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: 0038653

Facility Name: WOODSTOCK RESIDENCE

Address: 309 MCHENRY AVENUE (Number) WOODSTOCK (City) 60098 (Zip Code)

County: MCHENRY

Telephone Number: (815) 338-1700 **Fax #** (815) 338-1765

HFS ID Number:

Date of Initial License for Current Owners: 2/1/93

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: DARRYL BUEKER **Telephone Number:** (417) 865-8701
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 1/1/10 to 12/31/10 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) DARRYL BUEKER, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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 WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	115	Skilled (SNF)	115	41,975	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	115	TOTALS	115	41,975	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	20,446	2,789	5,686	28,921	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,446	2,789	5,686	28,921	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.90%

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 [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 2/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 3,569

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	252,621	24,513	4,988	282,122		282,122		282,122			1
2	Food Purchase		165,516		165,516		165,516	(79)	165,437			2
3	Housekeeping	84,085	33,269		117,354		117,354		117,354			3
4	Laundry	68,072	13,620		81,692		81,692		81,692			4
5	Heat and Other Utilities			97,532	97,532		97,532		97,532			5
6	Maintenance	58,596	8,028	59,020	125,644		125,644		125,644			6
7	Other (specify):*											7
8	TOTAL General Services	463,374	244,946	161,540	869,860		869,860	(79)	869,781			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,417,593	127,888	10,567	1,556,048		1,556,048		1,556,048			10
10a	Therapy	111,962		358,570	470,532		470,532		470,532			10a
11	Activities	52,693	1,506	7,589	61,788		61,788		61,788			11
12	Social Services	35,740		4,557	40,297		40,297		40,297			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,617,988	129,394	393,283	2,140,665		2,140,665		2,140,665			16
	C. General Administration											
17	Administrative	81,686		216,491	298,177		298,177	(124,246)	173,931			17
18	Directors Fees											18
19	Professional Services			72,017	72,017		72,017	3,086	75,103			19
20	Dues, Fees, Subscriptions & Promotions			68,508	68,508		68,508	(33,469)	35,039			20
21	Clerical & General Office Expenses	164,465	20,193	57,105	241,763		241,763	61,338	303,101			21
22	Employee Benefits & Payroll Taxes			361,016	361,016		361,016		361,016			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,838	4,838		4,838		4,838			24
25	Other Admin. Staff Transportation			9,605	9,605		9,605	12,819	22,424			25
26	Insurance-Prop.Liab.Malpractice			135,996	135,996		135,996	9,251	145,247			26
27	Other (specify):*							10,756	10,756			27
28	TOTAL General Administration	246,151	20,193	925,576	1,191,920		1,191,920	(60,465)	1,131,455			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,327,513	394,533	1,480,399	4,202,445		4,202,445	(60,544)	4,141,901			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: 1/1/10 Ending: 12/31/10

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			64,511	64,511		64,511	126,669	191,180			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,853	20,853		20,853	294,151	315,004			32
33	Real Estate Taxes			66,626	66,626		66,626	(9,598)	57,028			33
34	Rent-Facility & Grounds			373,179	373,179		373,179	(369,581)	3,598			34
35	Rent-Equipment & Vehicles			50,787	50,787		50,787	1,142	51,929			35
36	Other (specify):*											36
37	**TOTAL Ownership**			575,956	575,956		575,956	42,783	618,739			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			256,811	256,811		256,811		256,811			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**			319,774	319,774		319,774		319,774			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,327,513	394,533	2,376,129	5,098,175		5,098,175	(17,761)	5,080,414			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: 1/1/10 Ending: 12/31/10

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				9
10	Interest and Other Investment Income	(231)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(79)	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	(26,793)	21		18
19	Entertainment	(714)	21		19
20	Contributions	(7,872)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(29,996)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,004)	20		28
29	Other-Attach Schedule	(30,766)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (100,955)		$	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)	83,194		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 83,194		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (17,761)		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.			$		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

WOODSTOCK RESIDENCE

ID# 0038653

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (2,584)	20	1
2	MISC INCOME	(23,232)	21	2
3	REAL ESTATE TAX ADJ	(9,598)	33	3
4	ADJ TO SL DEPR	4,648	30	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(30,766)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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	(79)	0	0	0	0	0	0	0	0	0	0	(79)	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**	(79)	0	0	0	0	0	0	0	0	0	0	(79)	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	(124,246)	0	0	0	0	0	0	0	0	(124,246)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,500)	0	6,586	0	0	0	0	0	0	0	0	3,086	19
20	Fees, Subscriptions & Promotions	(33,584)	0	115	0	0	0	0	0	0	0	0	(33,469)	20
21	Clerical & General Office Expenses	(58,611)	0	119,949	0	0	0	0	0	0	0	0	61,338	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	12,819	0	0	0	0	0	0	0	0	12,819	25
26	Insurance-Prop.Liab.Malpractice	0	8,727	524	0	0	0	0	0	0	0	0	9,251	26
27	Other (specify):*	0	0	10,756	0	0	0	0	0	0	0	0	10,756	27
28	**TOTAL General Administration**	(95,695)	8,727	26,503	0	0	0	0	0	0	0	0	(60,465)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(95,774)	8,727	26,503	0	0	0	0	0	0	0	0	(60,544)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSTOCK RESIDENCE **#** 0038653 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,648	120,481	1,540	0	0	0	0	0	0	0	0	126,669	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(231)	294,167	215	0	0	0	0	0	0	0	0	294,151	32
33	Real Estate Taxes	(9,598)	0	0	0	0	0	0	0	0	0	0	(9,598)	33
34	Rent-Facility & Grounds	0	(373,179)	3,598	0	0	0	0	0	0	0	0	(369,581)	34
35	Rent-Equipment & Vehicles	0	0	1,142	0	0	0	0	0	0	0	0	1,142	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,181)	41,469	6,495	0	0	0	0	0	0	0	0	42,783	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)	(100,955)	50,196	32,998	0	0	0	0	0	0	0	0	(17,761)	45

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [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	34	RENT	$ 373,179	CCCW REALTY, LLC (pass thru to Woodstock Residence Realty, LLC)		$ 373,179	$	1
2	V								2
3	V	34	RENT	373,179	WOODSTOCK RESIDENCE REALTY, LLC			(373,179)	3
4	V	32	INTEREST				272,538	272,538	4
5	V	30	DEPRECIATION				120,481	120,481	5
6	V	32	MIP INSURANCE				21,629	21,629	6
7	V	26	INSURANCE				8,727	8,727	7
8	V								8
9	V								9
10	V								10
11	V	19	LEGAL FEES	5,038	LAW OFFICE OF ABRAHAM GUTNICKI		5,038		11
12	V								12
13	V								13
14	Total			$ 751,396			$ 801,592	$ * 50,196	14

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

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	17	HOME OFFICE	$ 216,491	AA HEALTHCARE MANAGEMENT, LLC	100.00%	$	$ (216,491)	15
16	V	5	Utilities		AA HEALTHCARE MANAGEMENT, LLC				16
17	V	6	Repairs & Maintenance		AA HEALTHCARE MANAGEMENT, LLC				17
18	V	17	Owners Compensation		AA HEALTHCARE MANAGEMENT, LLC		92,245	92,245	18
19	V	19	Professional Fees		AA HEALTHCARE MANAGEMENT, LLC		6,586	6,586	19
20	V	20	Fees, Subscriptions		AA HEALTHCARE MANAGEMENT, LLC		115	115	20
21	V	21	Clerical Salaries		AA HEALTHCARE MANAGEMENT, LLC		117,450	117,450	21
22	V	21	Office Expenses		AA HEALTHCARE MANAGEMENT, LLC		2,499	2,499	22
23	V	24	Travel & Seminars		AA HEALTHCARE MANAGEMENT, LLC				23
24	V	25	Transportation		AA HEALTHCARE MANAGEMENT, LLC		12,819	12,819	24
25	V	26	Insurance		AA HEALTHCARE MANAGEMENT, LLC		524	524	25
26	V	27	Employee Benefits		AA HEALTHCARE MANAGEMENT, LLC		10,756	10,756	26
27	V	30	Depreciation		AA HEALTHCARE MANAGEMENT, LLC		1,540	1,540	27
28	V	32	Interest		AA HEALTHCARE MANAGEMENT, LLC		215	215	28
29	V	34	Rent		AA HEALTHCARE MANAGEMENT, LLC		3,598	3,598	29
30	V	35	Equipment Rental		AA HEALTHCARE MANAGEMENT, LLC		1,142	1,142	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			$ 216,491			$ 249,489	$ * 32,998	39

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

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AARON TOPPER	MANAGER	Administrative	75.00	SEE ATTACHED	10	20.00	Mgt Fees	$ 92,245	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	$ 92,245		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: 1/1/10 Ending: 12/31/10

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: 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

	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						$	$		$	1
2										2
3	17	Owners Compensation	Patient Days	62,705	2	200,000		28,921	92,245	3
4	19	Professional Fees	Patient Days	62,705	2	14,279		28,921	6,586	4
5	20	Fees, Subscriptions	Patient Days	62,705	2	250		28,921	115	5
6	21	Clerical Salaries	Patient Days	62,705	2	254,650	254,650	28,921	117,450	6
7	21	Office Expenses	Patient Days	62,705	2	5,418		28,921	2,499	7
8	24	Travel & Seminars	Patient Days	62,705	2			28,921	0	8
9	25	Transportation	Patient Days	62,705	2	27,794		28,921	12,819	9
10	26	Insurance	Patient Days	62,705	2	1,136		28,921	524	10
11	27	Employee Benefits	Patient Days	62,705	2	23,320		28,921	10,756	11
12	30	Depreciation	Patient Days	62,705	2	3,338		28,921	1,540	12
13	32	Interest	Patient Days	62,705	2	467		28,921	215	13
14	34	Rent	Patient Days	62,705	2	7,800		28,921	3,598	14
15	35	Equipment Rental	Patient Days	62,705	2	2,476		28,921	1,142	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 540,928	$ 254,650		$ 249,489	25

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	CAPSTONE		X	MORTGAGE		8/1/00	$ 4,513,800	$			$ 272,538	1
2				MIP							21,629	2
3												3
4												4
5												5
	Working Capital											
6	HP BANK		X	LINE OF CREDIT							13,784	6
7												7
8	MISC										7,069	8
9	TOTAL Facility Related						$ 4,513,800	$			$ 315,020	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(231)	10
11												11
12												12
13	ALLOCATION FROM AA HC MGT										215	13
14	TOTAL Non-Facility Related						$	$			$ (16)	14
15	TOTALS (line 9+line14)						$ 4,513,800	$			$ 315,004	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 21,629 Line # 32

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

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

Facility Name & ID Number WOODSTOCK RESIDENCE **#** 0038653 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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.**	$	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.)		$ 57,028	2
3. Under or (over) accrual (line 2 minus line 1).		$ 57,028	3
4. Real Estate Tax accrual used for 2010 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.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 57,028	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	71,990	8
2006	74,027	9
2007	67,605	10
2008	62,764	11
2009	57,028	12

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 WOODSTOCK RESIDENCE COUNTY MCHENRY

FACILITY IDPH LICENSE NUMBER 0038653

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

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

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

Enter the tax index number and real estate tax assessed for 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.	13-05-254-015	NURSING HOME	$ 54,982.12	$ 54,982.12
2.	13-05-254-011	NURSING HOME	$ 2,045.88	$ 2,045.88
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 57,028.00	$ 57,028.00

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 WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [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).

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY			$ 450,000	1
2					2
3	TOTALS			$ 450,000	3

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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			2000	1969	$ 2,919,309	$ 75,483	40	$ 75,483	$	$ 824,874	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENTS			2000	206,585	10,329	20	10,329			9
10	IMPROVEMENTS			2001	132,870	5,597	20	5,597			10
11											11
12	VARIOUS			1994	6,149		20	307	307		12
13	VARIOUS			1995	9,053		20	453	453		13
14	VARIOUS			1996	9,800		20	490	490		14
15	VARIOUS			1998	6,435		20	322	322		15
16	VARIOUS			2001	2,617		20	131	131		16
17	VARIOUS			2002	1,702		20	85	85		17
18	VARIOUS			2003	7,264		20	363	363		18
19											19
20	PHONES			2004	2,804		20	140	140		20
21	PHONES			2004	2,738		20	137	137		21
22	CONSTRUCTION DOORS			2004	2,437		20	122	122		22
23	DOORS			2004	1,399		20	70	70		23
24	FIRE ALARM DOOR			2005	1,511		20	76	76		24
25											25
26											26
27	LANDSCAPING			2008	9,250	925	10	925		7,015	27
28	LANDSCAPING			2008	3,145	315	10	315		2,411	28
29	WINDOW TINTING			2009	2,597	519	5	519		1,645	29
30	LANDSCAPING-BOXWOOD & STONE			2009	750	50	15	50		662	30
31	DIALYSIS PLUMBING			2009	24,582	615	40	615		23,609	31
32	REPLACEMENT PART-GENERATOR			2009	3,247	325	10	325		2,733	32
33	A/C UNIT			2009	4,880	488	10	488		4,148	33
34	WATER HEATER			2009	13,687	1,369	10	1,369		11,634	34
35	DIALYSIS PLUMBING			2009	22,249	557	40	557		21,368	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	BLOCK RETAINING WALL	2009	$ 1,400	$ 70	20	$ 70	$	$ 1,289	37
38	REMODELING	2009	2,506	63	40	63		2,412	38
39	DIALYSIS STATION & ELEC	2009	2,394	60	40	60		2,309	39
40	DIALYSIS ROOM COSTS	2009	290	8	39	8		280	40
41	GLASS	2009	424	43	10	43		367	41
42	FLOOR FIXTURES	2009	514	74	7	74		422	42
43	GLASS	2009	460	46	10	46		402	43
44	LIGHT FIXTURES & ELECTRICAL	2009	1,489	149	10	149		1,315	44
45	PLUMBING	2009	2,516	84	30	84		2,425	45
46	STAINLESS STEEL SINK & ACCESSORIES	2009	1,935	97	20	97		1,830	46
47	SIGNAGE	2009	6,254	625	10	625		5,368	47
48	REMODELING - FLOORING	2009	99,038	9,903	10	9,903		85,008	48
49	DRAPERIES & CUBICLE CURTAINS	2009	22,171	4,434	5	4,434		15,889	49
50	NURSES STATION	2009	26,145	1,743	15	1,743		23,676	50
51	WALLCOVERING	2009	64,464	12,893	5	12,893		46,199	51
52	HANDRAILS & BUMPER GUARDS	2009	32,751	2,183	15	2,183		29,658	52
53	RECESSED CANNED LIGHTING	2009	37,123	1,237	30	1,237		35,370	53
54	SHOWER/GUEST BATHROOM REMODELING	2009	39,205	1,005	39	1,005		38,200	54
55	LIGHTING	2009	427	42	10	42		381	55
56	PARKING LOT LIGHTS	2009	570	29	20	29		541	56
57	RESIDENT ROOMS-NEW LIGHTING, ETC	2009	1,930	50	39	50		1,876	57
58	REMODELING PHASE 2-SHOWER ROOMS-CONTRACT-BO	2010	31,892	750	39	750		750	58
59	FIREDOORS	2010	1,459	31	39	31		31	59
60	REMODELING-P/Y-ADD'L PMT	2010	426	9	39	9		9	60
61	PLUMBING	2010	1,249	27	39	27		27	61
62	DINING ROOM DOOR EQUIP	2010	2,250	169	10	169		169	62
63	PLUMBING	2010	1,953	38	39	38		38	63
64	FIRE DAMPERS	2010	1,250	24	39	24		24	64
65	DOORS	2010	4,957	193	15	193		193	65
66	HANDICAP RAMP	2010	4,926	192	15	192		192	66
67	ROYAL CLOSET FLUSH VALVE	2010	696	9	39	9		9	67
68	EDPM RUBBER FLAT ROOF	2010	1,024	13	39	13		13	68
69	FIRE DOOR IMPROVEMENTS	2010	2,100	88	10	88		88	69
70	TOTAL (lines 4 thru 69)		$ 3,795,248	$ 132,953		$ 135,649	$ 2,696	$ 1,196,859	70

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

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	
1	Totals from Page 12A, Carried Forward		$ 3,795,248	$ 132,953		$ 135,649	$ 2,696	$ 1,196,859	1
2	DUCT WORK	2010	1,023	11	40	11		11	2
3	DIFFUSER INSTALLATION	2010	1,575	16	40	16		16	3
4	FRONT DOOR EXIT DEVICE	2010	605	20	10	20		20	4
5	THERAPY ROOM DIFFUSERS	2010	821	27	10	27		27	5
6	RELIEF VALVE	2010	1,279	32	10	32		32	6
7	RETUBING BOILER	2010	5,122	57	15	57		57	7
8	GAS VALVE	2010	1,002	17	10	17		17	8
9	BOILER TUBES	2010	1,536	17	15	17		17	9
10	LIGHT FIXTURES	2010	558		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	TOTAL (lines 1 thru 33)		$ 3,808,769	$ 133,150		$ 135,846	$ 2,696	$ 1,197,056	34

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

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	$ 894,968	$ 45,202	$ 47,154	$ 1,952	VAR	$ 758,401	71
72	Current Year Purchases	116,160	6,640	6,640			6,640	72
73	Fully Depreciated Assets							73
74	ALLOC FROM AA HC MGT		1,540	1,540				74
75	TOTALS	$ 1,011,128	$ 53,382	$ 55,334	$ 1,952		$ 765,041	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)	$ 5,269,897	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 186,532	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 191,180	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,648	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,962,097	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 $50,787 .

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: $ $50,787 Description: Medical equip $50,187; Dish Machine $600
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

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 WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	10a-03	hrs	$		$ 156,364	$		$ 156,364	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			20,880			20,880	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			180,491			180,491	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				191,924		191,924	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RT	10a-3			12	621		12	621	12
13	Other (specify): Lab/Dialysis	39-02					64,887		64,887	13
14	TOTAL			$	12	$ 358,356	$ 256,811	12	$ 615,167	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 WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	$ (15,394)	$	1
2	Cash-Patient Deposits	16,791		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	719,252		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,571		6
7	Other Prepaid Expenses	13,453		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	141,087		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 916,760	$	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	496,098		15
16	Equipment, at Historical Cost	242,805		16
17	Accumulated Depreciation (book methods)	(94,888)		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)**	$ 644,015	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,560,775	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 957,336	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,823		28
29	Short-Term Notes Payable	160,000		29
30	Accrued Salaries Payable	109,580		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	45,885		36
37	Due Others	965,031		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,261,655	$	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)**	$ 2,261,655	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (700,880)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,560,775	$	48

*(See instructions.)

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (555,401)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(56,242)	3
4	**Rounding**	1	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (611,642)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(89,238)	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)**	$ (89,238)	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)**	$ (700,880)	24 *

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

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	$ 4,197,091	1
2	Discounts and Allowances for all Levels	123,727	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,320,818	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	513,550	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 513,550	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	136,446	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,660	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 151,106	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	231	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 231	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INC	23,232	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 23,232	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,008,937	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	869,860	31
32	Health Care	2,140,665	32
33	General Administration	1,191,920	33
	B. Capital Expense		
34	Ownership	575,956	34
	C. Ancillary Expense		
35	Special Cost Centers	256,811	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)***	$ 5,098,175	40
41	**Income before Income Taxes (line 30 minus line 40)****	(89,238)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (89,238)	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: 1/1/10 Ending: 12/31/10

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	1,976	2,008	$ 64,154	$ 31.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,113	12,671	377,019	29.75	3
4	Licensed Practical Nurses	14,052	14,692	350,365	23.85	4
5	CNAs & Orderlies	46,274	47,812	598,195	12.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,128	5,690	111,962	19.68	8
9	Activity Director	1,292	1,440	34,190	23.74	9
10	Activity Assistants	1,579	1,595	18,503	11.60	10
11	Social Service Workers	1,968	2,112	35,740	16.92	11
12	Dietician					12
13	Food Service Supervisor	3,102	3,238	89,225	27.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,555	17,773	163,396	9.19	15
16	Dishwashers					16
17	Maintenance Workers	2,539	2,831	58,596	20.70	17
18	Housekeepers	9,295	9,662	84,085	8.70	18
19	Laundry	7,550	8,015	68,072	8.49	19
20	Administrator	2,080	2,080	81,686	39.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,984	10,864	164,465	15.14	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	1,968	2,080	27,860	13.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,455	144,563	$ 2,327,513 *	$ 16.10	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	100	$ 4,988	1-03	35
36	Medical Director		12,000	9-03	36
37	Medical Records Consultant	96	4,608	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	4	214	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	76	4,241	11-03	44
45	Social Service Consultant	83	4,557	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	359	$ 30,608		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	72	$ 3,969	10-03	50
51	Licensed Practical Nurses	37	1,990	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	109	$ 5,959		53

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SAMUEL BIBER	ADMINISTRATOR		$ 81,686
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,686

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ABRAHAM GUTNICKI	LEGAL	$ 5,038
MEYER MAGENCE	LEGAL	937
KENETH A. HENRY	LEGAL	630
SKIDELSKY & ASSOCIATES	LEGAL	1,048
		3,500
BKD	ACCOUNTING	29,505
VARIOUS	DATA PROC/COMP	29,627
ACTIVITY COLLECTION SERV	COLLECTION FEES	162
ANTONIO NATAL	CONSULTING	250
PERSONNEL PLANNERS	UNEMP CONSULTING	1,320
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 72,017

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,784
Unemployment Compensation Insurance	36,087
FICA Taxes	176,249
Employee Health Insurance	81,953
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS-OTHER	9,943
TOTAL (agree to Schedule V, line 22, col.8)	$ 361,016

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	26,241
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
ADVERTISING & MARKETING	31,000
DUES & SUBSCRIPTIONS	4,778
LICENSES	3,905
ALLOCATION FROM AA HC MGT	115
Less: Public Relations Expense	( )
Non-allowable advertising	(29,996)
Yellow page advertising	(1,004)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,039

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,838
ALLOCATION FROM AA HC MGT	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,838

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 WOODSTOCK RESIDENCE **#** 0038653 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 $6,384**

(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. $ **19,404** 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?
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.