

Facility Name & ID Number WOODSTOCK RESIDENCE

0038653 Report Period Beginning: 1/1/09 Ending: 12/31/09

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>41,975</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>41,975</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>17,012</u>	<u>1,608</u>	<u>6,277</u>	<u>24,897</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>17,012</u>	<u>1,608</u>	<u>6,277</u>	<u>24,897</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.31%

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/A

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 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 4,773

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number **WOODSTOCK RESIDENCE** # **0038653** Report Period Beginning: **1/1/09** Ending: **12/31/09**

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	223,588	12,007	4,530	240,125		240,125		240,125		1
2	Food Purchase		139,875		139,875		139,875	(45)	139,830		2
3	Housekeeping	73,208	31,003		104,211		104,211		104,211		3
4	Laundry	59,928	13,018		72,946		72,946		72,946		4
5	Heat and Other Utilities			96,713	96,713		96,713		96,713		5
6	Maintenance	59,948	13,551	44,694	118,193		118,193		118,193		6
7	Other (specify):*										7
8	TOTAL General Services	416,672	209,454	145,937	772,063		772,063	(45)	772,018		8
	B. Health Care and Programs										
9	Medical Director			13,000	13,000		13,000		13,000		9
10	Nursing and Medical Records	1,238,075	146,381	43,685	1,428,141		1,428,141		1,428,141		10
10a	Therapy	119,066	227	484,385	603,678		603,678		603,678		10a
11	Activities	50,915	3,455	10,180	64,550		64,550		64,550		11
12	Social Services	33,590		6,420	40,010		40,010		40,010		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,441,646	150,063	557,670	2,149,379		2,149,379		2,149,379		16
	C. General Administration										
17	Administrative	82,851		222,000	304,851		304,851	(135,218)	169,633		17
18	Directors Fees										18
19	Professional Services			94,395	94,395	(6,147)	88,248	9,695	97,943		19
20	Dues, Fees, Subscriptions & Promotions			54,987	54,987		54,987	(44,772)	10,215		20
21	Clerical & General Office Expenses	177,702	18,001	56,003	251,706		251,706	112,180	363,886		21
22	Employee Benefits & Payroll Taxes			324,037	324,037		324,037		324,037		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,916	5,916		5,916	869	6,785		24
25	Other Admin. Staff Transportation			8,805	8,805		8,805	12,801	21,606		25
26	Insurance-Prop.Liab.Malpractice			136,899	136,899		136,899	7,398	144,297		26
27	Other (specify):*							10,804	10,804		27
28	TOTAL General Administration	260,553	18,001	903,042	1,181,596	(6,147)	1,175,449	(26,243)	1,149,206		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,118,871	377,518	1,606,649	4,103,038	(6,147)	4,096,891	(26,288)	4,070,603		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:

1/1/09

Ending:

12/31/09

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			26,643	26,643		26,643	156,340	182,983			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,738	23,738		23,738	318,672	342,410			32
33	Real Estate Taxes			36,130	36,130	6,147	42,277	9,505	51,782			33
34	Rent-Facility & Grounds			363,405	363,405		363,405	(360,020)	3,385			34
35	Rent-Equipment & Vehicles			28,243	28,243		28,243		28,243			35
36	Other (specify):*											36
37	TOTAL Ownership			478,159	478,159	6,147	484,306	124,497	608,803			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			229,624	229,624		229,624		229,624			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			292,587	292,587		292,587		292,587			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,118,871	377,518	2,377,395	4,873,784		4,873,784	98,209	4,971,993			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:

1/1/09

Ending:

12/31/09

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	(1,365)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(45)	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	(12,603)	21		18
19	Entertainment	(534)	21		19
20	Contributions	(13,600)	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	(42,589)	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	11,860			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,876)		\$	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)	157,085		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 157,085		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 98,209		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	
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WOODSTOCK RESIDENCE

ID# 0038653

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	IL COUNCIL LTC - COPE	\$ (2,336)	20	1
2	MISC INCOME	(167)	32	2
3	LATE FEES	(1,590)	21	3
4	REAL ESTATE TAX ADJ.	9,505	33	4
5	ADJ DEPR TO S/L	6,448	30	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	11,860		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSTOCK RESIDENCE# 0038653

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(45)	0	0	0	0	0	0	0	0	0	0	(45)	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	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(45)	0	0	0	0	0	0	0	0	0	0	(45)	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	(135,218)	0	0	0	0	0	0	0	0	(135,218)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	9,695	0	0	0	0	0	0	0	0	9,695	19
20	Fees, Subscriptions & Promotions	(44,925)	0	153	0	0	0	0	0	0	0	0	(44,772)	20
21	Clerical & General Office Expenses	(28,327)	0	140,507	0	0	0	0	0	0	0	0	112,180	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	869	0	0	0	0	0	0	0	0	869	24
25	Other Admin. Staff Transportation	0	0	12,801	0	0	0	0	0	0	0	0	12,801	25
26	Insurance-Prop.Liab.Malpractice	0	7,368	30	0	0	0	0	0	0	0	0	7,398	26
27	Other (specify):*	0	0	10,804	0	0	0	0	0	0	0	0	10,804	27
28	TOTAL General Administration	(73,252)	7,368	39,641	0	(26,243)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,297)	7,368	39,641	0	(26,288)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSTOCK RESIDENCE# 0038653

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	6,448	148,753	1,139	0	0	0	0	0	0	0	0	156,340	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,532)	320,203	1	0	0	0	0	0	0	0	0	318,672	32
33	Real Estate Taxes	9,505	0	0	0	0	0	0	0	0	0	0	9,505	33
34	Rent-Facility & Grounds	0	(363,405)	3,385	0	0	0	0	0	0	0	0	(360,020)	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	14,421	105,551	4,525	0	124,497	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(58,876)	112,919	44,166	0	0	0	0	0	0	0	0	98,209	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ESTATE OF ROBERT NATUAPSKY	100	SEE ATTACHED		WOODSTOCK RESIDENCE REALTY, LLC		BUILDING

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 363,405	CCCW REALTY, LLC (pass thru to Woodstock Residence Realty, LLC)		\$ 363,405		1
2	V							2
3	V	34 RENT	363,405	WOODSTOCK RESIDENCE REALTY, INC.			(363,405)	3
4	V	32 INTEREST				298,344	298,344	4
5	V	30 DEPRECIATION				148,753	148,753	5
6	V	32 MIP INSURANCE				21,859	21,859	6
7	V	26 INSURANCE				7,368	7,368	7
8	V							8
9	V							9
10	V							10
11	V	19 LEGAL FEES	9,064	LAW OFFICE OF ABRAHAM GUTNICKI		9,064		11
12	V							12
13	V							13
14	Total		\$ 735,874			\$ 848,793	\$ *	112,919 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Home Office	\$ 222,000	AA Healthcare Management, LLC	100.00%	\$	\$ (222,000)
16	V	5 Utilities		AA Healthcare Management, LLC			
17	V	6 Repairs & Maintenance		AA Healthcare Management, LLC			
18	V	17 Owners Compensation		AA Healthcare Management, LLC		86,782	86,782
19	V	19 Professional Fees		AA Healthcare Management, LLC		9,695	9,695
20	V	20 Fees, Subscriptions		AA Healthcare Management, LLC		153	153
21	V	21 Clerical Salaries		AA Healthcare Management, LLC		138,749	138,749
22	V	21 Office Expenses		AA Healthcare Management, LLC		1,758	1,758
23	V	24 Travel & Seminars		AA Healthcare Management, LLC		869	869
24	V	25 Transportation		AA Healthcare Management, LLC		12,801	12,801
25	V	26 Insurance		AA Healthcare Management, LLC		30	30
26	V	27 Employee Benefits		AA Healthcare Management, LLC		10,804	10,804
27	V	30 Depreciation		AA Healthcare Management, LLC		1,139	1,139
28	V	32 Interest		AA Healthcare Management, LLC		1	1
29	V	34 Rent		AA Healthcare Management, LLC		3,385	3,385
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 222,000			\$ 266,166	\$ * 44,166

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

Facility Name & ID Number

WOODSTOCK RESIDENCE

#

0038653

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	Administrative		SEE ATTACHED	12	23.08	Mgt Fees	\$ 86,782	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 86,782		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

Report Period Beginning:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

AA Healthcare Management

Street Address

8320 Skokie Blvd. Suite 18

City / State / Zip Code

Skokie, IL 60077

Phone Number

(847) 983-4860

Fax Number

(847) 673-3379

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3	17	Owners Compensation	Patient Days	57,378	2	200,000	24,897	86,782	3
4	19	Professional Fees	Patient Days	57,378	2	22,344	24,897	9,695	4
5	20	Fees, Subscriptions	Patient Days	57,378	2	353	24,897	153	5
6	21	Clerical Salaries	Patient Days	57,378	2	319,763	319,763	138,749	6
7	21	Office Expenses	Patient Days	57,378	2	4,051	24,897	1,758	7
8	24	Travel & Seminars	Patient Days	57,378	2	2,003	24,897	869	8
9	25	Transportation	Patient Days	57,378	2	29,501	24,897	12,801	9
10	26	Insurance	Patient Days	57,378	2	70	24,897	30	10
11	27	Employee Benefits	Patient Days	57,378	2	24,899	24,897	10,804	11
12	30	Depreciation	Patient Days	57,378	2	2,626	24,897	1,139	12
13	32	Interest	Patient Days	57,378	2	3	24,897	1	13
14	34	Rent	Patient Days	57,378	2	7,800	24,897	3,385	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 613,413	\$ 319,763	\$ 266,166	25

Facility Name & ID Number

WOODSTOCK RESIDENCE

0038653

Report Period Beginning:

1/1/09

Ending:

12/31/09

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		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	\$			\$ 298,344	1							
2				MIP							21,859	2							
3												3							
4												4							
5												5							
	Working Capital																		
6	HP BANK		X	LINE OF CREDIT				300,000			23,738	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 4,513,800	\$ 300,000			\$ 343,941	9							
	B. Non-Facility Related*																		
10	INTEREST INCOME OFFSET										(1,532)	10							
11												11							
12												12							
13	ALLOCATION FROM HO										1	13							
14	TOTAL Non-Facility Related						\$	\$			\$ (1,531)	14							
15	TOTALS (line 9+line14)						\$ 4,513,800	\$ 300,000			\$ 342,410	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,859 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.)

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

1. Real Estate Tax accrual used on 2008 report.		\$		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.)		\$	62,764	2
3. Under or (over) accrual (line 2 minus line 1).		\$	62,764	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		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.)		\$	16,190	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 \$ <u>31,475</u> For <u>05/06</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(27,172)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	51,782	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	69,340		8
	2005	71,990		9
	2006	74,027		10
	2007	67,605		11
	2008	62,764		12
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

Facility Name & ID Number WOODSTOCK RESIDENCE

0038653

Report Period Beginning:

1/1/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,252 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

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).

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>FACILITY</u>		<u>2000</u>	<u>\$ 450,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 450,000	3

Facility Name & ID Number WOODSTOCK RESIDENCE

0038653

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		2000	1969	\$ 2,919,309	\$ 75,483	40	\$ 75,483	\$	\$ 749,391
5									
6									
7									
8									
	Improvement Type**								
9	IMPROVEMENTS		2000	206,585	10,329	20	10,329		93,824
10	IMPROVEMENTS		2001	132,870	5,597	20	5,597		47,714
11									
12	VARIOUS		1994	6,149		20	307	307	2,666
13	VARIOUS		1995	9,053		20	453	453	3,693
14	VARIOUS		1996	9,800		20	490	490	3,746
15	VARIOUS		1998	6,435		20	322	322	2,130
16	VARIOUS		2001	2,617		20	131	131	665
17	VARIOUS		2002	1,702		20	85	85	1,645
18	VARIOUS		2003	7,264		20	363	363	2,420
19									
20	PHONES		2004	2,804		20	140	140	712
21	PHONES		2004	2,738		20	137	137	696
22	CONSTRUCTION DOORS		2004	2,437		20	122	122	732
23	DOORS		2004	1,399		20	70	70	367
24	FIRE ALARM DOOR		2005	1,511		20	76	76	354
25									
26									
27	LANDSCAPING		2008	9,250	925	10	925		1,310
28	LANDSCAPING		2008	3,145	314	10	314		419
29	WINDOW TINTING		2009	2,597	433	5	433		433
30	LANDSCAPING-BOXWOOD & STONE		2009	750	38	15	38		38
31	DIALYSIS PLUMBING		2009	24,582	358	40	358		358
32	REPLACEMENT PART-GENERATOR		2009	3,247	189	10	189		189
33	A/C UNIT		2009	4,880	244	10	244		244
34	WATER HEATER		2009	13,687	684	10	684		684
35	DIALYSIS PLUMBING		2009	22,249	324	40	324		324
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:

1/1/09

Ending:

12/31/09

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BLOCK RETAINING WALL	2009	\$ 1,400	\$ 41	20	\$ 41	\$	\$ 41	37
38	REMODELING		2,506	31	40	31		31	38
39	DIALYSIS STATION & ELEC		2,394	25	40	25		25	39
40	DIALYSIS ROOM COSTS		290	2	39	2		2	40
41	GLASS		424	14	10	14		14	41
42	FLOOR FIXTURES		514	18	7	18		18	42
43	GLASS		460	12	10	12		12	43
44	LIGHT FIXTURES & ELECTRICAL		1,489	25	10	25		25	44
45	PLUMBING		2,516	7	30	7		7	45
46	STAINLESS STEEL SINK & ACCESSORIES		1,935	8	20	8		8	46
47	SIGNAGE		6,254	261	10	261		261	47
48	REMODELING - FLOORING		99,038	4,127	10	4,127		4,127	48
49	DRAPERIES & CUBICLE CURTAINS		22,171	1,848	5	1,848		1,848	49
50	NURSES STATION		26,145	726	15	726		726	50
51	WALLCOVERING		64,464	5,372	5	5,372		5,372	51
52	HANDRAILS & BUMPER GUARDS		32,751	910	15	910		910	52
53	RECESSED CANNED LIGHTING		37,123	516	30	516		516	53
54	SHOWER/GUEST BATHROOM REMODELING		39,205		39				54
55	LIGHTING		427	4	10	4		4	55
56	PARKING LOT LIGHTS		570		20				56
57	RESIDENT ROOMS-NEW LIGHTING, ETC		1,930	4	39	4		4	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)		\$ 3,741,066	\$ 108,869		\$ 111,564	\$ 2,695	\$ 928,704	70

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

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	\$ 792,069	\$ 62,092	\$ 65,845	\$ 3,753	VAR	\$ 756,296	71
72	Current Year Purchases	102,899	4,435	4,435			4,435	72
73	Fully Depreciated Assets							73
74	Allocation from AA HC Mgt		1,139	1,139				74
75	TOTALS	\$ 894,968	\$ 67,666	\$ 71,419	\$ 3,753		\$ 760,731	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,086,034	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 176,535	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 182,983	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,448	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,689,435	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ **28,243** Description: **Medical Equip \$26,901; Dish Machine \$600; Rented equip @ grand opening \$742**

(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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	\$		\$ 115,692	\$		\$ 115,692	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			10,129			10,129	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			351,797			351,797	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 prescripts				205,278		205,278	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab/X-ray/Dialysis</u>	39-3					24,346		24,346	12
13	Other (specify): <u>RT</u>	10a-3				3,047			3,047	13
14	TOTAL			\$		\$ 480,665	\$ 229,624		\$ 710,289	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09**

(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	\$ 25,488	\$	1
2	Cash-Patient Deposits	47,760		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	850,601		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,660		6
7	Other Prepaid Expenses	9,375		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	133,080		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,099,964	\$	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	428,394		15
16	Equipment, at Historical Cost	126,644		16
17	Accumulated Depreciation (book methods)	(30,377)		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)	\$ 524,661	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,624,625	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 903,556	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,323		28
29	Short-Term Notes Payable	300,000		29
30	Accrued Salaries Payable	86,574		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	<u>Accrued Expenses</u>	54,777		36
37	<u>Due Others</u>	803,796		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,180,026	\$	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)	\$ 2,180,026	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (555,401)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,624,625	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (397,596)	1
2	Restatements (describe):		2
3	Prior Period Adjustments	(58,202)	3
4	Rounding	2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (455,796)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(99,605)	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)	\$ (99,605)	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)	\$ (555,401)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WOODSTOCK RESIDENCE

0038653

Report Period Beginning: 1/1/09

Ending: 12/31/09

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	\$ 3,241,980	1
2	Discounts and Allowances for all Levels	477,413	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,719,393	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	819,873	6
7	Oxygen	26,869	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 846,742	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	179,415	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,670	19
20	Radiology and X-Ray	60	20
21	Other Medical Services	4,367	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 206,512	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,365	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,365	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	167	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 167	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,774,179	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	772,063	31
32	Health Care	2,149,379	32
33	General Administration	1,181,596	33
B. Capital Expense			
34	Ownership	478,159	34
C. Ancillary Expense			
35	Special Cost Centers	229,624	35
36	Provider Participation Fee	62,963	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,873,784	40
41	Income before Income Taxes (line 30 minus line 40)**	(99,605)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (99,605)	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 filed 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:

1/1/09

Ending:

12/31/09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,624	1,632	\$ 58,834	\$ 36.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,825	10,216	291,492	28.53	3
4	Licensed Practical Nurses	12,643	13,926	333,017	23.91	4
5	CNAs & Orderlies	41,924	44,054	525,708	11.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,199	6,923	119,066	17.20	8
9	Activity Director	2,570	2,818	33,404	11.85	9
10	Activity Assistants	1,959	2,071	17,511	8.46	10
11	Social Service Workers	1,936	2,080	33,590	16.15	11
12	Dietician					12
13	Food Service Supervisor	2,796	3,204	72,048	22.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,361	17,061	151,540	8.88	15
16	Dishwashers					16
17	Maintenance Workers	4,006	4,251	59,948	14.10	17
18	Housekeepers	8,521	8,899	73,208	8.23	18
19	Laundry	6,702	7,185	59,928	8.34	19
20	Administrator	1,974	2,080	82,851	39.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,973	9,702	177,702	18.32	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	1,920	2,088	29,024	13.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,933	138,190	\$ 2,118,871 *	\$ 15.33	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	99	\$ 4,530	1-03	35
36	Medical Director	Monthly	13,000	9-03	36
37	Medical Records Consultant	96	3,840	10-03	37
38	Nurse Consultant		5,666	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	62	3,720	10-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	102	5,793	11-03	44
45	Social Service Consultant	113	6,420	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	472	\$ 42,969		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	468	\$ 23,496	10-03	50
51	Licensed Practical Nurses	255	10,683	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	723	\$ 34,179		53

Facility Name & ID Number WOODSTOCK RESIDENCE

0038653

Report Period Beginning: 1/1/09

Ending: 12/31/09

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 \$5,754
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,024 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. \$ 62,963
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? _____
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: _____
- (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.