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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 11/1/1997

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: SANFORD BOKOR **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 01/01/2012 to 12/31/2012 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) AVRUM WEINFELD
(Title)

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, 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: 01/01/2012 Ending: 12/31/2012

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	23,424	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,992	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,443	4,443	8
9	SNF/PED					9
10	ICF	34,672	659	232	35,563	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,672	659	4,675	40,006	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.59%

D. How many bed-hold days during this year were paid by the Department?
212 (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 4,443

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	201,060	13,426	19,710	234,196		234,196	(3,311)	230,885			1
2	Food Purchase		202,225		202,225		202,225	(264)	201,961			2
3	Housekeeping	147,750	33,659		181,409		181,409		181,409			3
4	Laundry	50,349	10,755	8,521	69,625		69,625		69,625			4
5	Heat and Other Utilities			103,754	103,754		103,754	213	103,967			5
6	Maintenance	86,006	36,359	40,797	163,162		163,162	1,656	164,818			6
7	Other (specify):* TRANSP/SECURITY	70,449		8,987	79,436		79,436	109	79,545			7
8	**TOTAL General Services**	555,614	296,424	181,769	1,033,807		1,033,807	(1,597)	1,032,210			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,444,987	91,653	55,101	1,591,741		1,591,741	(20,118)	1,571,623			10
10a	Therapy	111,955	6,429	39,985	158,369		158,369		158,369			10a
11	Activities	104,299	17,888		122,187		122,187		122,187			11
12	Social Services	102,651		4,654	107,305		107,305		107,305			12
13	CNA Training											13
14	Program Transportation			9,063	9,063		9,063		9,063			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,763,892	115,970	117,803	1,997,665		1,997,665	(20,118)	1,977,547			16
	C. General Administration											
17	Administrative	100,550		513,000	613,550		613,550	(401,100)	212,450			17
18	Directors Fees											18
19	Professional Services			58,701	58,701		58,701	6,636	65,337			19
20	Dues, Fees, Subscriptions & Promotions			28,085	28,085		28,085	(14,638)	13,447			20
21	Clerical & General Office Expenses	93,278	24,607	54,375	172,260		172,260	(34,045)	138,215			21
22	Employee Benefits & Payroll Taxes			443,810	443,810		443,810		443,810			22
23	Inservice Training & Education			1,434	1,434		1,434	198	1,632			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			5,664	5,664		5,664	2,084	7,748			25
26	Insurance-Prop.Liab.Malpractice			50,922	50,922		50,922	6,637	57,559			26
27	Other (specify):*			62,862	62,862		62,862	(55,357)	7,505			27
28	**TOTAL General Administration**	193,828	24,607	1,218,853	1,437,288		1,437,288	(489,585)	947,703			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,513,334	437,001	1,518,425	4,468,760		4,468,760	(511,300)	3,957,460			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: 01/01/2012** **Ending: 12/31/2012**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	19,710	
	REPAIRS & MAINTENANCE		0	
			0	19,710
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		8,521	
			0	8,521
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		18,875	
	ELECTRICITY		47,523	
	WATER		35,406	
	CABLE TV - LOBBY		1,950	
			0	103,754
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,890	
	PAINTING & DECORATING		1,030	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		21,261	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,568	
	FIRE SERVICE		11,048	
			0	
			0	
			0	
			0	40,797
7	**OTHER**			
	SCAVENGER		7,363	
	SECURITY SERVICE		1,624	
			0	
			0	8,987
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		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	5,376	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	47,625	
	DENTAL CONSULTANT	XVIII B 47-2	2,100	
			0	55,101
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		862	
	SPEECH THERAPY SERVICES		1,378	
	OCCUPATIONAL THERAPY SERVICES		1,185	
	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	36,560	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				39,985
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		4,654	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				4,654
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WOODSIDE EXTENDED CARE **#0043406** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		9,063	9,063
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	513,000	513,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,005	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	43,696	
			0	58,701
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	10,589	
	EMPLOYEE WANT ADS	XIX F	1,392	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	7,212	
	LICENSES & PERMITS	XIX F	1,888	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,486	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	250	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,583	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	
	PATIENT BACKGROUND CHECKS	XIX F	685	
				28,085
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		308	
	EQUIPMENT REPAIR & MAINTENANCE		3,041	
	OUTSIDE CLERICAL SERVICES		36,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,026	
	MESSENGER SERVICE		0	
			0	54,375

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	188,992	
	UNEMPLOYMENT COMPENSATION	XIX D	63,059	
	WORKERS COMPENSATION INSURANC	XIX D	65,468	
	HOSPITALIZATION INSURANCE	XIX D	101,616	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,480	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	22,195	
	CHICAGO HEAD TAX	XIX D	0	
			0	443,810
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,434	
	TRAVEL	XIX G	0	
				1,434
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,664	
				5,664
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		50,922	
				50,922
27	**OTHER**			
	BAD DEBTS	VI 24	62,862	
				62,862

GRAND TOTAL COLUMN 3 OTHER **1,518,425**

WOODSIDE EXTENDED CARE
SCHEDULES
12/31/2012

EQUIPMENT RENTAL
PAGE 14 XII. B. LINE 16

KREG THERAPEUTIC	THERAPEUTIC BED	6,651
MEIKEM	DISHWASHER	141
DE LAGE	COPIER	2,985
PI SURVEILLANCE	TV SECURITY MONITOR	7,500
PITNEY BOWES	POSTAGE METER	924
PUBLIC STORAGE	STORAGE	2,172
	EQUIPMENT RENTAL	**20,373**

STAFF TRANSPORTATION
PAGE 3 V. COLUMN 3 LINE 25

DATE	NAME	DESCRIPTION	DEPARTMENT
JAN	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation
FEB	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation
APR	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation
MAY	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation
JUN	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation
JUL	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation
AUG	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation
SEP	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation
SEP	SECRETARY OF STATE	LICENSE RENEWAL	
OCT	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation
NOV	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation
DEC	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation

STAFF TRANSPORTATION

AMOUNT
247
651
496
829
562
416
995
530
99
441
170
228
5,664

Facility Name & ID Number WOODSIDE EXTENDED CARE #0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			9,176	9,176		9,176	215,753	224,929			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,797	17,797		17,797	239,767	257,564			32
33	Real Estate Taxes							390,181	390,181			33
34	Rent-Facility & Grounds			703,000	703,000		703,000	(700,521)	2,479			34
35	Rent-Equipment & Vehicles			28,653	28,653		28,653	2,094	30,747			35
36	Other (specify):* OFFICE RENT			9,336	9,336		9,336	15,924	25,260			36
37	TOTAL Ownership			767,962	767,962		767,962	163,198	931,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,790	713,687	871,477		871,477		871,477			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			384,411	384,411		384,411		384,411			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		157,790	1,098,098	1,255,888		1,255,888		1,255,888			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,513,334	594,791	3,384,485	6,492,610		6,492,610	(348,102)	6,144,508			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: 01/01/2012 Ending: 12/31/2012

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	33,105	30		9
10	Interest and Other Investment Income	(15)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(264)	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	(250)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,583)	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	(62,862)	27		24
25	Fund Raising, Advertising and Promotional	(10,589)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,486)	20		28
29	Other-Attach Schedule MARKETING SALARY	(22,660)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (69,604)		$	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)	(278,498)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (278,498)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (348,102)		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

WOODSIDE EXTENDED CARE

ID# 0043406

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (22,660)	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
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**	(22,660)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(3,311)	0	0	0	0	0	0	0	0	(3,311)	1
2	Food Purchase	(264)	0	0	0	0	0	0	0	0	0	0	(264)	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	213	0	0	0	0	0	0	0	213	5
6	Maintenance	0	1,164	0	492	0	0	0	0	0	0	0	1,656	6
7	Other (specify):*	0	109	0	0	0	0	0	0	0	0	0	109	7
8	**TOTAL General Services**	(264)	1,273	(3,311)	705	0	0	0	0	0	0	0	(1,597)	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	(20,118)	0	0	0	0	0	0	0	0	(20,118)	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	(20,118)	0	0	0	0	0	0	0	0	(20,118)	16
	C. General Administration													
17	Administrative	0	7,216	(408,316)	0	0	0	0	0	0	0	0	(401,100)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,005	(14,059)	16,690	0	0	0	0	0	0	0	6,636	19
20	Fees, Subscriptions & Promotions	(16,908)	1,198	1,041	31	0	0	0	0	0	0	0	(14,638)	20
21	Clerical & General Office Expenses	(22,660)	(15,584)	4,199	0	0	0	0	0	0	0	0	(34,045)	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	198	0	0	0	0	0	0	0	0	198	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	1,140	944	0	0	0	0	0	0	0	0	2,084	25
26	Insurance-Prop.Liab.Malpractice	0	278	252	6,107	0	0	0	0	0	0	0	6,637	26
27	Other (specify):*	(62,862)	3,355	4,150	0	0	0	0	0	0	0	0	(55,357)	27
28	**TOTAL General Administration**	(102,430)	1,608	(411,591)	22,828	0	0	0	0	0	0	0	(489,585)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(102,694)	2,881	(435,020)	23,533	0	0	0	0	0	0	0	(511,300)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSIDE EXTENDED CARE **#** 0043406 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	33,105	186	0	182,462	0	0	0	0	0	0	0	215,753	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15)	0	0	239,782	0	0	0	0	0	0	0	239,767	32
33	Real Estate Taxes	0	0	0	390,181	0	0	0	0	0	0	0	390,181	33
34	Rent-Facility & Grounds	0	0	2,479	(703,000)	0	0	0	0	0	0	0	(700,521)	34
35	Rent-Equipment & Vehicles	0	1,409	248	437	0	0	0	0	0	0	0	2,094	35
36	Other (specify):*	0	0	0	15,924	0	0	0	0	0	0	0	15,924	36
37	TOTAL Ownership	33,090	1,595	2,727	125,786	0	0	0	0	0	0	0	163,198	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)	(69,604)	4,476	(432,293)	149,319	0	0	0	0	0	0	0	(348,102)	45

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6-SUPPLEMENTAL						

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	6	MAINTENANCE	$	EKS MANAGEMENT		$ 1,164	$ 1,164	1
2	V	7	SCAVENGER		" "		109	109	2
3	V	17	CFO SALARY		" "		7,216	7,216	3
4	V	19	PROFESSIONAL FEES		" "		4,005	4,005	4
5	V	20	WANT ADS/BACKGRD CKS		" "		1,198	1,198	5
6	V	21	CLERICAL	36,000	" "		20,416	(15,584)	6
7	V	25	STAFF TRANSPORTATION		" "		1,140	1,140	7
8	V	26	INSURANCE		" "		278	278	8
9	V	27	EMPLOYEE BENEFITS		" "		3,355	3,355	9
10	V	30	SL DEPRECIATION		" "		186	186	10
11	V	35	EQUIPMENT RENT		" "		1,409	1,409	11
12	V				" "				12
13	V				" "				13
14	Total			$ 36,000			$ 40,476	$ * 4,476	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: 01/01/2012 Ending: 12/31/2012

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	MANAGEMENT FEES	$ 513,000	DA WESTMONT		$	$ (513,000)	15
16	V	19	ACCOUNTING FEES		" "		593	593	16
17	V	17	ADMIN CONSULTANT-S.HOLT		" "		26,343	26,343	17
18	V	17	ADMIN CONSULTANT-A.R.M.-F.WEISS		" "		78,341	78,341	18
19	V								19
20	V	1	DIETARY CONSULTANT	9,375	BRIA HEALTH SERVICES		3,616	(5,759)	20
21	V	10	NURSING CONSULTANT	29,625	" "		12,816	(16,809)	21
22	V	19	PURCHASING CONSULTANT	18,750	" "		4,062	(14,688)	22
23	V	20	WANT ADS		" "		1,041	1,041	23
24	V	21	OFFICE EXPENSE		" "		4,199	4,199	24
25	V	23	SEMINARS		" "		198	198	25
26	V	25	TRANSPORTATION-STAFF		" "		944	944	26
27	V	26	INSURANCE		" "		252	252	27
28	V	27	EMPLOYEE BENEFITS		" "		4,150	4,150	28
29	V	34	OFFICE RENT		" "		2,479	2,479	29
30	V	35	AUTO LEASE		" "		248	248	30
31	V	19	DATA PROCESSING		" "		36	36	31
32	V								32
33	V	1	DIETARY CONSULTANT	7,500	WEISS MANAGEMENT		9,948	2,448	33
34	V	10	NURSING CONSULTANT	18,000	" "		14,691	(3,309)	34
35	V				" "				35
36	V				" "				36
37	V				" "				37
38	V				" "				38
39	Total			$ 596,250			$ 163,957	$ * (432,293)	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: 01/01/2012 Ending: 12/31/2012

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	5	UTILITIES	$	IME REALTY		$ 213	$ 213	15
16	V	6	REPAIRS/MAINTENANCE		" "		492	492	16
17	V	19	ACCOUNTING FEES		" "		46	46	17
18	V	20	LICENSES & PERMITS		" "		31	31	18
19	V	26	INSURANCE		" "		50	50	19
20	V	30	SL DEPRECIATION		" "		823	823	20
21	V	32	INTEREST		" "		1,117	1,117	21
22	V	33	REAL ESTATE TAX		" "		1,806	1,806	22
23	V	35	STORAGE FEES		" "		437	437	23
24	V	36	OFFICE RENT	9,336	" "			(9,336)	24
25	V								25
26	V								26
27	V								27
28	V	19	ACCOUNTING FEES		MST REAL ESTATE LLC		16,644	16,644	28
29	V	26	HAZARD INSURANCE		" "		6,057	6,057	29
30	V	34	RENT	703,000	" "			(703,000)	30
31	V	30	SL DEPRECIATION		" "		181,639	181,639	31
32	V	32	INTEREST	138	" "		232,622	232,484	32
33	V	32	AMORT LOAN COST		" "		6,181	6,181	33
34	V	33	REAL ESTATE TAX		" "		388,375	388,375	34
35	V	36	MIP INSURANCE		" "		25,260	25,260	35
36	V								36
37	V								37
38	V								38
39	Total			$ 712,474			$ 861,793	$ * 149,319	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: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Avrum Weinfeld	26.5%	Atrium Healthcare & Rehab	Cahokia	EKS Management, Inc	Lincolnwood	Bookkeeping	1
2	Daniel Weiss	26.5%	Forest Edge Healthcare Rehab Ctr formerly Preside	Chicago	DA Westmont, Inc	Lincolnwood	Mgt Consulting	2
3	Michael Rosen	5%	Geneva Nursing & Rehab	Geneva	IME Realty Corp	Lincolnwood	Home Office Building	3
4	Dov Segal	5%	Lake Park	Waukegan	MST Real Estate LLC	South Chicago Heights	Rental Real Estate	4
5	Sandra Segal	5%	Palos Hills Healthcare	Palos Hills	Weiss Management Grp	Lincolnwood	Consulting	5
6	Morris Esformes	32%	River Oaks Healthcare Rehab Center formerly Burn	Burnham	Bria Health Services LL	Lincolnwood	Consulting	6
7			Westmont Nursing & Rehab Ctr.	Westmont				7
8			Belleview Healthcare & Rehab	Belleville				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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	ALLOCATION FROM DA WESTMONT:				SEE ATTACHED				$		1
2	FLORA WEISS (A.R.M. ENTERPRISES)	ADMIN CONSULTANT		0.00	SCHEDULES	2	3.57	CONSULT FEE	78,341	17-7	2
3											3
4	ALLOCATION FROM EKS MANAGEMENT:										4
5	AVRUM WEINFELD	CFO	CFO	26.50		3	4.62	SALARY	7,216	17-7	5
6											6
7	ALLOCATION FROM BRIA HEALTH SERVICES LLC:										7
8	DOV SEGAL	PURCHASING CONSULTANT		5.00				SALARY	4,062	19-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 89,619		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: 01/01/2012 Ending: 2/31/2012

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	6	MAINTENANCE	CENSUS DAYS	584,290	14 FACILITIES	$ 17,002	$ 17,002	40,006	$ 1,164	1
2	7	SCAVENGER	" "	584,290	14 FACILITIES	1,589		40,006	109	2
3	17	CFO SALARY-A. WEINFELD	" "	584,290	14 FACILITIES	105,390	105,390	40,006	7,216	3
4	19	PROFESSIONAL FEES	" "	584,290	14 FACILITIES	58,487	48,494	40,006	4,005	4
5	20	WANT ADS/BACKGRND CHKS	" "	584,290	14 FACILITIES	17,500		40,006	1,198	5
6	21	CLERICAL	" "	584,290	14 FACILITIES	298,180	206,170	40,006	20,416	6
7	25	STAFF TRANSPORTATION	" "	584,290	14 FACILITIES	16,652		40,006	1,140	7
8	26	INSURANCE	" "	584,290	14 FACILITIES	4,061		40,006	278	8
9	27	EMPLOYEE BENEFITS	" "	584,290	14 FACILITIES	48,997		40,006	3,355	9
10	30	SL DEPRECIATION	" "	584,290	14 FACILITIES	2,710		40,006	186	10
11	35	EQUIPMENT RENT	" "	584,290	14 FACILITIES	20,572		40,006	1,409	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					$ 591,140	$ 377,056		$ 40,476	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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: DA WESTMONT
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	19	ACCOUNTANT FEES	CENSUS DAYS	185524	3 FACILITIES	$ 2,750	$	40,006	$ 593	1
2	17	ADMIN CONSULT-A.R.M.	" "	185524	3 FACILITIES	363,300		40,006	78,341	2
3	17	ADMIN CONSULT-S.HOLT	" "	185524	3 FACILITIES	122,163		40,006	26,343	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 488,213	$		$ 105,277	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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	193,277	14 FACILITIES	$ 4,400	$	9,336	$ 213	1
2	6	REPAIRS/MAINTENANCE	" "	193,277	14 FACILITIES	10,190		9,336	492	2
3	19	ACCOUNTING FEES	" "	193,277	14 FACILITIES	962		9,336	46	3
4	20	LICENSES & PERMITS	" "	193,277	14 FACILITIES	632		9,336	31	4
5	26	INSURANCE	" "	193,277	14 FACILITIES	1,045		9,336	50	5
6	30	SL DEPRECIATION	" "	193,277	14 FACILITIES	17,044		9,336	823	6
7	32	INTEREST	" "	193,277	14 FACILITIES	23,132		9,336	1,117	7
8	33	REAL ESTATE TAX	" "	193,277	14 FACILITIES	37,391		9,336	1,806	8
9	35	STORAGE FEES	" "	193,277	14 FACILITIES	9,043		9,336	437	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					$ 103,839	$		$ 5,015	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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: BRIA HEALTH SERVICES LLC
Street Address: 6865 N LINCOLN AVE
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	1	DIETARY CONSULTANT	CENSUS DAYS	322,729	8 FACILITIES	$ 29,170	$ 29,170	40,006	$ 3,616	1
2	10	NURSING CONSULTANT	" "	322,729	8 FACILITIES	103,388	103,388	40,006	12,816	2
3	19	PURCHASING CONSULT-D.SEGAL	" "	322,729	8 FACILITIES	32,765	32,765	40,006	4,062	3
4	20	WANT ADS	" "	322,729	8 FACILITIES	8,400		40,006	1,041	4
5	21	OFFICE EXPENSE	" "	322,729	8 FACILITIES	33,871	9,940	40,006	4,199	5
6	23	SEMINARS	" "	322,729	8 FACILITIES	1,599		40,006	198	6
7	24	TRANSPORTATION-STAFF	" "	322,729	8 FACILITIES	7,616		40,006	944	7
8	26	INSURANCE	" "	322,729	8 FACILITIES	2,036		40,006	252	8
9	27	EMPLOYEE BENEFITS	" "	322,729	8 FACILITIES	33,481		40,006	4,150	9
10	34	OFFICE RENT	" "	322,729	8 FACILITIES	20,000		40,006	2,479	10
11	35	AUTO LEASE	" "	322,729	8 FACILITIES	2,000		40,006	248	11
12	19	DATA PROCESSING	" "	322,729	8 FACILITIES	289		40,006	36	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					$ 274,615	$ 175,263		$ 34,041	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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: WEISS MANAGEMENT GROUP
Street Address: 6865 N LINCOLN AVE
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	1	DIETARY CONSULTANT	CENSUS DAYS	193,748	4 FACILITIES	$ 48,175	$ 48,175	40,006	$ 9,948	1
2	10	NURSING CONSULTANT	" "	287,415	6 FACILITIES	105,543	105,543	40,006	14,691	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 153,718	$ 153,718		$ 24,639	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	4,336,822	09/35	5.3100	232,622	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		09/05	178,250	128,972	09/35		6,181	3
4												4
5	RELATED PARTY: IME REALTY		X	MORTGAGE							1,117	5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL	DEMAND	04/12	1,600,000	350,000		PRIME+	13,437	6
7	US BANK		X	WORKING CAPITAL	DEMAND	10/11	195,000			PRIME+	4,360	7
8												8
9	TOTAL Facility Related				$52,947.11		$ 6,892,450	$ 4,815,794			$ 257,717	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,892,450	$ 4,815,794			$ 257,717	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 25,260 **Line #** 36

*** 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: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 223,528	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.)		$ 312,862	2
3. Under or (over) accrual (line 2 minus line 1).		$ 89,334	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 312,872	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 $ 13,831 For 2010 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (13,831)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 388,375	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	244,003	8
	2008	264,735	9
	2009	271,767	10
	2010	247,847	11
	2011	312,862	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 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-29-401-011-0000	NURSING HOME	$ 312,861.81	$ 312,861.81
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 312,861.81	$ 312,861.81

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 01/01/2012 Ending: 12/31/2012

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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		1,311,748	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		1,452	9
10	WATER SOFTENING SYSTEM			1997	6,926	178	39	178		2,692	10
11	FLOORING			1997	3,910	100	39	100		1,504	11
12	FLOORING / DOORS / WINDOWS			1998	29,194	748	39	748		10,946	12
13	ROOF			1998	84,450	2,165	39	2,165		32,208	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.			1998	30,915	793	39	793		11,806	14
15	PAINTING / DECORATING			1998	15,111	387	39	387		5,628	15
16	FLOORING / DOORS / BATHROOM FIXTURES			1999	11,198	288	39	288		4,012	16
17	CHAIN LINK FENCE			1999	5,100	131	39	131		1,763	17
18	FLOOR TILES/COVE BASE			2000	22,766	828	27.5	828		10,729	18
19	PAIR OF ALUMINUM DOORS			2000	2,193	80	27.5	80		1,023	19
20	PLUMBING			2000	9,913	360	27.5	360		4,365	20
21	PLUMBING / VANITY / SINK / FLOORING			2001	37,788	1,374	27.5	1,374		16,116	21
22	PAVING			2002	18,562	675	27.5	675		7,116	22
23	BATHROOM SINKS			2002	3,888	141	27.5	141		1,416	23
24	BATHROOM SINKS			2003	7,776	283	27.5	283		2,818	24
25	FLOORING / CARPETING & TILE			2003	13,887	504	27.5	504		4,653	25
26	ROOF			2003	7,800	284	27.5	284		2,733	26
27	FENCE			2003	9,500	634	15	634		6,022	27
28	WINDOWS			2004	46,880	1,705	27.5	1,705		14,706	28
29	SPRINKLER SYSTEM / ELECTRICAL / ROOF AC / TILING			2007	298,345	10,849	27.5	10,849		63,708	29
30	ADDL FIRE SAFETY/TANK/GENERATOR/SECURITY SYST			2008	73,619	2,677	27.5	2,677		13,274	30
31	ROLLING SHUTTER			2008	3,970	144	27.5	144		666	31
32	BUILT-IN CABINET			2008	6,200	413	15	413		1,859	32
33	CANOPY			2009	6,500	236	27.5	236		757	33
34	SLIDING PATIO DOORS			2010	6,951	253	27.5	253		685	34
35	FLAT ROOF			2011	110,200	4,007	27.5	4,007		6,511	35
36	ROOFTOP A/C			2011	3,906	142	27.5	142		219	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	MST HEALTH PROPERTIES LLC d/b/a WOODSIDE EXTENDED CARE LLC:		$	$		$	$	$	37
38	DRAPERIES	2001	7,578		10			7,578	38
39	CUBICLE CURTAINS/FLOORING	2004	33,108		10	3,311	3,311	28,143	39
40	PATIO/FLOORING/TILE/LIGHTING/FIRE PANEL/ROOF AC	2005	30,694	1,116	27.5	1,116		8,168	40
41	WALL TILE / EXIT SIGNS / PLUMBING / DOORS	2006	49,079	1,784	27.5	1,784		11,894	41
42									42
43									43
44	RELATED PARTY-MST REAL ESTATE LLC-SL DEPN CONTINUED FROM PAGE 12:								44
45	ANNUNCIATOR PANEL	2011	4,350	158	27.5	158		217	45
46	DRIVEWAY/FRONT STEPS/FENCE	2012	10,158	339	15	339		339	46
47	CANOPY W/LOGO	2012	2,818	38	27.5	38		38	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56	RELATED PARTY ALLOCATION - IME REALTY		25,771	777	39	777			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)		$ 5,187,452	$ 185,316		$ 188,627	$ 3,311	$ 1,599,512	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 418,491	$ 2,678	$ 35,770	$ 33,092	8-15 YRS	$ 335,535	71
72	Current Year Purchases	5,996	3,598	300	(3,298)	10 YRS	300	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC - EKS MGMT 186//IME REALTY 46		232	232				74
75	TOTALS	$ 424,487	$ 6,508	$ 36,302	$ 29,794		$ 335,835	75

D. Vehicle Costs. (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)	$ 5,841,765	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 191,824	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 224,929	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,105	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,935,347	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: 01/01/2012 Ending: 12/31/2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 20,373 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,	'09 FORD E350 VAN	690.00	8,280	18
19	MARKETING, NSG				19
20	ACTIVITIES				20
21	TOTAL		$ 690.00	$ 8,280	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: 01/01/2012 Ending: 12/31/2012

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: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 412,416	$		$ 412,416	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,935			2,935	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			298,336			298,336	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				144,356		144,356	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): LABS/SUPPLIES	39-2					13,434		13,434	13
14	TOTAL			$		$ 713,687	$ 157,790		$ 871,477	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 496	$ 6,407	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 125,000)	2,005,361	2,005,361	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,315	103,570	6
7	Other Prepaid Expenses	54,582	68,490	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX/INSUR ESCROWS	125,750	274,713	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,263,504	$ 2,458,541	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	1,005,201	15
16	Equipment, at Historical Cost	432,064	438,264	16
17	Accumulated Depreciation (book methods)	(480,068)	(2,024,818)	17
18	Deferred Charges		133,782	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	99,064		22
23	Other(specify): REPLACEMENT RESERVE		191,586	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 163,941	$ 4,116,543	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,427,445	$ 6,575,084	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 425,419	$ 425,419	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	350,000	455,755	29
30	Accrued Salaries Payable	67,139	67,139	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,263	14,263	31
32	Accrued Real Estate Taxes(Sch.IX-B)		312,872	32
33	Accrued Interest Payable		19,190	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)**	$ 856,821	$ 1,294,638	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	606,277	4,837,344	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)**	$ 606,277	$ 4,837,344	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,463,098	$ 6,131,982	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 964,347	$ 443,102	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,427,445	$ 6,575,084	48

*(See instructions.)

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 537,438	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 537,438	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	847,490	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	(420,581)	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)**	$ 426,909	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)**	$ 964,347	24	*

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,970,549	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,970,549	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	369,536	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 369,536	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***	15	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15	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)**	$ 7,340,100	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,033,807	31
32	Health Care	1,997,665	32
33	General Administration	1,437,288	33
	B. Capital Expense		
34	Ownership	767,962	34
	C. Ancillary Expense		
35	Special Cost Centers	871,477	35
36	Provider Participation Fee	384,411	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,492,610	40
41	**Income before Income Taxes (line 30 minus line 40)****	847,490	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 847,490	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,628,227	44
45	Private Pay - Net Inpatient Revenue	94,381	45
46	Medicare - Net Inpatient Revenue	2,165,039	46
47	Other-(specify) HOSPICE,INSURANCE,ETC	82,902	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,970,549	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

*** **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: 01/01/2012 Ending: 12/31/2012

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	2,003	2,091	$ 90,494	$ 43.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,740	3,886	103,682	26.68	3
4	Licensed Practical Nurses	19,399	20,163	473,569	23.49	4
5	CNAs & Orderlies	57,384	61,058	600,448	9.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,230	6,699	111,955	16.71	8
9	Activity Director					9
10	Activity Assistants	9,100	9,513	104,299	10.96	10
11	Social Service Workers	6,464	6,584	102,651	15.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,144	20,644	201,060	9.74	15
16	Dishwashers					16
17	Maintenance Workers	5,994	6,511	86,006	13.21	17
18	Housekeepers	15,831	16,482	147,750	8.96	18
19	Laundry	5,389	5,677	50,349	8.87	19
20	Administrator	2,011	2,091	100,550	48.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,030	8,413	93,278	11.09	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	2,009	2,124	21,750	10.24	31
32	Other Health C: MDS/ADMIT/QA	5,598	5,897	155,044	26.29	32
33	Other(specify) TRANSP/SECURI	7,010	7,251	70,449	9.72	33
34	TOTAL (lines 1 - 33)	175,336	185,084	$ 2,513,334 *	$ 13.58	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	$ 19,710	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	47,625	10-3	38
39	Pharmacist Consultant	H	5,376	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		36,560	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	0	12-3	45
46	Other(specify)	S			46
47	DENTAL CONSULTANT		2,100	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 120,371		49

C. CONTRACT NURSES

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARCITA CARTER	ADMINISTRATOR		$ 100,550
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 100,550

B. Administrative - Other

Description	Amount
DA WESTMONT - MANAGEMENT FEES	$ 513,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 513,000

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SERVICES	DATA PROCESSING	$ 5,032
HEALTH DATA SYSTEMS	DATA PROCESSING	6,560
IVANS	DATA PROCESSING	1,763
LTC SOLUTION	DATA PROCESSING	1,650
KBKB	ACCOUNTING	18,000
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULT	1,196
RICHARD PEELO	MEDICARE COST REPORT	4,500
WALTON MGT SERVICES	NEW HIRE ACT SAVINGS	1,250
BRIA HEALTH SERVICES	see related party pg 6A,8C	18,750
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 58,701

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,468
Unemployment Compensation Insurance	63,059
FICA Taxes	188,992
Employee Health Insurance	101,616
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,480
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	22,195
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 443,810

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	$
Advertising: Employee Recruitment	1,392
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 7	685
TRUST/FRANCHISE/CONTRIB/ETC	4,833
MARKETING/ADV/PROMO	12,075
LICENSES/DUES/SUBSCRIPTIONS	9,100
MGMT CO ALLOC	2,270
TRUST/FRANCHISE/CONTRIB/ETC	(4,833)
Less: Public Relations Expense	(0)
Non-allowable advertising	(10,589)
Yellow page advertising	(1,486)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,447

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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: 01/01/2012 Ending: 12/31/2012

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? **YES**
If YES, give association name and amount. **ICLTC 7,212**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **384,411**
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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.