOFTENING SYSTEM		1997	6,926	178	39	178		1,980	10
11		FLOORING		1997	3,910	100	39	100		1,104	11
12		FLOORING / DOORS / WINDOWS		1998	29,194	748	39	748		7,954	12
13		ROOF		1998	84,450	2,165	39	2,165		23,548	13
14		DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.		1998	30,915	793	39	793		8,634	14
15		PAINTING / DECORATING		1998	15,111	387	39	387		4,080	15
16		FLOORING / DOORS / BATHROOM FIXTURES		1999	11,198	288	39	288		2,860	16
17		CHAIN LINK FENCE		1999	5,100	131	39	131		1,239	17
18		FLOOR TILES/COVE BASE		2000	22,766	828	27.5	828		7,417	18
19		PAIR OF ALUMINUM DOORS		2000	2,193	80	27.5	80		703	19
20		PLUMBING		2000	9,913	360	27.5	360		2,925	20
21		PLUMBING / VANITY / SINK / FLOORING		2001	37,788	1,374	27.5	1,374		10,620	21
22		PAVING		2002	18,562	675	27.5	675		4,416	22
23		BATHROOM SINKS		2002	3,888	141	27.5	141		852	23
24		BATHROOM SINKS		2003	7,776	283	27.5	283		1,686	24
25		FLOORING / CARPETING & TILE		2003	13,887	504	27.5	504		2,637	25
26		ROOF		2003	7,800	284	27.5	284		1,597	26
27		FENCE		2003	9,500	634	15	634		3,486	27
28		WINDOWS		2004	46,880	1,705	27.5	1,705		7,886	28
29		SPRINKLER SYSTEM / ELECTRICAL / ROOF AC / TILING		2007	298,345	10,849	27.5	10,849		20,312	29
30		ADDL FIRE SAFETY/TANK/GENERATOR/SECURITY SYST		2008	73,619	2,566	27.5	2,566		2,566	30
31		ROLLING SHUTTER		2008	3,970	90	27.5	90		90	31
32		BUILT-IN CABINET		2008	6,200	207	15	207		207	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.

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	2001	7,578		10	758	758	5,685	38
39	2004	33,108	1,907	10	3,311	1,404	14,899	39
40	2005	30,694	1,116	27.5	1,116		3,704	40
41	2006	49,079	1,784	27.5	1,784		4,758	41
42								42
43								43
44								44
45								45
46								46
47								47
48		25,771	778	39	778			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		\$ 5,042,569	\$ 181,680		\$ 183,842	\$ 2,162	\$ 858,145	70

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

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

0043406

Report Period Beginning:

01/01/2008

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	\$ 428,005	\$ 33,526	\$ 38,098	\$ 4,572	8-15 YRS	\$ 218,673	71
72	Current Year Purchases	9,519	1,714	476	(1,238)	10 YRS	476	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC - EKS MGMT 140/EMI ENTERP 64/IME REALTY 32		236	236				74
75	TOTALS	\$ 437,524	\$ 35,476	\$ 38,810	\$ 3,334		\$ 219,149	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	2	
	Reference	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)	\$ 5,709,919	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 217,156	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 222,652	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,496	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,077,294	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.

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

0043406

Report Period Beginning: **01/01/2008**

Ending: **12/31/2008**

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

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 \$ _____

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: \$ **18,454**

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:	LANDROVER	\$ 1100 LESS P/R DED	\$ 6,485	17
18	BANKING,MAINT,	'05 BMW X53	695.00	4,343	18
19	MARKETING, NSG,	'07 NISSAN MURANO	699.14	8,440	19
20	ACTIVITIES	'06 FORD E350 VAN	690.00	8,280	20
21	TOTAL		\$ #####	\$ 27,548	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
					Units	Cost								
1	Licensed Occupational Therapist	39-3	hrs	\$				\$ 93,083	\$			\$ 93,083	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs					1,116				1,116	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39-3	hrs					85,067				85,067	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						55,096			55,096	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify): RADIOL/LAB/SUPPL	39-2							5,171			5,171	13	
14	TOTAL			\$				\$ 179,266	\$ 60,267			\$ 239,533	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: **01/01/2008**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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 527	\$ 27,663	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,000)	1,386,527	1,386,527	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	132,462	158,458	6
7	Other Prepaid Expenses		1,476	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX/INSUR ESCROWS	125,750	239,071	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,645,266	\$ 1,813,195	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	860,319	15
16	Equipment, at Historical Cost	445,101	451,301	16
17	Accumulated Depreciation (book methods)	(456,285)	(1,287,628)	17
18	Deferred Charges		152,357	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe DUE FROM LLC)	54,847		22
23	Other(specify): REPLACEMENT RESERVE		166,569	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 156,544	\$ 4,715,446	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,801,810	\$ 6,528,641	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 218,274	\$ 218,274	26
27	Officer's Accounts Payable	598,777	598,777	27
28	Accounts Payable-Patient Deposits	4,030	4,030	28
29	Short-Term Notes Payable	715,000	796,143	29
30	Accrued Salaries Payable	71,613	71,613	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,503	31,503	31
32	Accrued Real Estate Taxes(Sch.IX-B)		256,204	32
33	Accrued Interest Payable	3,090	23,838	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)	\$ 1,642,287	\$ 2,000,382	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,991	9,991	39
40	Mortgage Payable		4,607,715	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)	\$ 9,991	\$ 4,617,706	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,652,278	\$ 6,618,088	46
47	TOTAL EQUITY(page 18, line 24)	\$ 149,532	\$ (89,447)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,801,810	\$ 6,528,641	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 215,349	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 215,353	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	557,679	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	(623,500)	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)	\$ (65,821)	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)	\$ 149,532	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **WOODSIDE EXTENDED CARE**# **0043406**Report Period Beginning: **01/01/2008**Ending: **12/31/2008****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,217,364	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,217,364	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	170,506	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 170,506	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,387,870	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	912,741	31
32	Health Care	1,503,492	32
33	General Administration	1,315,953	33
B. Capital Expense			
34	Ownership	792,967	34
C. Ancillary Expense			
35	Special Cost Centers	239,533	35
36	Provider Participation Fee	61,488	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,826,174	40
41	Income before Income Taxes (line 30 minus line 40)**	561,696	41
42	Income Taxes	(4,017)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 557,679	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: **01/01/2008**

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	2,115	2,158	\$ 69,138	\$ 32.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,883	8,024	176,582	22.01	3
4	Licensed Practical Nurses	13,570	14,057	314,485	22.37	4
5	CNAs & Orderlies	49,048	52,364	504,262	9.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,756	6,267	101,374	16.18	8
9	Activity Director					9
10	Activity Assistants	7,879	8,340	78,057	9.36	10
11	Social Service Workers	1,790	1,900	27,725	14.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,286	16,058	147,979	9.22	15
16	Dishwashers					16
17	Maintenance Workers	6,935	7,181	92,979	12.95	17
18	Housekeepers	11,389	12,021	97,692	8.13	18
19	Laundry	5,316	5,721	45,833	8.01	19
20	Administrator	2,160	2,160	94,192	43.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,941	9,346	82,268	8.80	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	1,501	1,539	15,345	9.97	31
32	Other Health Ca <u>MDS/ADMISSION</u>	6,248	6,637	114,705	17.28	32
33	Other(specify) <u>TRANSP/SECURI</u>	6,296	6,326	54,260	8.58	33
34	TOTAL (lines 1 - 33)	152,113	160,099	\$ 2,016,876 *	\$ 12.60	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	6,826	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	3,066	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)		\$ 33,832		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	\$ 94,192	Workers' Compensation Insurance	\$ 52,627	IDPH License Fee	\$	
				Unemployment Compensation Insurance	36,180	Advertising: Employee Recruitment	601	
				FICA Taxes	151,404	Health Care Worker Background Check	0	
				Employee Health Insurance	39,281	(Indicate # of checks performed _____)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	5,952	
				EMPLOYEE BENEFITS - OTHER	345	MARKETING/ADV/PROMO	2,604	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	7,960	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,495	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(5,952)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(2,604)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,192	TOTAL (agree to Schedule V, line 22, col.8)	\$ 279,837	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,056	
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			\$ 92,500				Out-of-State Travel	\$
PHILIP ESFORMES - MANAGEMENT FEES			87,500					
							In-State Travel	
								0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 180,000	TOTAL		\$	Seminar Expense	
								0
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	\$
ALPHA DATA	DATA PROCESSING		\$ 4,228				TOTAL	
E-HEALTH DATA SOLUTIONS	DATA PROCESSING		4,251					
HDSI	DATA PROCESSING		6,081					
LTC SOLUTION	DATA PROCESSING		1,500					
MAXX SOURCE	DATA PROCESSING		1,379					
WISC PHYSICIANS SERVICE	DATA PROCESSING		356					
IVANS	DATA PROCESSING		127					
KBKB	ACCOUNTING FEES		19,900					
CHARLES BUTZOW	FIRE SAFETY CODE CONSUI		392					
PERSONNEL PLANNERS	EMPLOYMENT CONSULT		1,285					
MICHELLE RATCLIFF	PRE-HUD INSPECTION		800					
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.)			\$ 44,799					

* Attach copy of IMRF notifications

**See instructions.

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?
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$ 4,282
- (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. \$ 0 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. \$ 61,488
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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.