FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0043406

Facility Name: WOODSIDE EXTENDED CARE

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

County: COOK

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,208	3,208	8
9	SNF/PED					9
10	ICF	36,594	418		37,012	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,594	418	3,208	40,220	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.39%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 3,208

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	184,860	14,165	11,340	210,365		210,365		210,365			1
2	Food Purchase		185,564		185,564		185,564	(52)	185,512			2
3	Housekeeping	140,076	18,720		158,796		158,796	571	159,367			3
4	Laundry	48,840	14,611	5,213	68,664		68,664		68,664			4
5	Heat and Other Utilities			110,171	110,171		110,171	270	110,441			5
6	Maintenance	124,635	41,441	47,063	213,139		213,139	5,133	218,272			6
7	Other (specify):* TRANSP/SECURITY	71,481		9,823	81,304		81,304	49	81,353			7
8	TOTAL General Services	569,892	274,501	183,610	1,028,003		1,028,003	5,971	1,033,974			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,479,764	82,322	8,657	1,570,743		1,570,743		1,570,743			10
10a	Therapy	110,239		25,711	135,950		135,950		135,950			10a
11	Activities	111,737	4,586		116,323		116,323		116,323			11
12	Social Services	96,758		1,967	98,725		98,725		98,725			12
13	CNA Training											13
14	Program Transportation			7,583	7,583		7,583		7,583			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,798,498	86,908	52,918	1,938,324		1,938,324		1,938,324			16
	C. General Administration											
17	Administrative	102,866		12,500	115,366		115,366	5,301	120,667			17
18	Directors Fees											18
19	Professional Services			57,522	57,522		57,522	24,358	81,880			19
20	Dues, Fees, Subscriptions & Promotions			16,980	16,980		16,980	(6,572)	10,408			20
21	Clerical & General Office Expenses	91,500	28,895	73,344	193,739		193,739	(47,505)	146,234			21
22	Employee Benefits & Payroll Taxes			351,788	351,788		351,788		351,788			22
23	Inservice Training & Education			1,659	1,659		1,659	8	1,667			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			5,698	5,698		5,698	677	6,375			25
26	Insurance-Prop.Liab.Malpractice			57,954	57,954		57,954	10,270	68,224			26
27	Other (specify):*			73,413	73,413		73,413	(64,549)	8,864			27
28	TOTAL General Administration	194,366	28,895	650,858	874,119		874,119	(78,012)	796,107			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,562,756	390,304	887,386	3,840,446		3,840,446	(72,041)	3,768,405			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#: WOODSIDE EXTENDED CARE #0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,340	
	REPAIRS & MAINTENANCE		0	
			0	11,340
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,213	
			0	5,213
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		26,194	
	ELECTRICITY		50,849	
	WATER		31,274	
	CABLE TV - LOBBY		1,854	
			0	110,171
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,573	
	PAINTING & DECORATING		117	
	BUILDING REPAIRS		686	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		21,245	
	ELEVATOR MAINTENANCE & REPAIR		1,085	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,686	
	FIRE SERVICE		15,671	
			0	
			0	
			0	
			0	47,063
7	**OTHER**			
	SCAVENGER		9,097	
	SECURITY SERVICE		726	
			0	
			0	9,823
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,000	9,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		577	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,480	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL CONSULTANT	XVIII B 47-2	3,600	
			0	8,657
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		229	
	SPEECH THERAPY SERVICES		632	
	OCCUPATIONAL THERAPY SERVICES		350	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	24,500	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				25,711
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,967	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	1,967
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WOODSIDE EXTENDED CARE **#0043406** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		7,583	7,583
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	12,500	12,500
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,001	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	43,521	
			0	57,522
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,974	
	EMPLOYEE WANT ADS	XIX F	456	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	5,405	
	LICENSES & PERMITS	XIX F	2,538	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	591	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	400	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,936	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	180	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				16,980
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		1,679	
	OUTSIDE CLERICAL SERVICES		54,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17,665	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		0	73,344

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	191,679	
	UNEMPLOYMENT COMPENSATION	XIX D	36,815	
	WORKERS COMPENSATION INSURANC	XIX D	59,295	
	HOSPITALIZATION INSURANCE	XIX D	55,389	
	EMPLOYEE BENEFITS - OTHER	XIX D	529	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	8,081	
	CHICAGO HEAD TAX	XIX D	0	
			0	351,788
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,659	
				1,659
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,698	
				5,698
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		57,954	
				57,954
27	**OTHER**			
	BAD DEBTS	VI 24	73,413	
				73,413

GRAND TOTAL COLUMN 3 OTHER **887,386**

WOODSIDE EXTENDED CARE
SCHEDULES
12/31/2010

EQUIPMENT RENTAL
PAGE 14 XII. B. LINE 16

KREG THERAPEUTIC	THERAPEUTIC BED	2,961
PRO-CARE	THERAPEUTIC BED	1,860
I-EQUIP RENTAL	PLANT EQUIP	79
DE LAGE	COPIER	2805
MEIKEM	DISHWASHER	440
PI SURVEILLANCE	TV SECURITY MONITOR	9,000
PITNEY BOWES	POSTAGE METER	524
PUBLIC STORAGE	STORAGE	2,139
	EQUIPMENT RENTAL	**19,808**

STAFF TRANSPORTATION
PAGE 3 V. COLUMN 3 LINE 25

DATE	NAME	DESCRIPTION	DEPARTMENT	AMOUNT
JAN	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	372.72
JAN	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	255.42
FEB	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	166.76
FEB	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	246.30
MAR	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	110.00
MAR	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	202.21
APR	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	120.00
APR	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	244.69
MAY	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	110.00
MAY	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	272.19
JUN	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	100.00
JUN	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	281.59
JUL	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	320.00
JUL	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	253.51
AUG	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	155.00
AUG	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	248.83
AUG	PAYROLL REIMB	GASOLINE	banking, maintenance, & activities, transportation	200.00
SEP	SECRETARY OF STATE	AUTO LICENSE	banking, maintenance, & activities, transportation	99.00
SEP	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	275.00
SEP	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	212.70
SEP	PAYROLL REIMB	GASOLINE	banking, maintenance, & activities, transportation	200.00
OCT	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	380.00
OCT	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	243.41
NOV	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	150.00
NOV	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	85.92
DEC	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	85.00
DEC	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	308.22
			STAFF TRANSPORTATION	**5,698.47**

Facility Name & ID Number WOODSIDE EXTENDED CARE #0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			8,569	8,569		8,569	214,471	223,040			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							230,951	230,951			32
33	Real Estate Taxes							272,734	272,734			33
34	Rent-Facility & Grounds			685,000	685,000		685,000	(685,000)				34
35	Rent-Equipment & Vehicles			29,587	29,587		29,587	1,986	31,573			35
36	Other (specify):* **OFFICE RENT**			8,736	8,736		8,736	14,134	22,870			36
37	**TOTAL Ownership**			731,892	731,892		731,892	49,276	781,168			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,612	380,745	461,357		461,357		461,357			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		80,612	442,065	522,677		522,677		522,677			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,562,756	470,916	2,061,343	5,095,015		5,095,015	(22,765)	5,072,250			45

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	36,706	30		9
10	Interest and Other Investment Income	(18,867)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(52)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(400)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,436)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(73,413)	27		24
25	Fund Raising, Advertising and Promotional	(2,974)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(591)	20		28
29	Other-Attach Schedule MARKETING SALARY	(18,066)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (82,093)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	59,328		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 59,328		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (22,765)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WOODSIDE EXTENDED CARE

ID# 0043406

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ -18066	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(18,066)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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	(52)	0	0	0	0	0	0	0	0	0	0	(52)	2
3	Housekeeping	0	571	0	0	0	0	0	0	0	0	0	571	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	270	0	0	0	0	0	0	0	0	270	5
6	Maintenance	0	2,264	2,869	0	0	0	0	0	0	0	0	5,133	6
7	Other (specify):*	0	21	28	0	0	0	0	0	0	0	0	49	7
8	**TOTAL General Services**	(52)	2,856	3,167	0	0	0	0	0	0	0	0	5,971	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	5,471	(170)	0	0	0	0	0	0	0	0	5,301	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,739	357	20,262	0	0	0	0	0	0	0	24,358	19
20	Fees, Subscriptions & Promotions	(8,401)	1,784	45	0	0	0	0	0	0	0	0	(6,572)	20
21	Clerical & General Office Expenses	(18,066)	(34,728)	5,289	0	0	0	0	0	0	0	0	(47,505)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	8	0	0	0	0	0	0	0	0	0	8	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	568	109	0	0	0	0	0	0	0	0	677	25
26	Insurance-Prop.Liab.Malpractice	0	242	554	9,474	0	0	0	0	0	0	0	10,270	26
27	Other (specify):*	(73,413)	2,928	5,936	0	0	0	0	0	0	0	0	(64,549)	27
28	**TOTAL General Administration**	(99,880)	(19,988)	12,120	29,736	0	0	0	0	0	0	0	(78,012)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(99,932)	(17,132)	15,287	29,736	0	0	0	0	0	0	0	(72,041)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSIDE EXTENDED CARE **#** 0043406 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	36,706	73	811	176,881	0	0	0	0	0	0	0	214,471	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,867)	0	1,403	248,415	0	0	0	0	0	0	0	230,951	32
33	Real Estate Taxes	0	0	1,135	271,599	0	0	0	0	0	0	0	272,734	33
34	Rent-Facility & Grounds	0	0	0	(685,000)	0	0	0	0	0	0	0	(685,000)	34
35	Rent-Equipment & Vehicles	0	1,384	602	0	0	0	0	0	0	0	0	1,986	35
36	Other (specify):*	0	0	(8,736)	22,870	0	0	0	0	0	0	0	14,134	36
37	**TOTAL Ownership**	17,839	1,457	(4,785)	34,765	0	0	0	0	0	0	0	49,276	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)**	(82,093)	(15,675)	10,502	64,501	0	0	0	0	0	0	0	(22,765)	45

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	HOUSEKEEPING	$	EKS MANAGEMENT		$ 571	$ 571	1
2	V	6	MAINTENANCE		" "		2,264	2,264	2
3	V	7	SCAVENGER		" "		21	21	3
4	V	17	CFO SALARY		" "		5,471	5,471	4
5	V	19	PROFESSIONAL FEES		" "		3,739	3,739	5
6	V	20	WANT ADS/BACKGRD CKS		" "		1,784	1,784	6
7	V	21	CLERICAL	54,000	" "		19,272	(34,728)	7
8	V	23	SEMINARS		" "		8	8	8
9	V	25	STAFF TRANSPORTATION		" "		568	568	9
10	V	26	INSURANCE		" "		242	242	10
11	V	27	EMPLOYEE BENEFITS		" "		2,928	2,928	11
12	V	30	SL DEPRECIATION		" "		73	73	12
13	V	35	EQUIPMENT RENT		" "		1,384	1,384	13
14	Total			$ 54,000			$ 38,325	$ * (15,675)	14

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	DRIVERS SALARY	$	EMI ENTERPRISES		$ 1,884	$ 1,884	15
16	V	17	REGIONAL DIRECTOR		" "		3,052	3,052	16
17	V	17	MANAGEMENT FEES	12,500	" "			(12,500)	17
18	V	17	OFFICERS SALARY		" "		9,278	9,278	18
19	V	19	ACCOUNTING FEES		" "		310	310	19
20	V	21	CLERICAL		" "		5,276	5,276	20
21	V	25	STAFF TRANSPORTATION		" "		109	109	21
22	V	26	INSURANCE		" "		497	497	22
23	V	27	EMPLOYEE BENEFITS		" "		5,936	5,936	23
24	V	35	AUTO LEASE		" "		230	230	24
25	V								25
26	V								26
27	V	5	UTILITIES		IME REALTY		270	270	27
28	V	6	REPAIRS/MAINTENANCE		" "		985	985	28
29	V	7	ALARM SERVICE		" "		28	28	29
30	V	19	ACCOUNTING FEES		" "		47	47	30
31	V	20	LICENSES & PERMITS		" "		45	45	31
32	V	21	OFFICE EXPENSE		" "		13	13	32
33	V	26	INSURANCE		" "		57	57	33
34	V	30	SL DEPRECIATION		" "		811	811	34
35	V	32	INTEREST		" "		1,403	1,403	35
36	V	33	REAL ESTATE TAX		" "		1,135	1,135	36
37	V	35	STORAGE FEES		" "		372	372	37
38	V	36	OFFICE RENT	8,736	" "			(8,736)	38
39	Total			$ 21,236			$ 31,738	$ * 10,502	39

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	ACCOUNTING FEES	$	MST REAL ESTATE LLC		$ 12,000	$ 12,000	15
16	V	26	HAZARD INSURANCE		" "		9,474	9,474	16
17	V	34	RENT	685,000	" "			(685,000)	17
18	V	30	SL DEPRECIATION		" "		176,881	176,881	18
19	V	32	INTEREST		" "		242,347	242,347	19
20	V	32	AMORT LOAN COST		" "		6,068	6,068	20
21	V	33	REAL ESTATE TAX		" "		271,599	271,599	21
22	V	36	MIP INSURANCE		" "		22,870	22,870	22
23	V	19	KLAFTER&BURKE-REAL ESTATE LEGAL		" "		8,262	8,262	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 685,000			$ 749,501	$ * 64,501	39

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	ALLOCATION FROM EMI ENTERPRISES:				SEE ATTACHED				$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT CONSULT	43.82	SCHEDULE			SALARY	9,278	17-7	2
3											3
4											4
5											5
6											6
7											7
8	ALLOCATION FROM EKS MANAGEMENT:										8
9	AVRUM WEINFELD		CFO	0.00				SALARY	5,471	17-7	9
10											10
11											11
12											12
13								TOTAL	$ 14,749		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	CENSUS DAYS	845,281	14 FACILITIES	$ 12,000	$	40,220	$ 571	1
2	6	MAINTENANCE	" "	845,281	14 FACILITIES	47,580	47,580	40,220	2,264	2
3	7	SCAVENGER	" "	845,281	14 FACILITIES	441		40,220	21	3
4	17	CFO SALARY-A. WEINFELD	" "	845,281	14 FACILITIES	114,971	114,971	40,220	5,471	4
5	19	PROFESSIONAL FEES	" "	845,281	14 FACILITIES	78,585	66,116	40,220	3,739	5
6	20	WANT ADS/BACKGRND CHKS	" "	845,281	14 FACILITIES	37,500		40,220	1,784	6
7	21	CLERICAL	" "	845,281	14 FACILITIES	405,027	295,327	40,220	19,272	7
8	23	SEMINARS	" "	845,281	14 FACILITIES	175		40,220	8	8
9	25	STAFF TRANSPORTATION	" "	845,281	14 FACILITIES	11,931		40,220	568	9
10	26	INSURANCE	" "	845,281	14 FACILITIES	5,077		40,220	242	10
11	27	EMPLOYEE BENEFITS	" "	845,281	14 FACILITIES	61,528		40,220	2,928	11
12	30	SL DEPRECIATION	" "	845,281	14 FACILITIES	1,536		40,220	73	12
13	35	EQUIPMENT RENT	" "	845,281	14 FACILITIES	29,093		40,220	1,384	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					$ 805,444	$ 523,994		$ 38,325	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	DRIVERS SALARY	CENSUS DAYS	845,281	14 FACILITIES	$ 39,600	$ 39,600	40,220	$ 1,884	1
2	17	REGIONAL DIRECTOR	" "	845,281	14 FACILITIES	64,150	64,150	40,220	3,052	2
3	17	OFFICERS SALARY-M.ESFORMES	" "	845,281	14 FACILITIES	195,000	195,000	40,220	9,278	3
4	19	ACCOUNTING FEES	" "	845,281	14 FACILITIES	6,525		40,220	310	4
5	21	CLERICAL	" "	845,281	14 FACILITIES	110,874	58,558	40,220	5,276	5
6	25	STAFF TRANSPORTATION	" "	845,281	14 FACILITIES	2,287		40,220	109	6
7	26	INSURANCE	" "	845,281	14 FACILITIES	10,450		40,220	497	7
8	27	EMPLOYEE BENEFITS	" "	845,281	14 FACILITIES	124,762		40,220	5,936	8
9	35	AUTO LEASE	" "	845,281	14 FACILITIES	4,824		40,220	230	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	TOTALS					$ 558,472	$ 357,308		$ 26,572	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: IME REALTY
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	187,059	14 FACILITIES	$	$	8,736	$	1
2	6	REPAIRS/MAINTENANCE	" "	187,059	14 FACILITIES			8,736		2
3	7	ALARM FEES	" "	187,059	14 FACILITIES			8,736		3
4	19	ACCOUNTING FEES	" "	187,059	14 FACILITIES			8,736		4
5	20	LICENSES & PERMITS	" "	187,059	14 FACILITIES			8,736		5
6	21	OFFICE EXPENSE	" "	187,059	14 FACILITIES			8,736		6
7	26	INSURANCE	" "	187,059	14 FACILITIES			8,736		7
8	30	SL DEPRECIATION	" "	187,059	14 FACILITIES			8,736		8
9	32	INTEREST	" "	187,059	14 FACILITIES			8,736		9
10	33	REAL ESTATE TAX	" "	187,059	14 FACILITIES			8,736		10
11	35	STORAGE FEES	" "	187,059	14 FACILITIES			8,736		11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: MST REAL ESTATE LLC						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$52,947.11	09/05	4,919,200	4,607,716	09/35	5.3100	242,347	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		09/05	172,440	141,221	09/35		6,068	3
4												4
5	RELATED PARTY: IME REALTY		X	MORTGAGE							1,403	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$52,947.11		$ 5,091,640	$ 4,748,937			$ 249,818	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,091,640	$ 4,748,937			$ 249,818	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 22,870 **Line #** 36-7

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 277,972	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.)		$ 271,767	2
3. Under or (over) accrual (line 2 minus line 1).		$ (6,205)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 278,356	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 552 **For** 2001 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (552)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 271,599	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	248,800	8
	2006	249,133	9
	2007	244,003	10
	2008	264,735	11
	2009	271,767	12

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOODSIDE EXTENDED CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043406

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-29-401-011-0000	NURSING HOME	$ 271,767.16	$ 271,767.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 271,767.16	$ 271,767.16

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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,900 B. General Construction Type: Exterior CONCRETE Frame METAL/CONCRETE Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RELATED PARTY-MST REAL ESTATE LLC:			$	1
2	NURSING HOME		2004	229,826	2
3	TOTALS			$ 229,826	3

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	RELATED PARTY-MST REAL ESTATE LLC:				$	$		$	$	$	4
5	112		2004		4,142,702	150,629	27.5	150,629		1,010,490	5
6											6
7											7
8	RELATED PARTY-MST REAL ESTATE LLC-SL DEPN:										8
	Improvement Type**										
9	CEILING LIGHTING			1997	3,746	96	39	96		1,260	9
10	WATER SOFTENING SYSTEM			1997	6,926	178	39	178		2,336	10
11	FLOORING			1997	3,910	100	39	100		1,304	11
12	FLOORING / DOORS / WINDOWS			1998	29,194	748	39	748		9,450	12
13	ROOF			1998	84,450	2,165	39	2,165		27,878	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.			1998	30,915	793	39	793		10,220	14
15	PAINTING / DECORATING			1998	15,111	387	39	387		4,854	15
16	FLOORING / DOORS / BATHROOM FIXTURES			1999	11,198	288	39	288		3,436	16
17	CHAIN LINK FENCE			1999	5,100	131	39	131		1,501	17
18	FLOOR TILES/COVE BASE			2000	22,766	828	27.5	828		9,073	18
19	PAIR OF ALUMINUM DOORS			2000	2,193	80	27.5	80		863	19
20	PLUMBING			2000	9,913	360	27.5	360		3,645	20
21	PLUMBING / VANITY / SINK / FLOORING			2001	37,788	1,374	27.5	1,374		13,368	21
22	PAVING			2002	18,562	675	27.5	675		5,766	22
23	BATHROOM SINKS			2002	3,888	141	27.5	141		1,134	23
24	BATHROOM SINKS			2003	7,776	283	27.5	283		2,252	24
25	FLOORING / CARPETING & TILE			2003	13,887	504	27.5	504		3,645	25
26	ROOF			2003	7,800	284	27.5	284		2,165	26
27	FENCE			2003	9,500	634	15	634		4,754	27
28	WINDOWS			2004	46,880	1,705	27.5	1,705		11,296	28
29	SPRINKLER SYSTEM / ELECTRICAL / ROOF AC / TILING			2007	298,345	10,849	27.5	10,849		42,010	29
30	ADDL FIRE SAFETY/TANK/GENERATOR/SECURITY SYST			2008	73,619	2,677	27.5	2,677		7,920	30
31	ROLLING SHUTTER			2008	3,970	144	27.5	144		378	31
32	BUILT-IN CABINET			2008	6,200	413	15	413		1,033	32
33	CANOPY			2009	6,500	236	27.5	236		285	33
34	SLIDING PATIO DOORS			2010	6,951	179	27.5	179		179	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 WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WOODSIDE EXTENDED CARE:		$	$		$	$	$	37
38	DRAPERIES	2001	7,578		10	758	758	7,201	38
39	CUBICLE CURTAINS/FLOORING	2004	33,108		10	3,311	3,311	21,521	39
40	PATIO/FLOORING/TILE/LIGHTING/FIRE PANEL/ROOF AC	2005	30,694	1,116	27.5	1,116		5,936	40
41	WALL TILE / EXIT SIGNS / PLUMBING / DOORS	2006	49,079	1,784	27.5	1,784		8,326	41
42									42
43									43
44									44
45									45
46									46
47									47
48	RELATED PARTY ALLOCATION - IME REALTY		25,771	779	39	779			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)		$ 5,056,020	$ 180,560		$ 184,629	$ 4,069	$ 1,225,479	70

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 429,840	$ 5,669	$ 38,306	$ 32,637	8-15 YRS	$ 281,578	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC - EKS MGMT 73//IME REALTY 32		105	105				74
75	TOTALS	$ 429,840	$ 5,774	$ 38,411	$ 32,637		$ 281,578	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)	$ 5,715,686	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 186,334	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 223,040	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 36,706	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,507,057	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 19,808 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE:		$	$	17
18	BANKING,MAINT,				18
19	MARKETING, NSG	'09 NISSAN MURANO	749.53	1,499	19
20	ACTIVITIES	'09 FORD E350 VAN	690.00	8,280	20
21	TOTAL		$ #######	$ 9,779	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.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 203,581	$		$ 203,581	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,066			2,066	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			175,098			175,098	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				71,976		71,976	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	LAB/SUPPLIES Other (specify):	39-2					8,636		8,636	13
14	TOTAL			$		$ 380,745	$ 80,612		$ 461,357	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.

STATE OF ILLINOIS

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 581,189	$ 616,708	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 125,000)	157,753	157,753	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,578	111,526	6
7	Other Prepaid Expenses	20,445	20,445	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX/INSUR ESCROWS	125,750	238,156	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 971,715	$ 1,144,588	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		229,826	13
14	Buildings, at Historical Cost		4,142,702	14
15	Leasehold Improvements, at Historical Cost	112,881	873,770	15
16	Equipment, at Historical Cost	447,732	453,932	16
17	Accumulated Depreciation (book methods)	(479,087)	(1,663,288)	17
18	Deferred Charges		140,221	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe DUE FROM LLC	67,801		22
23	Other(specify): REPLACEMENT RESERVE		234,250	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 149,327	$ 4,411,413	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,121,042	$ 5,556,001	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 116,501	$ 116,501	26
27	Officer's Accounts Payable	618,277	618,277	27
28	Accounts Payable-Patient Deposits	108,220	108,220	28
29	Short-Term Notes Payable		90,213	29
30	Accrued Salaries Payable	42,776	42,776	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,273	7,273	31
32	Accrued Real Estate Taxes(Sch.IX-B)		278,356	32
33	Accrued Interest Payable		20,011	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 893,047	$ 1,281,627	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,431,944	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)**	$	$ 4,431,944	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 893,047	$ 5,713,571	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 227,995	$ (157,570)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,121,042	$ 5,556,001	48

***(See instructions.)**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 264,938	1	
2	Restatements (describe):		2	
3			3	
4	ROUNDING	(2)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 264,936	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	702,059	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	(739,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (36,941)	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)**	$ 227,995	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,543,195	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,543,195	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	271,831	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 271,831	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,867	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,867	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,833,893	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,028,003	31
32	Health Care	1,938,324	32
33	General Administration	874,119	33
	B. Capital Expense		
34	Ownership	731,892	34
	C. Ancillary Expense		
35	Special Cost Centers	461,357	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	336	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,095,351	40
41	**Income before Income Taxes (line 30 minus line 40)****	738,542	41
42	**Income Taxes**	(36,483)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 702,059	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,017	2,088	$ 80,293	$ 38.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,002	8,221	219,120	26.65	3
4	Licensed Practical Nurses	21,088	22,301	527,214	23.64	4
5	CNAs & Orderlies	60,406	63,344	588,113	9.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,105	6,512	110,239	16.93	8
9	Activity Director					9
10	Activity Assistants	9,851	10,493	111,737	10.65	10
11	Social Service Workers	6,000	6,276	96,758	15.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,108	19,015	184,860	9.72	15
16	Dishwashers					16
17	Maintenance Workers	8,446	8,821	124,635	14.13	17
18	Housekeepers	15,416	16,187	140,076	8.65	18
19	Laundry	5,405	5,638	48,840	8.66	19
20	Administrator	2,064	2,064	102,866	49.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,455	9,900	91,500	9.24	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	844	955	9,577	10.03	31
32	Other Health C: MDS/QA/ADMIT	2,892	2,963	55,447	18.71	32
33	Other(specify) TRANSP/SECURI	7,812	7,908	71,481	9.04	33
34	TOTAL (lines 1 - 33)	183,911	192,686	$ 2,562,756 *	$ 13.30	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 11,340	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,480	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		24,500	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	1,967	12-3	45
46	Other(specify)	S			46
47	DENTAL CONSULTANT		3,600	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 54,887		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
FRED BERKOVITS	ADMINISTRATOR		$ 10,833
MARCITA CARTER	ADMINISTRATOR		92,033
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 102,866

B. Administrative - Other

Description	Amount
EMI ENTERPRISES - MANAGEMENT FEES	$ 12,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 12,500

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SERVICES	DATA PROCESSING	$ 5,393
HEALTH DATA SYSTEMS	DATA PROCESSING	6,146
IVANS	DATA PROCESSING	662
LTC SOLUTION	DATA PROCESSING	1,800
KBKB	ACCOUNTING	15,900
LONNY BEN OGUS	LEGAL	6,088
HUSCH BLACKWELL	LEGAL	3,375
KELLY APPRAISAL	APPRAISAL	2,300
RICHARD PEELO	MEDICARE CONSULTANT	4,500
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULT	1,358
ROSS J PETERS	LEGAL SETTLEMENT	10,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 57,522

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,295
Unemployment Compensation Insurance	36,815
FICA Taxes	191,679
Employee Health Insurance	55,389
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	529
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	8,081
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 351,788

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	456
Health Care Worker Background Check	180
(Indicate # of checks performed 18)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	4,836
MARKETING/ADV/PROMO	3,565
LICENSES/DUES/SUBSCRIPTIONS	6,948
MGMT CO ALLOC	1,829
TRUST/FRANCHISE/CONTRIB/ETC	(4,836)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,974)
Yellow page advertising	(591)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,408

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. **ICLTC 5,405**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **61,320**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____

(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.