

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: <u>0043406</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>MST HEALTH PROPERTIES LLC d/b/a WOODSIDE EXTENDED CARE LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> 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.																							
Address: <u>120 WEST 26TH ST</u> <u>SO.CHICAGO HTS.</u> <u>60411</u>																									
Number City Zip Code																									
County: <u>COOK</u>																									
Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>MORRIS ESFORMES</u></td></tr><tr><td>(Title) <u>MANAGER</u></td></tr><tr><td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td></tr><tr><td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MORRIS ESFORMES</u>	(Title) <u>MANAGER</u>	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)	Paid Preparer	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>												
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	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																								
Date of Initial License for Current Owners: <u>11/01/97</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u>																									
Email Address: _____																									

Facility Name & ID Number MST HEALTH PROPERTIES LLC d/b/a WOODSIDE EXTENDED CARE LLC # 0043406 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			4,763	4,763	8
9	SNF/PED					9
10	ICF	34,991	572		35,563	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,991	572	4,763	40,326	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.64%

D. How many bed-hold days during this year were paid by the Department? 230 (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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

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

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 20 and days of care provided 4,763

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

STATE OF ILLINOIS

Facility Name & ID Number

MST HEALTH PROPERTIES LLC d/b/a W

#

0043406

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

Page 3

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					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	192,233	12,452	11,340	216,025		216,025		216,025			1
2	Food Purchase		196,131		196,131		196,131	(333)	195,798			2
3	Housekeeping	154,238	27,520		181,758		181,758		181,758			3
4	Laundry	52,765	12,709	3,507	68,981		68,981		68,981			4
5	Heat and Other Utilities			124,959	124,959		124,959	245	125,204			5
6	Maintenance	144,150	37,098	35,020	216,268		216,268	4,405	220,673			6
7	Other (specify):* TRANSP/SECURITY	66,743		12,397	79,140		79,140	46	79,186			7
8	TOTAL General Services	610,129	285,910	187,223	1,083,262		1,083,262	4,363	1,087,625			8
	B. Health Care and Programs											
9	Medical Director			7,500	7,500		7,500		7,500			9
10	Nursing and Medical Records	1,485,441	91,262	8,851	1,585,554		1,585,554		1,585,554			10
10a	Therapy	106,930		38,236	145,166		145,166		145,166			10a
11	Activities	106,986	6,653		113,639		113,639		113,639			11
12	Social Services	101,435		6,381	107,816		107,816		107,816			12
13	CNA Training											13
14	Program Transportation			11,374	11,374		11,374		11,374			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,800,792	97,915	72,342	1,971,049		1,971,049		1,971,049			16
	C. General Administration											
17	Administrative	100,275		191,000	291,275		291,275	(134,160)	157,115			17
18	Directors Fees											18
19	Professional Services			44,977	44,977		44,977	16,971	61,948			19
20	Dues, Fees, Subscriptions & Promotions			22,689	22,689		22,689	(5,754)	16,935			20
21	Clerical & General Office Expenses	82,505	21,668	71,435	175,608		175,608	(43,825)	131,783			21
22	Employee Benefits & Payroll Taxes			417,962	417,962		417,962		417,962			22
23	Inservice Training & Education			1,085	1,085		1,085	5	1,090			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			7,484	7,484		7,484	745	8,229			25
26	Insurance-Prop.Liab.Malpractice			61,925	61,925		61,925	10,322	72,247			26
27	Other (specify):*			94,748	94,748		94,748	(87,404)	7,344			27
28	TOTAL General Administration	182,780	21,668	913,305	1,117,753		1,117,753	(243,100)	874,653			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,593,701	405,493	1,172,870	4,172,064		4,172,064	(238,737)	3,933,327			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.

V.COST CENTER EXPENSES
 PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	11,340
	REPAIRS & MAINTENANCE	0
		0
		11,340
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,507
		0
		3,507
5	HEAT & OTHER UTILITIES	
	GAS HEAT	31,710
	ELECTRICITY	55,654
	WATER	35,739
	CABLE TV - LOBBY	1,856
		0
		124,959
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,008
	PAINTING & DECORATING	2,403
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	14,822
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,684
	FIRE SERVICE	12,103
		0
		0
		0
		0
		35,020
7	OTHER	
	SCAVENGER	10,169
	SECURITY SERVICE	2,228
		0
		0
		12,397
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	7,500
		7,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	323
	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	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
	DENTAL CONSULTANT XVIII B 47-2	3,600
		0
		8,851
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	761
	SPEECH THERAPY SERVICES	853
	OCCUPATIONAL THERAPY SERVICES	122
	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	36,500
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		38,236
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	6,381
	SOCIAL WORKER XVIII B 45-2	0
		6,381
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	11,374
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	191,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	13,721
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	25,756
	LEGAL SETTLEMENT	5,500
20	FEES,SUBSCRIPTIONS,PROMOTIONS	44,977
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	880
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	6,822
	LICENSES & PERMITS XIX F	5,953
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,922
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	250
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,892
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	2,470
		22,689
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,730
	OUTSIDE CLERICAL SERVICES	51,000
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,705
	MESSENGER SERVICE	0
		0
		71,435

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	195,953
	UNEMPLOYMENT COMPENSATION XIX D	43,244
	WORKERS COMPENSATION INSURANC XIX D	65,849
	HOSPITALIZATION INSURANCE XIX D	90,873
	EMPLOYEE BENEFITS - OTHER XIX D	500
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	21,543
	CHICAGO HEAD TAX XIX D	0
		0
		417,962
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,085
		1,085
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,484
		7,484
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	61,925
		61,925
27	OTHER	
	BAD DEBTS VI 24	94,748
		94,748

GRAND TOTAL COLUMN 3 OTHER 1,172,870

MST HEALTH PROPERTIES LLC d/b/a WOODSIDE EXTENDED CARE LLC
SCHEDULES
12/31/2011

STAFF TRANSPORTATION
PAGE 3 V. COLUMN 3 LINE 25

			DATE	NAME	DESCRIPTION	DEPARTMENT	AMOUNT
EQUIPMENT RENTAL PAGE 14 XII. B. LINE 16			JAN	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	135.00
			JAN	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	258.30
			FEB	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	207.99
			FEB	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	289.29
KREG THERAPEUTIC	THERAPEUTIC BED	660	MAR	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	100.00
PRO-CARE	THERAPEUTIC BED	930	MAR	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	258.54
DE LAGE	COPIER	2,924	APR	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	160.00
PI SURVEILLANCE	TV SECURITY MONITOR	9,000	APR	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	357.12
PITNEY BOWES	POSTAGE METER	786	MAY	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	245.00
PUBLIC STORAGE	STORAGE	2,139	MAY	FLEET SERVICES	GASOLINE	banking, maintenance, & activities, transportation	442.30
EQUIPMENT RENTAL 16,439			JUN	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	295.00
			JUN	SPEEDWAY	GASOLINE	banking, maintenance, & activities, transportation	49.17
			JUN	PAYROLL	GASOLINE	banking, maintenance, & activities, transportation	200.00
			JUL	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	245.00
			JUL	SPEEDWAY	GASOLINE	banking, maintenance, & activities, transportation	351.12
			JUL	PAYROLL	GASOLINE	banking, maintenance, & activities, transportation	600.00
			AUG	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	170.00
			AUG	SPEEDWAY	GASOLINE	banking, maintenance, & activities, transportation	320.95
			AUG	SECRETARY OF STATE	AUTO LICENSE	banking, maintenance, & activities, transportation	99.00
			SEP	SECRETARY OF STATE	AUTO LICENSE	banking, maintenance, & activities, transportation	99.00
			SEP	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	100.00
			SEP	SPEEDWAY	GASOLINE	banking, maintenance, & activities, transportation	310.48
			OCT	PAYROLL	GASOLINE	banking, maintenance, & activities, transportation	1,000.00
			OCT	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	185.00
OCT	SPEEDWAY	GASOLINE	banking, maintenance, & activities, transportation	339.48			
			NOV	PETTY CASH	GASOLINE	banking, maintenance, & activities, transportation	466.22
			NOV	PAYROLL	GASOLINE	banking, maintenance, & activities, transportation	200.00
STAFF TRANSPORTATION							7,483.96

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			11,335	11,335		11,335	213,446	224,781			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,756	4,756		4,756	244,974	249,730			32
33	Real Estate Taxes							194,342	194,342			33
34	Rent-Facility & Grounds			678,000	678,000		678,000	(678,000)				34
35	Rent-Equipment & Vehicles			25,628	25,628		25,628	2,415	28,043			35
36	Other (specify):* OFFICE RENT			9,336	9,336		9,336	13,021	22,357			36
37	TOTAL Ownership			729,055	729,055		729,055	(9,802)	719,253			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,757	574,538	722,295		722,295		722,295			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		147,757	635,858	783,615		783,615		783,615			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,593,701	553,250	2,537,783	5,684,734		5,684,734	(248,539)	5,436,195			45

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

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	32,969	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	(333)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(250)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,392)	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	(94,748)	27		24
25	Fund Raising, Advertising and Promotional	(880)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,922)	20		28
29	Other-Attach Schedule MARKETING SALARY	(14,934)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (84,505)		\$	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)	(164,034)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (164,034)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (248,539)		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

Report Period Beginning:

Ending:

ID#

0043406

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (14,934)	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	(14,934)		49

Summary A

12/31/2011

[illegible]

Summary B

Facility Name & ID Number	MST HEALTH PROPERTIES LLC d/b/a WOODSIDE EX	#	0043406	Report Period Beginning:	01/01/2011	Ending:	12/31/2011
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

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
			EKS MGMT	LINCOLNWOOD	BOOKKEEPING	
			EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT	
SEE ATTACHED SCHEDULES			DA WESTMONT	LINCOLNWOOD	MGMT CONSULT	
			IME REALTY	LINCOLNWOOD	HOME OFFICE	
			MST REAL ESTATE LLC		RENTAL REAL	
				LINCOLNWOOD	ESTATE	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$	EKS MANAGEMENT		\$		1
2	V	6	MAINTENANCE		" "		1,852	1,852	2
3	V	7	SCAVENGER		" "		46	46	3
4	V	17	CFO SALARY		" "		5,470	5,470	4
5	V	19	PROFESSIONAL FEES		" "		4,186	4,186	5
6	V	20	WANT ADS/BACKGRD CKS		" "		1,665	1,665	6
7	V	21	CLERICAL	51,000	" "		17,963	(33,037)	7
8	V	23	SEMINARS		" "		5	5	8
9	V	25	STAFF TRANSPORTATION		" "		633	633	9
10	V	26	INSURANCE		" "		119	119	10
11	V	27	EMPLOYEE BENEFITS		" "		2,862	2,862	11
12	V	30	SL DEPRECIATION		" "		73	73	12
13	V	35	EQUIPMENT RENT		" "		1,753	1,753	13
14	Total			\$ 51,000			\$ 36,627	\$ * (14,373)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	DRIVERS SALARY	\$	EMI ENTERPRISES		\$ 1,925	\$ 1,925	15
16	V	17	REGIONAL DIRECTOR		" "		285	285	16
17	V	17	MANAGEMENT FEES	145,000	" "			(145,000)	17
18	V	17	OFFICERS SALARY		" "		9,277	9,277	18
19	V	17	MANAGEMENT CONSULTANT		" "		9,277	9,277	19
20	V	19	ACCOUNTING FEES		" "		308	308	20
21	V	21	CLERICAL		" "		4,146	4,146	21
22	V	25	STAFF TRANSPORTATION		" "		112	112	22
23	V	26	INSURANCE		" "		611	611	23
24	V	27	EMPLOYEE BENEFITS		" "		4,482	4,482	24
25	V	35	AUTO LEASE				258	258	25
26	V								26
27	V								27
28	V	17	MANAGEMENT FEES	46,000	DA WESTMONT			(46,000)	28
29	V	19	ACCOUNTING FEES		" "		181	181	29
30	V	17	ADMIN CONSULTANT-S.HOLT		" "		8,186	8,186	30
31	V	17	ADMIN CONSULTANT-A.R.M.		" "		24,345	24,345	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 191,000			\$ 63,393	\$ * (127,607)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	IME REALTY		\$ 245	\$ 245	15
16	V	6	REPAIRS/MAINTENANCE		" "		628	628	16
17	V	19	ACCOUNTING FEES		" "		46	46	17
18	V	20	LICENSES & PERMITS		" "		25	25	18
19	V	26	INSURANCE		" "		60	60	19
20	V	30	SL DEPRECIATION		" "		809	809	20
21	V	32	INTEREST		" "		1,368	1,368	21
22	V	33	REAL ESTATE TAX		" "		1,323	1,323	22
23	V	35	STORAGE FEES		" "		404	404	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		12,250	12,250	28
29	V	26	HAZARD INSURANCE		" "		9,532	9,532	29
30	V	34	RENT	678,000	" "			(678,000)	30
31	V	30	SL DEPRECIATION		" "		179,595	179,595	31
32	V	32	INTEREST		" "		237,553	237,553	32
33	V	32	AMORT LOAN COST		" "		6,068	6,068	33
34	V	33	REAL ESTATE TAX		" "		193,019	193,019	34
35	V	36	MIP INSURANCE		" "		22,357	22,357	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 687,336			\$ 665,282	\$ * (22,054)	39

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

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								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

Facility Name & ID Number MST HEALTH PROPERTIES LLC d/b/a W # 0043406 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 EMI ENTERPRISES:				SEE ATTACHED				\$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT	76.65	SCHEDULES	5	6.25	SALARY	9,277	17-3	2
3	MICHAEL ROSEN	REGIONAL DIRECTOR		5.00				SALARY	285	17-3	3
4	PHILIP ESFORMES	ADMIN CONSULTANT		0.00		3	4.55	CONSULT FEE	9,277	17-3	4
5											5
6	ALLOCATION FROM DA WESTMONT:										6
7	FLORA WEISS (A.R.M. ENTERPRISES)	ADMIN CONSULTANT		0.00		2	3.57	CONSULT FEE	24,345	17-3	7
8											8
9	ALLOCATION FROM EKS MANAGEMENT:										9
10	AVRUM WEINFELD	CFO	CFO	4.17		3	4.62	SALARY	5,470	17-3	10
11											11
12											12
13								TOTAL	\$ 48,654		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 MST HEALTH PROPERTIES LLC d/b/a WOODSIDE EΛ # 0043406 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1			CENSUS DAYS			\$	\$			1
2	6	MAINTENANCE	" "	847,662	14 FACILITIES	38,929	38,929	40,326	1,852	2
3	7	SCAVENGER	" "	847,662	14 FACILITIES	971		40,326	46	3
4	17	CFO SALARY-A. WEINFELD	" "	847,662	14 FACILITIES	114,971	114,971	40,326	5,470	4
5	19	PROFESSIONAL FEES	" "	847,662	14 FACILITIES	87,982	76,534	40,326	4,186	5
6	20	WANT ADS/BACKGRND CHKS	" "	847,662	14 FACILITIES	35,000		40,326	1,665	6
7	21	CLERICAL	" "	847,662	14 FACILITIES	377,586	282,348	40,326	17,963	7
8	23	SEMINARS	" "	847,662	14 FACILITIES	115		40,326	5	8
9	25	STAFF TRANSPORTATION	" "	847,662	14 FACILITIES	13,315		40,326	633	9
10	26	INSURANCE	" "	847,662	14 FACILITIES	2,501		40,326	119	10
11	27	EMPLOYEE BENEFITS	" "	847,662	14 FACILITIES	60,163		40,326	2,862	11
12	30	SL DEPRECIATION	" "	847,662	14 FACILITIES	1,536		40,326	73	12
13	35	EQUIPMENT RENT	" "	847,662	14 FACILITIES	36,848		40,326	1,753	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					\$ 769,917	\$ 512,782		\$ 36,627	25

Facility Name & ID Number MST HEALTH PROPERTIES LLC d/b/a WOODSIDE E # 0043406 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 ☒ NO ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	DRIVERS SALARY	CENSUS DAYS	847,662	14 FACILITIES	\$ 40,460	\$ 40,460	40,326	\$ 1,925	1
2	17	REGIONAL DIRECTOR-M.ROSEN	" "	847,662	14 FACILITIES	6,000	6,000	40,326	285	2
3	17	OFFICERS SALARY-M.ESFORMES	" "	847,662	14 FACILITIES	195,000	195,000	40,326	9,277	3
4	17	ADMIN CONSUL-P.ESFORMES	" "	847,662	14 FACILITIES	195,000		40,326	9,277	4
5	19	ACCOUNTING FEES	" "	847,662	14 FACILITIES	6,480		40,326	308	5
6	21	CLERICAL	" "	847,662	14 FACILITIES	87,144	58,016	40,326	4,146	6
7	25	STAFF TRANSPORTATION	" "	847,662	14 FACILITIES	2,349		40,326	112	7
8	26	INSURANCE	" "	847,662	14 FACILITIES	12,837		40,326	611	8
9	27	EMPLOYEE BENEFITS	" "	847,662	14 FACILITIES	94,218		40,326	4,482	9
10	35	AUTO LEASE		847,662	14 FACILITIES	5,423		40,326	258	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					\$ 644,911	\$ 299,476		\$ 30,681	25

Facility Name & ID Number MST HEALTH PROPERTIES LLC d/b/a WOODSIDE E # 0043406 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	ACCOUNTANT FEES	CENSUS DAYS	91,323	3 FACILITIES	\$ 2,475	\$	6,676	\$ 181	1
2	17	ADMIN CONSULT-A.R.M.	" "	91,323	3 FACILITIES	333,025		6,676	24,345	2
3	17	ADMIN CONSULT-S.HOLT	" "	91,323	3 FACILITIES	111,983		6,676	8,186	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					\$ 447,483	\$		\$ 32,712	25

Facility Name & ID Number MST HEALTH PROPERTIES LLC d/b/a WOODSIDE E # 0043406 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	RENTAL INCOME	195,459	14 FACILITIES	\$ 5,131	\$	9,336	\$ 245	1
2	6	REPAIRS/MAINTENANCE	" "	195,459	14 FACILITIES	13,157		9,336	628	2
3	19	ACCOUNTING FEES	" "	195,459	14 FACILITIES	973		9,336	46	3
4	20	LICENSES & PERMITS	" "	195,459	14 FACILITIES	526		9,336	25	4
5	26	INSURANCE	" "	195,459	14 FACILITIES	1,254		9,336	60	5
6	30	SL DEPRECIATION	" "	195,459	14 FACILITIES	16,930		9,336	809	6
7	32	INTEREST	" "	195,459	14 FACILITIES	28,650		9,336	1,368	7
8	33	REAL ESTATE TAX	" "	195,459	14 FACILITIES	27,693		9,336	1,323	8
9	35	STORAGE FEES	" "	195,459	14 FACILITIES	8,451		9,336	404	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					\$ 102,765	\$		\$ 4,908	25

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 LLC							\$					\$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	\$52,947.11	09/05		4,919,200	4,431,944	09/35	5.3100		237,553	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		09/05		172,440	135,153	09/35			6,068	3
4														4
5	RELATED PARTY: IME REALTY		X	MORTGAGE										5
	Working Capital													
6	US BANK LOC		X	WORKING CAPITAL	DEMAND	10/11		195,000	605,000		PRIME+		3,771	6
7	PRIVATE BK LOC		X	WORKING CAPITAL									985	7
8														8
9	TOTAL Facility Related					\$52,947.11		\$ 5,286,640	\$ 5,172,097			\$ 248,377	9	
	B. Non-Facility Related*													
10														10
11														11
12														12
13														13
14	TOTAL Non-Facility Related							\$				\$		14
15	TOTALS (line 9+line14)							\$ 5,286,640	\$ 5,172,097			\$ 248,377	15	

16)

Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$

22,357

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.)

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

B. Real Estate Taxes

[illegible]

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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MST HEALTH PROPERTIES LLC d/b/a WOODSIDE EXT 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 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>32-29-401-011-0000</u>	<u>NURSING HOME</u>	\$ <u>247,846.50</u>	\$ <u>247,846.50</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>247,846.50</u></u>	\$ <u><u>247,846.50</u></u>

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

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

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	RELATED PARTY-MST REAL ESTATE LLC:			\$	1
2	NURSING HOME		2004	229,826	2
3	TOTALS			\$ 229,826	3

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		1,161,119	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		1,356	9
10		WATER SOFTENING SYSTEM	1997		6,926	178	39	178		2,514	10
11		FLOORING	1997		3,910	100	39	100		1,404	11
12		FLOORING / DOORS / WINDOWS	1998		29,194	748	39	748		10,198	12
13		ROOF	1998		84,450	2,165	39	2,165		30,043	13
14		DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.	1998		30,915	793	39	793		11,013	14
15		PAINTING / DECORATING	1998		15,111	387	39	387		5,241	15
16		FLOORING / DOORS / BATHROOM FIXTURES	1999		11,198	288	39	288		3,724	16
17		CHAIN LINK FENCE	1999		5,100	131	39	131		1,632	17
18		FLOOR TILES/COVE BASE	2000		22,766	828	27.5	828		9,901	18
19		PAIR OF ALUMINUM DOORS	2000		2,193	80	27.5	80		943	19
20		PLUMBING	2000		9,913	360	27.5	360		4,005	20
21		PLUMBING / VANITY / SINK / FLOORING	2001		37,788	1,374	27.5	1,374		14,742	21
22		PAVING	2002		18,562	675	27.5	675		6,441	22
23		BATHROOM SINKS	2002		3,888	141	27.5	141		1,275	23
24		BATHROOM SINKS	2003		7,776	283	27.5	283		2,535	24
25		FLOORING / CARPETING & TILE	2003		13,887	504	27.5	504		4,149	25
26		ROOF	2003		7,800	284	27.5	284		2,449	26
27		FENCE	2003		9,500	634	15	634		5,388	27
28		WINDOWS	2004		46,880	1,705	27.5	1,705		13,001	28
29		SPRINKLER SYSTEM / ELECTRICAL / ROOF AC / TILING	2007		298,345	10,849	27.5	10,849		52,859	29
30		ADDL FIRE SAFETY/TANK/GENERATOR/SECURITY SYST	2008		73,619	2,677	27.5	2,677		10,597	30
31		ROLLING SHUTTER	2008		3,970	144	27.5	144		522	31
32		BUILT-IN CABINET	2008		6,200	413	15	413		1,446	32
33		CANOPY	2009		6,500	236	27.5	236		521	33
34		SLIDING PATIO DOORS	2010		6,951	253	27.5	253		432	34
35		FLAT ROOF	2011		110,200	2,504	27.5	2,504		2,504	35
36		ROOFTOP A/C	2011		3,906	77	27.5	77		77	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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 MST HEALTH PROPERTIES LLC d/b/a WOODSIDE EXTENDED CARE LLC:		\$	\$		\$	\$	\$	37
38 DRAPERIES	2001	7,578		10	377	377	7,578	38
39 CUBICLE CURTAINS/FLOORING	2004	33,108		10	3,311	3,311	24,832	39
40 PATIO/FLOORING/TILE/LIGHTING/FIRE PANEL/ROOF AC	2005	30,694	1,116	27.5	1,116		7,052	40
41 WALL TILE / EXIT SIGNS / PLUMBING / DOORS	2006	49,079	1,784	27.5	1,784		10,110	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	59	27.5	59		59	45
46								46
47								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		39				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)		\$ 5,174,476	\$ 182,495		\$ 186,183	\$ 3,688	\$ 1,411,662	70

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

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	\$421,795	\$2,625	\$37,307	\$34,682	8-15 YRS	\$310,840	71
72	Current Year Purchases	8,180	5,810	409	(5,401)	10 YRS	409	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC - EKS MGMT 73//IME REALTY 32							74
75	TOTALS	\$429,975	\$8,435	\$37,716	\$29,281		\$311,249	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	2	
	Reference	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)	\$5,834,277	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$190,930	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$223,899	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$32,969	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,722,911	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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:
- *

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: \$ 16,439
- 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	9,189	18
19	MARKETING, NSG				19
20	ACTIVITIES				20
21	TOTAL		\$ 690.00	\$ 9,189	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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)	\$			

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 295,565	\$		\$ 295,565	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,010			2,010	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			276,963			276,963	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				137,784		137,784	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					9,973		9,973	13
14	TOTAL			\$		\$ 574,538	\$ 147,757		\$ 722,295	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 MST HEALTH PROPERTIES LLC d/b/a WOODSIDE EX1# 0043406Report Period Beginning: 01/01/2011Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(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	\$ 37,037	\$ 66,656	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>125,000</u>)	1,635,100	1,635,100	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,907	104,861	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>R.E.TAX/INSUR ESCROWS</u>	125,750	268,010	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,877,794	\$ 2,074,627	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	992,225	15
16	Equipment, at Historical Cost	437,552	443,752	16
17	Accumulated Depreciation (book methods)	(482,376)	(1,845,903)	17
18	Deferred Charges		134,153	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 <u>DUE FROM LLC</u>)	76,056		22
23	Other(specify): <u>REPLACEMENT RESERVE</u>		157,848	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 144,113	\$ 4,254,603	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,021,907	\$ 6,329,230	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 201,687	\$ 201,687	26
27	Officer's Accounts Payable	612,277	612,277	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	605,000	700,122	29
30	Accrued Salaries Payable	51,342	51,342	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,163	14,163	31
32	Accrued Real Estate Taxes(Sch.IX-B)		223,528	32
33	Accrued Interest Payable		19,611	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)	\$ 1,484,469	\$ 1,822,730	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,336,822	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,336,822	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,484,469	\$ 6,159,552	46
47	TOTAL EQUITY(page 18, line 24)	\$ 537,438	\$ 169,678	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,021,907	\$ 6,329,230	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 227,995	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 227,995	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,072,640	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	(763,197)	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)	\$ 309,443	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)	\$ 537,438	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,466,610	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,466,610	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	295,413	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 295,413	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)	\$ 6,762,038	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,083,262	31
32	Health Care	1,971,049	32
33	General Administration	1,117,753	33
	B. Capital Expense		
34	Ownership	729,055	34
	C. Ancillary Expense		
35	Special Cost Centers	722,295	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,684,734	40
41	Income before Income Taxes (line 30 minus line 40)**	1,077,304	41
42	Income Taxes	(4,664)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,072,640	43

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,938	2,091	\$ 81,366	\$ 38.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,780	10,273	274,424	26.71	3
4	Licensed Practical Nurses	15,463	16,005	382,701	23.91	4
5	CNAs & Orderlies	61,383	64,330	622,465	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,995	6,412	106,930	16.68	8
9	Activity Director					9
10	Activity Assistants	9,075	9,812	106,986	10.90	10
11	Social Service Workers	6,328	6,533	101,435	15.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,591	19,667	192,233	9.77	15
16	Dishwashers					16
17	Maintenance Workers	9,645	9,870	144,150	14.60	17
18	Housekeepers	16,287	17,058	154,238	9.04	18
19	Laundry	5,788	6,012	52,765	8.78	19
20	Administrator	2,078	2,086	100,275	48.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,794	8,236	82,505	10.02	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	1,928	2,102	21,171	10.07	31
32	Other Health Care: MDS/ADMITTING	4,522	4,778	103,314	21.62	32
33	Other(specify) TRANSP/SECURITY	7,083	7,166	66,743	9.31	33
34	TOTAL (lines 1 - 33)	183,678	192,431	\$ 2,593,701 *	\$ 13.48	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 11,340	1-3	35
36	Medical Director	O	7,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,928	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		36,500	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	6,381	12-3	45
46	Other(specify)	S			46
47	DENTAL CONSULTANT		3,600	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 70,249		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
MARCITA CARTER	ADMINISTRATOR		\$ 100,275	Workers' Compensation Insurance		\$ 65,849	IDPH License Fee	\$ 3,980
				Unemployment Compensation Insurance		43,244	Advertising: Employee Recruitment	0
				FICA Taxes		195,953	Health Care Worker Background Check	0
				Employee Health Insurance		90,873	(Indicate # of checks performed)	
				Employee Meals		0	Patient Background Checks	35 2,470
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	4,642
				EMPLOYEE BENEFITS - OTHER		500	MARKETING/ADV/PROMO	2,802
				EMPLOYEE PHYSICAL EXAMS		0	LICENSES/DUES/SUBSCRIPTIONS	8,795
				PENSION/PROFIT SHARING PLANS		21,543	MGMT CO ALLOC	1,690
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(4,642)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(880)
Description			Amount				Yellow page advertising	(1,922)
EMI ENTERPRISES - MANAGEMENT FEES			\$ 145,000					
DA WESTMONT - MANAGEMENT FEES			46,000					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V, line 22, col.8)		\$ 417,962	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,935
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
ALPHA DATA SERVICES	DATA PROCESSING		4,809					
HEALTH DATA SYSTEMS	DATA PROCESSING		6,320					
IVANS	DATA PROCESSING		792				In-State Travel	
LTC SOLUTION	DATA PROCESSING		1,800					0
KBKB	ACCOUNTING		18,000					
HARVEY A NATHAN	LEGAL		375					
J.VOHNHOF	ARBITRATOR		1,300				Seminar Expense	
XXX	LEGAL SETTLEMENT		5,500					0
RICHARD PEELO	MEDICARE CONSULTANT		4,500					
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULT		1,370					
WALTON MGT SERVICES	HIRE ACT FICA SAVINGS		211					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	
			\$ 44,977				TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MST HEALTH PROPERTIES LLC d/b/a WOODSIDE EXTENDED # 0043406 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. ICLTC 6,822
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,320
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.