FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

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 01/01/2013 to 12/31/2013 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) CEO

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		102	4,002	4,104	8
9	SNF/PED					9
10	ICF	34,739	311		35,050	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,739	413	4,002	39,154	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.78%

D. How many bed-hold days during this year were paid by the Department?
0 (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 4,002

Medicare Intermediary WPS WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	209,125	15,370	22,500	246,995		246,995	(16,109)	230,886			1
2	Food Purchase		209,769		209,769	(2,570)	207,199	(519)	206,680			2
3	Housekeeping	148,042	25,354		173,396		173,396		173,396			3
4	Laundry	51,726	12,035	3,632	67,393		67,393		67,393			4
5	Heat and Other Utilities			127,674	127,674		127,674	342	128,016			5
6	Maintenance	83,853	45,617	38,950	168,420		168,420	796	169,216			6
7	Other (specify):* TRANSP/SECURITY	75,643		8,959	84,602		84,602	253	84,855			7
8	TOTAL General Services	568,389	308,145	201,715	1,078,249	(2,570)	1,075,679	(15,237)	1,060,442			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,550,680	82,662	76,144	1,709,486		1,709,486	(47,339)	1,662,147			10
10a	Therapy	110,533	8,965	42,986	162,484		162,484		162,484			10a
11	Activities	101,709	14,210		115,919		115,919		115,919			11
12	Social Services	104,084		7,965	112,049		112,049		112,049			12
13	CNA Training											13
14	Program Transportation			6,592	6,592		6,592		6,592			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,867,006	105,837	142,687	2,115,530		2,115,530	(47,339)	2,068,191			16
	C. General Administration											
17	Administrative	100,274		456,000	556,274		556,274	(402,078)	154,196			17
18	Directors Fees											18
19	Professional Services			85,913	85,913		85,913	(11,507)	74,406			19
20	Dues, Fees, Subscriptions & Promotions			41,139	41,139		41,139	(25,041)	16,098			20
21	Clerical & General Office Expenses	105,430	23,985	64,283	193,698		193,698	(30,754)	162,944			21
22	Employee Benefits & Payroll Taxes			412,277	412,277	2,570	414,847		414,847			22
23	Inservice Training & Education			2,520	2,520		2,520	421	2,941			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,250	4,250		4,250	3,034	7,284			25
26	Insurance-Prop.Liab.Malpractice			46,429	46,429		46,429	18,981	65,410			26
27	Other (specify):*			38,637	38,637		38,637	(26,614)	12,023			27
28	TOTAL General Administration	205,704	23,985	1,151,448	1,381,137	2,570	1,383,707	(473,558)	910,149			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,641,099	437,967	1,495,850	4,574,916		4,574,916	(536,134)	4,038,782			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: 01/01/2013** **Ending: 12/31/2013**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	22,500	
	REPAIRS & MAINTENANCE		0	
			0	22,500
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,632	
			0	3,632
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		26,830	
	ELECTRICITY		51,608	
	WATER		46,723	
	CABLE TV - LOBBY		2,513	
			0	127,674
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,315	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		22,292	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,873	
	FIRE SERVICE		10,470	
			0	
			0	
			0	
			0	38,950
7	**OTHER**			
	SCAVENGER		6,312	
	SECURITY SERVICE		2,647	
			0	
			0	8,959
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		116	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	71,100	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,928	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	76,144
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		2,796	
	SPEECH THERAPY SERVICES		1,072	
	OCCUPATIONAL THERAPY SERVICES		3,458	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	35,660	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				42,986
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	7,965	
	SOCIAL WORKER	XVIII B 45-2	0	
				7,965
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WOODSIDE EXTENDED CARE **#0043406** **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		6,592	6,592
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	456,000	456,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	16,872	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	69,041	
			0	85,913
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	21,494	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	7,426	
	LICENSES & PERMITS	XIX F	3,658	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	3,768	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	250	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,248	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	295	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				41,139
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		11,721	
	OUTSIDE CLERICAL SERVICES		36,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	100	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,462	
	MESSENGER SERVICE		0	
			0	64,283

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	199,203	
	UNEMPLOYMENT COMPENSATION	XIX D	58,395	
	WORKERS COMPENSATION INSURANC	XIX D	34,511	
	HOSPITALIZATION INSURANCE	XIX D	101,725	
	EMPLOYEE BENEFITS - OTHER	XIX D	9,539	
	EMPLOYEE PHYSICAL EXAMS	XIX D	240	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	8,664	
	CHICAGO HEAD TAX	XIX D	0	
			0	412,277
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,520	
				2,520
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,250	
				4,250
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		46,429	
				46,429
27	**OTHER**			
	BAD DEBTS	VI 24	38,637	
				38,637

GRAND TOTAL COLUMN 3 OTHER **1,495,850**

WOODSIDE EXTENDED CARE
SCHEDULES
12/31/2013

EQUIPMENT RENTAL
PAGE 14 XII. B. LINE 16

	DESCRIPTION	AMOUNT
KREG THERAPEUTIC	NURSING EQUIPMENT	492
DE LAGE	COPIER	2,673
CDS OFFICE TECH	OFFICE EQUIP	42
PITNEY BOWES	POSTAGE METER	720
PUBLIC STORAGE	STORAGE	3,621
	EQUIPMENT RENTAL	**7,548**

STAFF TRANSPORTATION
PAGE 3 V. COLUMN 3 LINE 25

DATE	NAME	DESCRIPTION		AMOUNT
JAN	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	310
FEB	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	350
MAR	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	173
APR	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	390
MAY	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	581
JUL	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	451
SEP	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	160
OCT	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	150
NOV	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	115
NOV	SHANNON JONES		CAR ALLOWANCE	500
DEC	SHANNON JONES		CAR ALLOWANCE	500
DEC	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	570
			STAFF TRANSPORTATION	**4,250**

EDUCATION & SEMINARS
PAGE 3 V. COLUMN 3 LINE 23

DATE	SPONSOR	PURPOSE OF SEMINAR	PERSONNEL	DEPT	LOC	COST OF SEMINAR
1/16/2013	ICLTC	THINK YOU KNOW RUGS?	MELIESA MORAGA	MDS	IL	450.00
			SUSAN ESCONDO	RN		
			MARCITA CARTER	ADMINISTRATOR		
2/5/2013	ICLTC	DEVELOPING A CORPORATE COMPLIANCE PLAN	MARCITA CARTER	ADMINISTRATOR	IL	105.00
2/7/2013	ICLTC	NEW OBRA GUIDELINES FOR END-OF-LIFE CARE	MARCITA CARTER	ADMINISTRATOR	IL	105.00
4/11/2013	ICLTC	OSHA REQUIREMENTS: 2013 UPDATE	MARCITA CARTER	ADMINISTRATOR	IL	210.00
			CARMELA LEDESMA	DON		
4/23/2013	ICLTC	CONQUERING THE READMISSION CHALLENGE	MARCITA CARTER	ADMINISTRATOR	IL	210.00
			CARMELA LEDESMA	DON		
6/20/2013	ICLTC	DEVELOPING LEADERS, NOT JUST MANAGERS	MARCITA CARTER	ADMINISTRATOR	IL	210.00
			CARMELA LEDESMA	DON		
7/23/2013	ICLTC	IN-DEPTH TRAINING FOR WOUND CARE NURSES	JANIE TYSON	LPN	IL	390.00
			CARMELA LEDESMA	DON		
7/30/2013	ICLTC	ARE YOU READY FOR MEDICAID RUG 48	MARCITA CARTER	ADMINISTRATOR	IL	315.00
			CARMELA LEDESMA	DON		
			LAI MORANGA	RN		

8/15/2013	ICLTC	PREPARING FOE THE FUTURE OF MANAGED CARE	MARCITA CARTER CARMELA LEDESMA	ADMINISTRATOR DON	IL	210.00
10/21/2013	ICLTC	MEDICARE: SOMEONE IS WATCHING YOU	MARCITA CARTER CARMELA LEDESMA LAI MORANGA	ADMINISTRATOR DON RN	IL	315.00
				TOTAL		**2,520.00**

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	209,769
LESS SALES TAX	(519)
NET FOOD	209,250
TOTAL PATIENT CENSUS	39,154
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	117,462
ADD # EMPLOYEE MEALS/DAY	4
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	1,460
PATIENT MEALS	117,462
ADD EMPLOYEE MEALS	1,460
TOTAL MEALS/YEAR	118,922
NET FOOD	209,250
DIVIDE TOTAL MEALS/YEAR	118,922
COST PER MEAL	1.76
TIMES EMPLOYEE MEALS	1,460
EMPLOYEE MEAL RECLASSIFIC	**2,570**

Facility Name & ID Number WOODSIDE EXTENDED CARE #0043406 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			9,240	9,240		9,240	215,244	224,484			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,200	8,200		8,200	267,373	275,573			32
33	Real Estate Taxes							349,764	349,764			33
34	Rent-Facility & Grounds			654,702	654,702		654,702	(649,762)	4,940			34
35	Rent-Equipment & Vehicles			17,198	17,198		17,198	2,577	19,775			35
36	Other (specify):* OFFICE RENT/MIP			9,556	9,556		9,556	12,694	22,250			36
37	TOTAL Ownership			698,896	698,896		698,896	197,890	896,786			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,738	556,898	703,636		703,636		703,636			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			279,002	279,002		279,002		279,002			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		146,738	835,900	982,638		982,638		982,638			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,641,099	584,705	3,030,646	6,256,450		6,256,450	(338,244)	5,918,206			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: 01/01/2013 Ending: 12/31/2013

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	30,658	30		9
10	Interest and Other Investment Income	(90,770)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(519)	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	(100)	21		18
19	Entertainment				19
20	Contributions	(4,248)	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	(38,637)	27		24
25	Fund Raising, Advertising and Promotional	(21,494)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,768)	20		28
29	Other-Attach Schedule MARKETING SALARY	(29,424)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (158,552)		$	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)	(179,692)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (179,692)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (338,244)		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: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (29,424)	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**	(29,424)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	(16,109)	0	0	0	0	0	0	0	(16,109)	1
2	Food Purchase	(519)	0	0	0	0	0	0	0	0	0	0	(519)	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	276	66	0	0	0	0	0	0	0	342	5
6	Maintenance	0	64	590	142	0	0	0	0	0	0	0	796	6
7	Other (specify):*	0	253	0	0	0	0	0	0	0	0	0	253	7
8	**TOTAL General Services**	(519)	317	866	(15,901)	0	0	0	0	0	0	0	(15,237)	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	(47,339)	0	0	0	0	0	0	0	(47,339)	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	(47,339)	0	0	0	0	0	0	0	(47,339)	16
	C. General Administration													
17	Administrative	0	9,876	0	(411,954)	0	0	0	0	0	0	0	(402,078)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	554	53	(12,114)	0	0	0	0	0	0	0	(11,507)	19
20	Fees, Subscriptions & Promotions	(29,760)	902	27	3,790	0	0	0	0	0	0	0	(25,041)	20
21	Clerical & General Office Expenses	(29,524)	(10,433)	0	9,203	0	0	0	0	0	0	0	(30,754)	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	421	0	0	0	0	0	0	0	421	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	0	3,034	0	0	0	0	0	0	0	3,034	25
26	Insurance-Prop.Liab.Malpractice	0	109	18,070	802	0	0	0	0	0	0	0	18,981	26
27	Other (specify):*	(38,637)	4,302	0	7,721	0	0	0	0	0	0	0	(26,614)	27
28	**TOTAL General Administration**	(97,921)	5,310	18,150	(399,097)	0	0	0	0	0	0	0	(473,558)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(98,440)	5,627	19,016	(462,337)	0	0	0	0	0	0	0	(536,134)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSIDE EXTENDED CARE **#** 0043406 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	30,658	183	183,925	478	0	0	0	0	0	0	0	215,244	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(90,770)	0	358,026	117	0	0	0	0	0	0	0	267,373	32
33	Real Estate Taxes	0	0	349,343	421	0	0	0	0	0	0	0	349,764	33
34	Rent-Facility & Grounds	0	0	(654,702)	4,940	0	0	0	0	0	0	0	(649,762)	34
35	Rent-Equipment & Vehicles	0	732	493	1,352	0	0	0	0	0	0	0	2,577	35
36	Other (specify):*	0	0	12,694	0	0	0	0	0	0	0	0	12,694	36
37	TOTAL Ownership	(60,112)	915	249,779	7,308	0	0	0	0	0	0	0	197,890	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)	(158,552)	6,542	268,795	(455,029)	0	0	0	0	0	0	0	(338,244)	45

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 64	$ 64	1
2	V	7	SCAVENGER		" "		253	253	2
3	V	17	CFO SALARY		" "		9,876	9,876	3
4	V	19	PROFESSIONAL FEES		" "		554	554	4
5	V	20	WANT ADS/BACKGRD CKS		" "		902	902	5
6	V	21	CLERICAL	36,000	" "		25,567	(10,433)	6
7	V	26	INSURANCE		" "		109	109	7
8	V	27	EMPLOYEE BENEFITS		" "		4,302	4,302	8
9	V	30	SL DEPRECIATION		" "		183	183	9
10	V	35	EQUIPMENT RENT		" "		732	732	10
11	V								11
12	V								12
13	V								13
14	Total			$ 36,000			$ 42,542	$ * 6,542	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: 01/01/2013 Ending: 12/31/2013

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		$ 276	$ 276	15
16	V	6	REPAIRS/MAINTENANCE		" "		590	590	16
17	V	19	ACCOUNTING FEES		" "		53	53	17
18	V	20	LICENSES & PERMITS		" "		27	27	18
19	V	26	INSURANCE		" "		63	63	19
20	V	30	SL DEPRECIATION		" "		922	922	20
21	V	32	INTEREST		" "		486	486	21
22	V	33	REAL ESTATE TAX		" "		1,750	1,750	22
23	V	35	STORAGE FEES		" "		493	493	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				28
29	V	26	HAZARD INSURANCE		" "		18,007	18,007	29
30	V	34	RENT	654,702	" "			(654,702)	30
31	V	30	SL DEPRECIATION		" "		183,003	183,003	31
32	V	32	INTEREST	239	" "		293,006	292,767	32
33	V	32	AMORT LOAN COST		" "		64,773	64,773	33
34	V	33	REAL ESTATE TAX		" "		347,593	347,593	34
35	V	36	MIP INSURANCE		" "		22,030	22,030	35
36	V		ACCOUNTING FEES		" "		12,500	12,500	36
37	V		SKIDELSKY & ASSOC-R.E.TAX-LEGAL		" "		3,250	3,250	37
38	V								38
39	Total			$ 664,277			$ 948,822	$ * 284,545	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: 01/01/2013 Ending: 12/31/2013

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	$ 456,000	DA WESTMONT		$	$ (456,000)	15
16	V	19	ACCOUNTING FEES		" "		507	507	16
17	V	17	ADMIN CONSULTANT-A.R.M.-F.WEISS		" "		44,046	44,046	17
18	V								18
19	V								19
20	V	1	DIETARY CONSULTANT	22,500	BRIA HEALTH SERVICES		6,391	(16,109)	20
21	V	10	NURSING CONSULTANT	71,100	" "		23,761	(47,339)	21
22	V	19	PROFESSIONAL FEES	45,000	" "		32,225	(12,775)	22
23	V	20	WANT ADS		" "		3,790	3,790	23
24	V	21	OFFICE EXPENSE		" "		9,203	9,203	24
25	V	23	SEMINARS		" "		421	421	25
26	V	25	TRANSPORTATION-STAFF		" "		3,034	3,034	26
27	V	26	INSURANCE		" "		802	802	27
28	V	27	EMPLOYEE BENEFITS		" "		7,721	7,721	28
29	V	34	OFFICE RENT		" "		4,940	4,940	29
30	V	35	AUTO LEASE		" "		1,352	1,352	30
31	V	19	STORAGE		" "		154	154	31
32	V	5	UTILITIES		" "		66	66	32
33	V	6	REPAIRS & MAINTENANCE		" "		142	142	33
34	V	32	INTEREST		" "		117	117	34
35	V	33	REAL ESTATE TAX		" "		421	421	35
36	V	30	DEPRECIATION-SL		" "		478	478	36
37	V								37
38	V								38
39	Total			$ 594,600			$ 139,571	$ * (455,029)	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: 01/01/2013 Ending: 12/31/2013

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	42.5%	Atrium Healthcare & Rehab	Cahokia	EKS Management, Inc	Lincolnwood	Bookkeeping	1
2	Daniel Weiss	42.5%	Forest Edge Healthcare Rehab Ctr	Chicago	IME Realty Corp	Lincolnwood	Home Office Building	2
3	Michael Rosen	5%	Geneva Nursing & Rehab	Geneva	MST Real Estate LLC	South Chicago Heights	Rental Real Estate	3
4	Dov Segal	5%	Lake Park	Waukegan	DA Westmont, Inc	Lincolnwood	Mgt Consulting	4
5	Sandra Segal	5%	Palos Hills Healthcare	Palos Hills	Bria Health Services LL	Lincolnwood	Consulting	5
6			River Oaks Healthcare Rehab Center	Burnham				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: 01/01/2013 Ending: 12/31/2013

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					SEE ATTACHED				$		1
2	ALLOCATION FROM DA WESTMONT & EKS MANAGEMENT:			0.00	SCHEDULES	10	14.29				2
3	FLORA WEISS (A.R.M. ENTERPRISES)	ADMIN CONSULTANT						CONSULT FEE	44,046	17-7	3
4	FLORA WEISS (A.R.M. ENTERPRISES)	CLERICAL						CONSULT FEE	2,155	21-7	4
5											5
6	ALLOCATION FROM EKS MANAGEMENT:										6
7	AVRUM WEINFELD	CFO	CFO	42.50		15	13.76	SALARY	9,876	17-7	7
8											8
9	ALLOCATION FROM BRIA HEALTH SERVICES LLC:										9
10	DOV SEGAL	ADMIN/PURCHASING CONSULTANT		5.00		10	20.00	SALARY&FEE	15,150	19-7	10
11											11
12											12
13								TOTAL	$ 71,227		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: 01/01/2013 Ending: 2/31/2013

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	303887	4 FACILITIES	$ 495	$	39,154	$ 64	1
2	7	SCAVENGER	" "	303887	4 FACILITIES	1,960		39,154	253	2
3	17	CFO SALARY-A. WEINFELD	" "	303887	4 FACILITIES	76,648	76,648	39,154	9,876	3
4	19	PROFESSIONAL FEES	" "	303887	4 FACILITIES	4,302		39,154	554	4
5	20	WANT ADS/BACKGRND CHKS	" "	303887	4 FACILITIES	7,000		39,154	902	5
6	21	CLERICAL	" "	303887	4 FACILITIES	198,433	139,928	39,154	25,567	6
7	26	INSURANCE	" "	303887	4 FACILITIES	848		39,154	109	7
8	27	EMPLOYEE BENEFITS	" "	303887	4 FACILITIES	33,390		39,154	4,302	8
9	30	SL DEPRECIATION	" "	303887	4 FACILITIES	1,420		39,154	183	9
10	35	EQUIPMENT RENT	" "	303887	4 FACILITIES	5,680		39,154	732	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					$ 330,176	$ 216,576		$ 42,542	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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	177,788	3 FACILITIES	$ 2,300	$	39,154	$ 507	1
2	17	ADMIN CONSULT-A.R.M.	" "	177,788	3 FACILITIES	200,000		39,154	44,046	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					$ 202,300	$		$ 44,553	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 SALARIES	CENSUS DAYS	475,523	8 FACILITIES	$ 77,622	$ 77,622	39,154	$ 6,391	1
2	10	NURSING SALARIES	" "	475,523	8 FACILITIES	288,582	288,582	39,154	23,761	2
3	19	PURCHASING CONSULT-D.SEGAL	" "	475,523	8 FACILITIES	184,000	100,000	39,154	15,150	3
4	19	ADMIN CONSULTANTS	" "	475,523	8 FACILITIES	202,669		39,154	16,688	4
5	19	DATA PROCESSING	" "	475,523	8 FACILITIES	1,212		39,154	100	5
6	19	ACCOUNTING & LEGAL	" "	475,523	8 FACILITIES	3,489		39,154	287	6
7	20	WANT ADS,LICENSES	" "	475,523	8 FACILITIES	46,030		39,154	3,790	7
8	21	OFFICE EXPENSE	" "	475,523	8 FACILITIES	111,765	36,036	39,154	9,203	8
9	23	SEMINARS	" "	475,523	8 FACILITIES	5,110		39,154	421	9
10	24	TRANSPORTATION-STAFF	" "	475,523	8 FACILITIES	36,847		39,154	3,034	10
11	26	INSURANCE	" "	475,523	8 FACILITIES	9,739		39,154	802	11
12	27	EMPLOYEE BENEFITS	" "	475,523	8 FACILITIES	93,769		39,154	7,721	12
13	34	OFFICE RENT	" "	475,523	8 FACILITIES	60,000		39,154	4,940	13
14	35	AUTO LEASE	" "	475,523	8 FACILITIES	16,418		39,154	1,352	14
15	35	PUBLIC STORAGE	" "	475,523	8 FACILITIES	1,868		39,154	154	15
16	5	UTILITIES	" "	475,523	8 FACILITIES	806		39,154	66	16
17	6	REPAIRS & MAINTENANCE	" "	475,523	8 FACILITIES	1,722		39,154	142	17
18	32	INTEREST	" "	475,523	8 FACILITIES	1,420		39,154	117	18
19	33	REAL ESTATE TAX	" "	475,523	8 FACILITIES	5,109		39,154	421	19
20	30	DEPRECIATION-SL	" "	475,523	8 FACILITIES	5,805		39,154	478	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,153,982	$ 502,240		$ 95,018	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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	121,840	6 FACILITIES	$ 3,521	$	9,556	$ 276	1
2	6	REPAIRS/MAINTENANCE	" "	121,840	6 FACILITIES	7,519		9,556	590	2
3	19	ACCOUNTING FEES	" "	121,840	6 FACILITIES	678		9,556	53	3
4	20	LICENSES & PERMITS	" "	121,840	6 FACILITIES	345		9,556	27	4
5	26	INSURANCE	" "	121,840	6 FACILITIES	807		9,556	63	5
6	30	SL DEPRECIATION	" "	121,840	6 FACILITIES	11,757		9,556	922	6
7	32	INTEREST	" "	121,840	6 FACILITIES	6,197		9,556	486	7
8	33	REAL ESTATE TAX	" "	121,840	6 FACILITIES	22,310		9,556	1,750	8
9	35	STORAGE FEES	" "	121,840	6 FACILITIES	6,286		9,556	493	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					$ 59,420	$		$ 4,660	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY: MST REAL ESTATE L			ACQUISITION COST			$ 94,490	$ 66,000			$ 3,436	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$52,947.11	09/05	4,919,200		09/35	5.3100	216,261	2
3	ACQ & LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		09/05	84,760		09/35		59,536	3
4	BEECH STREET		X	MORTGAGE		4/1/13	4,529,600	4,445,172	10/1/35	2.9000	76,745	4
5	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN			53,822	52,021			1,801	5
	Working Capital											
6	RELATED PARTY: IME REALTY		X	MORTGAGE							603	6
7												7
8	MB FINANCIAL		X	WORKING CAPITAL	DEMAND	04/12	1,101,000			PRIME+	8,200	8
9	TOTAL Facility Related				$52,947.11		$ 10,782,872	$ 4,563,193			$ 366,582	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,782,872	$ 4,563,193			$ 366,582	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 22,030 **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: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 312,872	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.)		$ 330,230	2
3. Under or (over) accrual (line 2 minus line 1).		$ 17,358	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 330,230	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.		$ 347,588	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	264,735	8
	2009	271,767	9
	2010	247,847	10
	2011	312,862	11
	2012	330,230	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 2012 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOODSIDE EXTENDED CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043406

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-29-401-011-0000	NURSING HOME	$ 330,229.54	$ 330,229.54
2.	32-29-401-021-0000	NURSING HOME-PARKING LOT	$	$
3.	32-29-401-027-0000	NURSING HOME-PARKING LOT	$	$
4.	PARKING LOT PURCHASED 10/17/2013		$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 330,229.54	$ 330,229.54

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,900 B. General Construction Type: Exterior CONCRETE Frame METAL/CONCRETE Number of Stories 2

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:NURSING HOME		2004	$ 229,826	1
2	PARKING LOT		2013	11,779	2
3	TOTALS			$ 241,605	3

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		1,462,377	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		1,548	9
10	WATER SOFTENING SYSTEM			1997	6,926	178	39	178		2,870	10
11	FLOORING			1997	3,910	100	39	100		1,604	11
12	FLOORING / DOORS / WINDOWS			1998	29,194	748	39	748		11,694	12
13	ROOF			1998	84,450	2,165	39	2,165		34,373	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.			1998	30,915	793	39	793		12,599	14
15	PAINTING / DECORATING			1998	15,111	387	39	387		6,015	15
16	FLOORING / DOORS / BATHROOM FIXTURES			1999	11,198	288	39	288		4,300	16
17	CHAIN LINK FENCE			1999	5,100	131	39	131		1,894	17
18	FLOOR TILES/COVE BASE			2000	22,766	828	27.5	828		11,557	18
19	PAIR OF ALUMINUM DOORS			2000	2,193	80	27.5	80		1,103	19
20	PLUMBING			2000	9,913	360	27.5	360		4,725	20
21	PLUMBING / VANITY / SINK / FLOORING			2001	37,788	1,374	27.5	1,374		17,490	21
22	PAVING			2002	18,562	675	27.5	675		7,791	22
23	BATHROOM SINKS			2002	3,888	141	27.5	141		1,557	23
24	BATHROOM SINKS			2003	7,776	283	27.5	283		3,101	24
25	FLOORING / CARPETING & TILE			2003	13,887	504	27.5	504		5,157	25
26	ROOF			2003	7,800	284	27.5	284		3,017	26
27	FENCE			2003	9,500	634	15	634		6,656	27
28	WINDOWS			2004	46,880	1,705	27.5	1,705		16,411	28
29	SPRINKLER SYSTEM / ELECTRICAL / ROOF AC / TILING			2007	298,345	10,849	27.5	10,849		74,557	29
30	ADDL FIRE SAFETY/TANK/GENERATOR/SECURITY SYST			2008	73,619	2,677	27.5	2,677		15,951	30
31	ROLLING SHUTTER			2008	3,970	144	27.5	144		810	31
32	BUILT-IN CABINET			2008	6,200	413	15	413		2,272	32
33	CANOPY			2009	6,500	236	27.5	236		993	33
34	SLIDING PATIO DOORS			2010	6,951	253	27.5	253		938	34
35	FLAT ROOF			2011	110,200	4,007	27.5	4,007		10,518	35
36	ROOFTOP A/C			2011	3,906	142	27.5	142		361	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: 01/01/2013 Ending: 12/31/2013

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	31,454	39
40	PATIO/FLOORING/TILE/LIGHTING/FIRE PANEL/ROOF AC	2005	30,694	1,116	27.5	1,116		9,284	40
41	WALL TILE / EXIT SIGNS / PLUMBING / DOORS	2006	49,079	1,784	27.5	1,784		13,678	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		375	45
46	DRIVEWAY/FRONT STEPS/FENCE	2012	10,158	677	15	677		1,016	46
47	CANOPY W/LOGO	2012	2,818	102	27.5	102		140	47
48	56 WINDOWS	2013	13,973	164	39	164		164	48
49	WIRING	2013	12,057	13	39	13		13	49
50	BLDG DEMOLITION & LANDFILL FOR NEW PARKING LOT	2013	32,544	271	15	271		271	50
51									51
52									52
53									53
54									54
55									55
56	RELATED PARTY ALLOCATION - IME REALTY		25,771	1,237	39	1,237			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)		$ 5,246,026	$ 186,626		$ 189,937	$ 3,311	$ 1,788,212	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: 01/01/2013 Ending: 12/31/2013

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	$ 378,382	$ 2,583	$ 33,296	$ 30,713	8-15 YRS	$ 323,026	71
72	Current Year Purchases	6,261	3,757	391	(3,366)	8-YRS	391	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC - MST BLDG 514/EKS MGMT 183/ IME REALTY 130+33		860	860				74
75	TOTALS	$ 384,643	$ 7,200	$ 34,547	$ 27,347		$ 323,417	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)	$ 5,872,274	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,826	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 224,484	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 30,658	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,111,629	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: 01/01/2013 Ending: 12/31/2013

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 7,548 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	5,520	18
19	MARKETING, NSG	'13 FORD XL VAN	690.00	4,130	19
20	ACTIVITIES				20
21	TOTAL		$ #######	$ 9,650	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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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	$		$ 259,497	$		$ 259,497	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			61,974			61,974	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			235,427			235,427	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				135,054		135,054	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LABS/SUPPLIES	39-2					11,684		11,684	12
13	Other (specify):									13
14	TOTAL			$		$ 556,898	$ 146,738		$ 703,636	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: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 163,914	$ 183,584	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 125,000)	1,243,242	1,243,242	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,621	103,525	6
7	Other Prepaid Expenses	5,054	130,054	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX/INSUR ESCROWS	125,750	296,553	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,617,581	$ 1,956,958	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		241,605	13
14	Buildings, at Historical Cost		4,142,702	14
15	Leasehold Improvements, at Historical Cost	112,881	1,063,773	15
16	Equipment, at Historical Cost	392,220	406,645	16
17	Accumulated Depreciation (book methods)	(443,204)	(2,174,122)	17
18	Deferred Charges		117,021	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	333,688		22
23	Other(specify): REPLACEMENT RESERVE		233,547	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 395,585	$ 4,031,171	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,013,166	$ 5,988,129	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 270,303	$ 274,303	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		148,093	29
30	Accrued Salaries Payable	77,782	77,782	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,839	14,839	31
32	Accrued Real Estate Taxes(Sch.IX-B)		330,230	32
33	Accrued Interest Payable		10,743	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)**	$ 362,924	$ 855,990	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	600,277	4,897,356	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)**	$ 600,277	$ 4,897,356	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 963,201	$ 5,753,346	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,049,965	$ 234,783	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,013,166	$ 5,988,129	48

***(See instructions.)**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 964,347	1	
2	Restatements (describe):		2	
3	ROUNDING	4	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 964,351	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	405,614	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	(320,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 85,614	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)**	$ 1,049,965	24	*

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

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 6,309,913	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,309,913	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	262,233	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 262,233	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***	90,770	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 90,770	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)**	$ 6,662,916	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,078,249	31
32	Health Care	2,115,530	32
33	General Administration	1,381,137	33
	B. Capital Expense		
34	Ownership	698,896	34
	C. Ancillary Expense		
35	Special Cost Centers	703,636	35
36	Provider Participation Fee	279,002	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,256,450	40
41	**Income before Income Taxes (line 30 minus line 40)****	406,466	41
42	**Income Taxes**	(852)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 405,614	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,255,516	44
45	Private Pay - Net Inpatient Revenue	44,290	45
46	Medicare - Net Inpatient Revenue	1,977,611	46
47	Other-(specify) HOSPICE,INSURANCE,ETC	32,496	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,309,913	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: 01/01/2013 Ending: 12/31/2013

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	2,022	2,086	$ 90,248	$ 43.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,514	6,801	193,764	28.49	3
4	Licensed Practical Nurses	19,719	20,890	490,110	23.46	4
5	CNAs & Orderlies	55,705	59,014	596,378	10.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,173	6,655	110,533	16.61	8
9	Activity Director					9
10	Activity Assistants	8,644	9,226	101,709	11.02	10
11	Social Service Workers	6,660	6,796	104,084	15.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,564	20,823	209,125	10.04	15
16	Dishwashers					16
17	Maintenance Workers	5,788	6,125	83,853	13.69	17
18	Housekeepers	15,428	16,221	148,042	9.13	18
19	Laundry	5,330	5,707	51,726	9.06	19
20	Administrator	2,062	2,086	100,274	48.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,762	9,344	105,430	11.28	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	1,902	2,046	20,917	10.22	31
32	Other Health C: MDS/ADMIT/QA	4,799	4,976	159,263	32.01	32
33	Other(specify) TRANSP/SECURI	7,598	7,824	75,643	9.67	33
34	TOTAL (lines 1 - 33)	176,670	186,620	$ 2,641,099 *	$ 14.15	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	$ 22,500	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	71,100	10-3	38
39	Pharmacist Consultant	H	4,928	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		35,660	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	7,965	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 151,153		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: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARCITA CARTER	ADMINISTRATOR		$ 100,274
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,274

B. Administrative - Other

Description	Amount
DA WESTMONT - MANAGEMENT FEES	$ 456,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 456,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
ALPHA DATA SERVICES	DATA PROCESSING	5,527
HEALTH DATA SYSTEMS	DATA PROCESSING	6,139
IVANS/ABILITY	DATA PROCESSING	2,886
LTC SOLUTION	DATA PROCESSING	1,650
IIT SOURCE TECH	DATA PROCESSING	670
KBKB	ACCOUNTING	18,000
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULT	1,171
RICHARD PEELO	MEDICARE COST REPORT	4,500
SKIDELSKY & ASSOC	REAL ESTATE TAX-LEGAL	370
BRIA HEALTH SERVICES	see related party pg 6B,8B	45,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 85,913

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,511
Unemployment Compensation Insurance	58,395
FICA Taxes	199,203
Employee Health Insurance	101,725
Employee Meals	2,570
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	9,539
EMPLOYEE PHYSICAL EXAMS	240
PENSION/PROFIT SHARING PLANS	8,664
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 414,847

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	$ 1,990
Advertising: Employee Recruitment	0
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 4	295
TRUST/FRANCHISE/CONTRIB/ETC	4,498
MARKETING/ADV/PROMO	25,262
LICENSES/DUES/SUBSCRIPTIONS	9,094
MGMT CO ALLOC	4,719
TRUST/FRANCHISE/CONTRIB/ETC	(4,498)
Less: Public Relations Expense	(0)
Non-allowable advertising	(21,494)
Yellow page advertising	(3,768)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,098

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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 7,426**

(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. $ **6,957** 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. $ **279,002**
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. $ **2,570** 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 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.