

Facility Name & ID Number WOODSTOCK RESIDENCE# 0038653 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>42,090</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>115</u>	TOTALS	<u>115</u>	<u>42,090</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,620</u>	<u>2,670</u>	<u>5,380</u>	<u>25,670</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,620</u>	<u>2,670</u>	<u>5,380</u>	<u>25,670</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.99%

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

None (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)

N/AF. 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 2/1/93

J. Was the facility purchased or leased after January 1, 1978?

YES Date 2/1/93 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 29 and days of care provided 3,346Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL 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.

Facility Name & ID Number **WOODSTOCK RESIDENCE** # **0038653** Report Period Beginning: **1/01/08** Ending: **12/31/08**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	198,113	15,812	4,588	218,513		218,513		218,513		1
2	Food Purchase		171,180		171,180		171,180	(88)	171,092		2
3	Housekeeping	83,659	24,856		108,515		108,515		108,515		3
4	Laundry	70,513	11,237		81,750		81,750		81,750		4
5	Heat and Other Utilities			101,286	101,286		101,286		101,286		5
6	Maintenance	49,591	10,713	45,343	105,647		105,647	170	105,817		6
7	Other (specify):*										7
8	TOTAL General Services	401,876	233,798	151,217	786,891		786,891	82	786,973		8
	B. Health Care and Programs										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	1,145,889	95,036	149,081	1,390,006		1,390,006		1,390,006		10
10a	Therapy	37,947		330,744	368,691		368,691		368,691		10a
11	Activities	48,118	14,144	3,132	65,394		65,394		65,394		11
12	Social Services	35,212		2,748	37,960		37,960		37,960		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,267,166	109,180	496,705	1,873,051		1,873,051		1,873,051		16
	C. General Administration										
17	Administrative	54,326		159,765	214,091		214,091	(72,937)	141,154		17
18	Directors Fees										18
19	Professional Services			116,010	116,010		116,010	1,666	117,676		19
20	Dues, Fees, Subscriptions & Promotions			77,454	77,454		77,454	(10,637)	66,817		20
21	Clerical & General Office Expenses	156,377	13,344	44,803	214,524		214,524	44,336	258,860		21
22	Employee Benefits & Payroll Taxes			268,020	268,020		268,020		268,020		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,144	1,144		1,144		1,144		24
25	Other Admin. Staff Transportation			6,642	6,642		6,642	6,504	13,146		25
26	Insurance-Prop.Liab.Malpractice			102,299	102,299		102,299	7,368	109,667		26
27	Other (specify):*							7,880	7,880		27
28	TOTAL General Administration	210,703	13,344	776,137	1,000,184		1,000,184	(15,820)	984,364		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,879,745	356,322	1,424,059	3,660,126		3,660,126	(15,738)	3,644,388		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.

Facility Name & ID Number **WOODSTOCK RESIDENCE**

#0038653

Report Period Beginning:

1/01/08

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			3,734	3,734		3,734	164,553	168,287			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,605	17,605		17,605	346,734	364,339			32
33	Real Estate Taxes			67,605	67,605		67,605		67,605			33
34	Rent-Facility & Grounds			391,067	391,067		391,067	(390,185)	882			34
35	Rent-Equipment & Vehicles			30,004	30,004		30,004		30,004			35
36	Other (specify):*											36
37	TOTAL Ownership			510,015	510,015		510,015	121,102	631,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			117,684	117,684		117,684		117,684			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,136	63,136		63,136		63,136			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			180,820	180,820		180,820		180,820			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,879,745	356,322	2,114,894	4,350,961		4,350,961	105,364	4,456,325			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 WOODSTOCK RESIDENCE

0038653

Report Period Beginning: 1/01/08

Ending: 12/31/08

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				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	(88)	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				17
18	Fines and Penalties	(20,771)	21		18
19	Entertainment	(1,085)	21		19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,516)	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	7,256			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,454)		\$	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)	128,818		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 128,818		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 105,364		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

WOODSTOCK RESIDENCE

ID# 0038653

Report Period Beginning: 1/01/08

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	IL COUNCIL LTC - COPE	\$ (2,234)	20	1
2	MISCELLANEOUS INCOME	(429)	21	2
3	ADJ. DEPRECIATION	9,919	30	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	7,256		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSTOCK RESIDENCE

0038653

Report Period Beginning:

1/01/08

Ending:

12/31/08

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	(88)	0	0	0	0	0	0	0	0	0	0	(88)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	170	0	0	0	0	0	0	0	0	170	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(88)	0	170	0	82	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	0	(72,937)	0	0	0	0	0	0	0	0	(72,937)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,666	0	0	0	0	0	0	0	0	1,666	19
20	Fees, Subscriptions & Promotions	(10,750)	0	113	0	0	0	0	0	0	0	0	(10,637)	20
21	Clerical & General Office Expenses	(22,535)	0	66,871	0	0	0	0	0	0	0	0	44,336	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	6,504	0	0	0	0	0	0	0	0	6,504	25
26	Insurance-Prop.Liab.Malpractice	0	7,368	0	0	0	0	0	0	0	0	0	7,368	26
27	Other (specify):*	0	0	7,880	0	0	0	0	0	0	0	0	7,880	27
28	TOTAL General Administration	(33,285)	7,368	10,097	0	(15,820)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,373)	7,368	10,267	0	(15,738)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **WOODSTOCK RESIDENCE**

0038653

Report Period Beginning:

1/01/08

Ending:

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	9,919	154,382	252	0	0	0	0	0	0	0	0	164,553	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	346,734	0	0	0	0	0	0	0	0	0	346,734	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(391,067)	882	0	0	0	0	0	0	0	0	(390,185)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,919	110,049	1,134	0	121,102	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)	(23,454)	117,417	11,401	0	105,364	45							

Facility Name & ID Number WOODSTOCK RESIDENCE

0038653

Report Period Beginning:

1/01/08

Ending:

12/31/08

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
ESTATE OF ROBERT NATAUPSKY	100			WOODSTOCK RESIDENCE REALTY, LLC		BUILDING
		SEE ATTACHED				

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	34 RENT	\$	CCCW REALTY, LLC (pass thru to Woodstock Residence Realty, LLC)		\$	\$	1
2	V							2
3	V	34 RENT	391,067	WOODSTOCK RESIDENCE REALTY, LLC			(391,067)	3
4	V	32 INTEREST				324,658	324,658	4
5	V	30 DEPRECIATION				154,382	154,382	5
6	V	32 MIP INSURANCE				22,076	22,076	6
7	V	26 INSURANCE				7,368	7,368	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V	19 LEGAL FEES	29,650	LAW OFFICE OF ABRAHAM GUTNICKI		29,650		12
13	V							13
14	Total		\$ 420,717			\$ 538,134	\$ * 117,417	14

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

Facility Name & ID Number WOODSTOCK RESIDENCE# 0038653Report Period Beginning: 1/01/08Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 Home Office	\$ 159,765	AA Healthcare Management, LLC	100.00%	\$		\$ (159,765)	15
16	V	5 Utilities		AA Healthcare Management, LLC					16
17	V	6 Repairs & Maintenance		AA Healthcare Management, LLC		170		170	17
18	V	17 Owners Compensation		AA Healthcare Management, LLC		86,828		86,828	18
19	V	19 Professional Fees		AA Healthcare Management, LLC		1,666		1,666	19
20	V	20 Fees, Subscriptions		AA Healthcare Management, LLC		113		113	20
21	V	21 Clerical Salaries		AA Healthcare Management, LLC		66,297		66,297	21
22	V	21 Office Expenses		AA Healthcare Management, LLC		574		574	22
23	V	24 Travel & Seminars		AA Healthcare Management, LLC					23
24	V	25 Transportation		AA Healthcare Management, LLC		6,504		6,504	24
25	V	26 Insurance		AA Healthcare Management, LLC					25
26	V	27 Employee Benefits		AA Healthcare Management, LLC		7,880		7,880	26
27	V	30 Depreciation		AA Healthcare Management, LLC		252		252	27
28	V	34 Rent		AA Healthcare Management, LLC		882		882	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		\$ 159,765			\$ 171,166	\$ *	11,401	39

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

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	AARON TOPPER	MANAGER	ADMINISTRATIV	NONE	SEE ATTACHED	12	23.00	MGT FEES	\$ 86,828	17-7	1
2											2
3	ALISSA NATAUPSKY	RELATIVE	ADMINISTRATIV	NONE		40	100.00	SALARY	19,900	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 106,728		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 WOODSTOCK RESIDENCE

0038653

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1/01/08

Ending: 12/31/08

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 AA Healthcare Management
 Street Address 8320 Skokie Blvd.
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 983-4860
 Fax Number (847) 673-3379

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					\$	\$		\$	1		
2	6	Repairs & Maintenance	Patient Days	56,739	2	375	25,670	170	2		
3	17	Owners Compensation	Patient Days	56,739	2	191,917	25,670	86,828	3		
4	19	Professional Fees	Patient Days	56,739	2	3,683	25,670	1,666	4		
5	20	Fees, Subscriptions	Patient Days	56,739	2	250	25,670	113	5		
6	21	Clerical Salaries	Patient Days	56,739	2	146,537	146,537	66,297	6		
7	21	Office Expenses	Patient Days	56,739	2	1,269	25,670	574	7		
8	24	Travel & Seminars	Patient Days	56,739	2		25,670	0	8		
9	25	Transportation	Patient Days	56,739	2	14,375	25,670	6,504	9		
10	26	Insurance	Patient Days	56,739	2	0	25,670	0	10		
11	27	Employee Benefits	Patient Days	56,739	2	17,417	25,670	7,880	11		
12	30	Depreciation	Patient Days	56,739	2	558	25,670	252	12		
13	34	Rent Expense	Patient Days	56,739	2	1,950	25,670	882	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				\$	378,331	\$	146,537	\$	171,166	25

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	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	CAPSTONE		X	MORTGAGE		8/1/00	\$ 4,513,800	\$ 4,427,357		\$ 324,658	1									
2				MIP						22,076	2									
3											3									
4											4									
5											5									
Working Capital																				
6	HP BANK		X	LINE OF CREDIT				500,000		17,605	6									
7											7									
8											8									
9	TOTAL Facility Related						\$ 4,513,800	\$ 4,927,357		\$ 364,339	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$ 4,513,800	\$ 4,927,357		\$ 364,339	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,076 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.)

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 WOODSTOCK RESIDENCE COUNTY MCHENRY

FACILITY IDPH LICENSE NUMBER 0038653

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

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>13-05-254-015</u>	<u>NURSING HOME</u>	\$ <u>65,607.38</u>	\$ <u>65,607.38</u>
2. <u>13-05-254-011</u>	<u>NURSING HOME</u>	\$ <u>1,997.75</u>	\$ <u>1,997.75</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>67,605.13</u>	\$ <u>67,605.13</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.

Facility Name & ID Number WOODSTOCK RESIDENCE# 0038653 Report Period Beginning:1/01/08 Ending:12/31/08**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 29,252 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1C. 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).

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>2000</u>	\$ <u>450,000</u>	1
2					2
3	TOTALS			\$ 450,000	3

Facility Name & ID Number **WOODSTOCK RESIDENCE**

0038653

Report Period Beginning:

1/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	115		2000	1969	\$ 2,919,309	\$ 75,483	40	\$ 75,483	\$	\$ 673,908	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		IMPROVEMENTS		2000	206,585	10,330	20	10,330		83,495	9
10		IMPROVEMENTS		2001	132,870	5,597	20	5,597		42,117	10
11											11
12		VARIOUS		1994	6,149		20	158	158	2,359	12
13		VARIOUS		1995	9,053		20	232	232	3,240	13
14		VARIOUS		1996	9,800		20	251	251	3,256	14
15		VARIOUS		1998	6,435		20	165	165	1,808	15
16		VARIOUS		2001	2,617		20	67	67	534	16
17		VARIOUS		2002	1,702		20	243	243	1,560	17
18		VARIOUS		2003	7,264		20	363	363	2,057	18
19											19
20		PHONES		2004	2,804		20	140	140	572	20
21		PHONES		2004	2,738		20	137	137	559	21
22		CONSTRUCTION DOORS		2004	2,437		20	122	122	610	22
23		DOORS		2004	1,399		20	70	70	297	23
24		FIRE ALARM DOOR		2005	1,511		20	76	76	278	24
25											25
26											26
27		LANDSCAPING		2008	9,250	385	10	385		385	27
28		LANDSCAPING		2008	3,145	105	10	105		105	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

Facility Name & ID Number WOODSTOCK RESIDENCE

0038653

Report Period Beginning:

1/01/08

Ending:

12/31/08

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)	\$ 3,325,068	\$ 91,900		\$ 93,924	\$ 2,024	\$ 817,140	70

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

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	\$ 768,322	\$ 62,973	\$ 70,867	\$ 7,894	VAR	\$ 669,300	71
72	Current Year Purchases	23,747	3,244	3,244		5	3,244	72
73	Fully Depreciated Assets							73
74	Allocation from AA HC Mgt		252	252				74
75	TOTALS	\$ 792,069	\$ 66,469	\$ 74,363	\$ 7,894		\$ 672,544	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,567,137	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 158,369	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 168,287	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,918	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,489,684	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 WOODSTOCK RESIDENCE

0038653

Report Period Beginning: 1/01/08

Ending: 12/31/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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: \$ 30,004 Description: DISH MACHINE \$1,398; MEDICAL EQUIP \$28,606

(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			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$ 31,775	\$		\$ 31,775	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			645			645	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			291,284			291,284	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				103,292		103,292	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-3					14,392		14,392	12
13	Other (specify): <u>RT</u>	10a-3				7,040			7,040	13
14	TOTAL			\$		\$ 330,744	\$ 117,684		\$ 448,428	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 **WOODSTOCK RESIDENCE**# **0038653**Report Period Beginning: **1/01/08**

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/08**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 731	\$	1
2	Cash-Patient Deposits	14,045		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,017,979		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,432		6
7	Other Prepaid Expenses	44,803		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	467,651		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,569,641	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	12,395		15
16	Equipment, at Historical Cost	23,746		16
17	Accumulated Depreciation (book methods)	(3,734)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 32,407	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,602,048	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 930,171	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,853		28
29	Short-Term Notes Payable	500,000		29
30	Accrued Salaries Payable	68,927		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	138,506		36
37	Due Others	341,187		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,999,644	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,999,644	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (397,596)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,602,048	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (17,541)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (17,541)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(380,055)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (380,055)	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)	\$ (397,596)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WOODSTOCK RESIDENCE# 0038653Report Period Beginning: 1/01/08Ending: 12/31/08**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	\$ 3,425,463	1
2	Discounts and Allowances for all Levels	65,797	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,491,260	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	387,250	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 387,250	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	82,450	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,517	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 91,967	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	Misc. Income	429	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 429	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,970,906	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	786,891	31
32	Health Care	1,873,051	32
33	General Administration	1,000,184	33
B. Capital Expense			
34	Ownership	510,015	34
C. Ancillary Expense			
35	Special Cost Centers	117,684	35
36	Provider Participation Fee	63,136	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,350,961	40
41	Income before Income Taxes (line 30 minus line 40)**	(380,055)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (380,055)	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 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 **WOODSTOCK RESIDENCE**

0038653

Report Period Beginning: **1/01/08**

Ending:

12/31/08

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	861	1,037	\$ 32,969	\$ 31.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,932	4,406	148,114	33.62	3
4	Licensed Practical Nurses	16,590	17,714	413,948	23.37	4
5	CNAs & Orderlies	42,069	45,129	520,132	11.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,236	3,364	37,947	11.28	8
9	Activity Director					9
10	Activity Assistants	3,804	4,108	48,118	11.71	10
11	Social Service Workers	1,936	2,080	35,212	16.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,249	18,171	198,113	10.90	15
16	Dishwashers					16
17	Maintenance Workers	2,626	2,810	49,591	17.65	17
18	Housekeepers	7,831	8,491	83,659	9.85	18
19	Laundry	8,320	9,133	70,513	7.72	19
20	Administrator	1,695	1,823	54,326	29.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,525	6,989	156,377	22.37	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	1,848	2,056	30,726	14.94	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	118,522	127,311	\$ 1,879,745 *	\$ 14.76	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	92	\$ 4,588	1-03	35
36	Medical Director	Monthly	11,000	9-03	36
37	Medical Records Consultant	72	1,152	10-03	37
38	Nurse Consultant		4,166	10-03	38
39	Pharmacist Consultant		1,145	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,679	11-03	44
45	Social Service Consultant		2,748	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	195	\$ 26,478		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,511	\$ 103,535	10-03	50
51	Licensed Practical Nurses	1,068	39,083	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,579	\$ 142,618		53

Facility Name & ID Number **WOODSTOCK RESIDENCE**

0038653

Report Period Beginning: **1/01/08**

Ending: **12/31/08**

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	
ALISSA NATAUPSKY	ADMINISTRATOR		\$ 19,900	Workers' Compensation Insurance	\$ 40,174	IDPH License Fee	\$ 8,273	
RICHARD RIMKUS	ADMINISTRATOR		2,288	Unemployment Compensation Insurance	32,036	Advertising: Employee Recruitment		
SAMUEL BIBER	ADMINISTRATOR		34,960	FICA Taxes	134,475	Health Care Worker Background Check (Indicate # of checks performed)	690	
				Employee Health Insurance	53,094	Patient Background Checks		
				Employee Meals		ADVERTISING & MARKETING	8,516	
				Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS	3,544	
ACCRUALS			(2,822)	401K		LICENSES	6,597	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 54,326	EMPLOYEE BENEFITS-OTHER	8,241	EMPLOYEE RECRUITMENT	47,600	
				EMPLOYEE PHYSICAL EXAMS		ALLOCATION FROM AA HC MGT	113	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(8,516)	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 268,020	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 66,817	
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	1,144
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 1,144
C. Professional Services								
Vendor/Payee	Type		Amount					
ABRAHAM GUTNICKI	LEGAL		\$ 29,650					
MEYER MAGENCE	LEGAL		5,436					
SARNOFF & BACC	LEGAL		3,362					
FR&R	ACCOUNTING		34,200					
VARIOUS	DATA PROCESSING		20,459					
PERSONNEL PLANNERS	UNEMPLOYMENT CONS		1,684					
ALARM DETECTION SERV			1,375					
MELVYN GOODMAN	ACCOUNTING		244					
VARIOUS	BILLING SERVICES		19,600					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 116,010					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WOODSTOCK RESIDENCE

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LTC \$4,795
- (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? 5 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,697 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. \$ 63,136
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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? N/A
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.