

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

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.

<p>I. IDPH Facility ID Number: <u>0035014</u></p> <p>Facility Name: <u>Glen Bridge Nursing and Rehabilitation Centre</u></p> <p>Address: <u>8333 West Golf Road</u> <u>Niles</u> <u>60714</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 966-9190</u> Fax # <u>(847) 966-4455</u></p> <p>IDPA ID Number: <u>363612592001</u></p> <p>Date of Initial License for Current Owners: <u>03/01/1989</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-3400</u> <u>Altschuler, Melvoin and Glasser LLP</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/2000</u> to <u>12/31/2000</u> and certify to the best of my knowledge and belief that the said content 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</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One S. Wacker Drive, Suite 800, Chicago, IL 60606-3392</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One S. Wacker Drive, Suite 800, Chicago, IL 60606-3392</u>		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre

0035014 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

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 N/A

	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	<u>151</u>	Skilled (SNF)	<u>151</u>	<u>55,266</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>151</u>	Intermediate (ICF)	<u>151</u>	<u>55,266</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>302</u>	TOTALS	<u>302</u>	<u>110,532</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>37,319</u>	<u>3,308</u>	<u>5,952</u>	<u>46,579</u>	8
9	SNF/PED					9
10	ICF	<u>46,729</u>	<u>1,971</u>	<u>189</u>	<u>48,889</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>84,048</u>	<u>5,279</u>	<u>6,141</u>	<u>95,468</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.37%

D. How many bed-hold days during this year were paid by Public Aid? 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

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 3/01/89

J. Was the facility purchased or leased after January 1, 1978?

YES Date 3/01/89 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 31 and days of care provided 4741

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number **Glen Bridge Nursing and Rehabilitation Cent** # **0035014** Report Period Beginning: **1/01/2000** Ending: **12/31/2000**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	331,687	90,430	15,803	437,920		437,920	0	437,920		1
2	Food Purchase		555,866		555,866	(26,935)	528,931	(5,744)	523,187		2
3	Housekeeping	205,335	50,636		255,971		255,971	0	255,971		3
4	Laundry	85,792	11,272	31,149	128,213		128,213	0	128,213		4
5	Heat and Other Utilities			184,199	184,199		184,199	8,493	192,692		5
6	Maintenance	94,373	38,585	165,412	298,370		298,370	8,212	306,582		6
7	Other (specify):*							0			7
8	TOTAL General Services	717,187	746,789	396,563	1,860,539	(26,935)	1,833,604	10,961	1,844,565		8
	B. Health Care and Programs										
9	Medical Director			24,600	24,600		24,600	0	24,600		9
10	Nursing and Medical Records	3,538,629	450,516	390,800	4,379,945	(52,738)	4,327,207	(136,116)	4,191,091		10
10a	Therapy	28,903	429	351,725	381,057		381,057	0	381,057		10a
11	Activities	134,354	5,579	2,520	142,453		142,453	0	142,453		11
12	Social Services	119,774		5,728	125,502		125,502	0	125,502		12
13	Nurse Aide Training							0			13
14	Program Transportation			1,581	1,581		1,581	0	1,581		14
15	Other (specify):* Religious Consult.			200	200		200	0	200		15
16	TOTAL Health Care and Programs	3,821,660	456,524	777,154	5,055,338	(52,738)	5,002,600	(136,116)	4,866,484		16
	C. General Administration										
17	Administrative	193,528		1,388,320	1,581,848		1,581,848	(1,388,320)	193,528		17
18	Directors Fees							0			18
19	Professional Services			142,244	142,244		142,244	11,239	153,483		19
20	Dues, Fees, Subscriptions & Promotions			38,855	38,855		38,855	1,948	40,803		20
21	Clerical & General Office Expenses	460,818	57,758	30,688	549,264		549,264	41,356	590,620		21
22	Employee Benefits & Payroll Taxes			612,587	612,587	26,935	639,522	60,063	699,585		22
23	Inservice Training & Education			2,594	2,594		2,594	700	3,294		23
24	Travel and Seminar							1,754	1,754		24
25	Other Admin. Staff Transportation			5,273	5,273		5,273	2,075	7,348		25
26	Insurance-Prop.Liab.Malpractice			187,152	187,152		187,152	2,370	189,522		26
27	Other (specify):*							0			27
28	TOTAL General Administration	654,346	57,758	2,407,713	3,119,817	26,935	3,146,752	(1,266,815)	1,879,937		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,193,193	1,261,071	3,581,430	10,035,694	(52,738)	9,982,956	(1,391,970)	8,590,986		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000 SEE ACCOUNTANTS' COMPILATION REPORT
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Cent # 0035014 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			109,797	109,797		109,797	226,980	336,777			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							309,875	309,875			32
33	Real Estate Taxes							439,063	439,063			33
34	Rent-Facility & Grounds			2,410,443	2,410,443		2,410,443	(2,410,443)				34
35	Rent-Equipment & Vehicles			10,567	10,567		10,567	10,563	21,130			35
36	Other (specify):*							0				36
37	TOTAL Ownership			2,530,807	2,530,807		2,530,807	(1,423,962)	1,106,845			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		129,179	10,569	139,748	52,738	192,486	0	192,486			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			165,348	165,348		165,348	0	165,348			42
43	Other (specify):* Non-Allowable			192,796	192,796		192,796	(192,796)				43
44	TOTAL Special Cost Centers		129,179	368,713	497,892	52,738	550,630	(192,796)	357,834			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,193,193	1,390,250	6,480,950	13,064,393	0	13,064,393	(3,008,728)	10,055,665			45

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

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number **Glen Bridge Nursing and Rehabilitation Centre** # **0035014** STATE OF ILLINOIS Report Period Beginning: **1/01/2000** Page 5
 Ending: **12/31/2000**

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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(203,209)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(535)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,720)	43		18
19	Entertainment	(3,352)	43		19
20	Contributions	(3,750)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(137,215)	43		24
25	Fund Raising, Advertising and Promotional	(15,854)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,054)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,818)	43		28
29	Other-Attach Schedule See Attached Schedule F	(171,724)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (568,231)		\$	30

OHF 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	2	
		Amount	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)	(2,440,497)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,440,497)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (3,008,728)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program	X		52,738	Ln 10	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 52,738		47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre # 0035014 Report Period Beginning: 1/01/2000 Ending: 12/31/2000 Summary A
 SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
A. General Services														
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,744)	0	0	0	0	0	0	0	0	0	0	(5,744)	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	8,493	0	0	0	0	0	0	0	0	8,493	5
6	Maintenance	(7,321)	0	15,533	0	0	0	0	0	0	0	0	8,212	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(13,065)	0	24,026	0	0	0	0	0	0	0	0	10,961	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	(136,116)	0	0	0	0	0	0	0	0	0	0	(136,116)	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	Nurse Aide 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	(136,116)	0	0	0	0	0	0	0	0	0	0	(136,116)	16
C. General Administration														
17	Administrative	0	0	(325,840)	(1,062,480)	0	0	0	0	0	0	0	(1,388,320)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,991)	0	32,230	0	0	0	0	0	0	0	0	11,239	19
20	Fees, Subscriptions & Promotions	0	0	1,948	0	0	0	0	0	0	0	0	1,948	20
21	Clerical & General Office Expenses	0	0	41,006	0	350	0	0	0	0	0	0	41,356	21
22	Employee Benefits & Payroll Taxes	0	0	60,063	0	0	0	0	0	0	0	0	60,063	22
23	Inservice Training & Education	0	0	700	0	0	0	0	0	0	0	0	700	23
24	Travel and Seminar	0	0	1,754	0	0	0	0	0	0	0	0	1,754	24
25	Other Admin. Staff Transportation	0	0	2,075	0	0	0	0	0	0	0	0	2,075	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,370	0	0	0	0	0	0	0	0	2,370	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,991)	0	(183,694)	(1,062,480)	350	0	0	0	0	0	0	(1,266,815)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(170,172)	0	(159,668)	(1,062,480)	350	0	0	0	0	0	0	(1,391,970)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre # 0035014 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

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

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	33,411	0	193,569	0	0	0	0	0	0	226,980	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(203,209)	0	35,941	0	477,143	0	0	0	0	0	0	309,875	32
33	Real Estate Taxes	0	0	12,760	0	426,303	0	0	0	0	0	0	439,063	33
34	Rent-Facility & Grounds	0	0	0	0	(2,410,443)	0	0	0	0	0	0	(2,410,443)	34
35	Rent-Equipment & Vehicles	0	0	10,563	0	0	0	0	0	0	0	0	10,563	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(203,209)	0	92,675	0	(1,313,428)	0	0	0	0	0	0	(1,423,962)	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):*	(194,850)	0	0	0	2,054	0	0	0	0	0	0	(192,796)	43
44	TOTAL Special Cost Centers	(194,850)	0	0	0	2,054	0	0	0	0	0	0	(192,796)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(568,231)	0	(66,993)	(1,062,480)	(1,311,024)	0	0	0	0	0	0	(3,008,728)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

VI. RELATED PARTIES
 Enter below the names of ALL owners and related organizations (affiliated) as defined in the instructions. Attach an additional schedule if necessary.

OWNER		RELATED ORGANIZATION		OTHER RELATED ORGANIZATION	
Name	Ownership %	Name	City	Name	City
State of Illinois	100%	Illinois State Board of Education	Springfield	Illinois State Board of Education	Springfield
Illinois State Board of Education		Illinois State Board of Education	Springfield	Illinois State Board of Education	Springfield

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

Schedule V Line	Item	Amount	Name of Related Organization	C. Cost of Related Organization		D. Reference to Related Organization Cost Center
				Period of Incurrence	Organization	
1	Cost of Related Organization					
2	Cost of Related Organization					
3	Cost of Related Organization					
4	Cost of Related Organization					
5	Cost of Related Organization					
6	Cost of Related Organization					
7	Cost of Related Organization					
8	Cost of Related Organization					
9	Cost of Related Organization					
10	Cost of Related Organization					
11	Cost of Related Organization					
12	Cost of Related Organization					
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44	Cost of Related Organization					
45	Cost of Related Organization					
46	Cost of Related Organization					
47	Cost of Related Organization					
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91	Cost of Related Organization					
92	Cost of Related Organization					
93	Cost of Related Organization					
94	Cost of Related Organization					
95	Cost of Related Organization					
96	Cost of Related Organization					
97	Cost of Related Organization					
98	Cost of Related Organization					
99	Cost of Related Organization					
100	Cost of Related Organization					

Print Preview
 1. Enter the information on pages 5 and 2A.
 2. For pages 6 thru 8, the information you enter does not need to be sorted by line reference.
 3. For pages 9 thru 10, a line can be referenced as many times as needed per page.
 4. For pages 11 thru 16, related organizations costs for therapy must be referenced as line number 1th.
 5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum 5

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 8 Line 9 Line 10 Line 11 Line 12 Line 13 Line 14 Line 15 Line 16 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 28 Line 29 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 37 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

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 17	Management Fees	\$ 325,840	Glen Health and Home Management, Inc.	A	\$	(325,840) 15
16	V 5	Utilities		Glen Health and Home Management, Inc.	A	8,493	8,493 16
17	V 6	Repairs and Maintenance		Glen Health and Home Management, Inc.	A	15,533	15,533 17
18	V 19	Professional Fees		Glen Health and Home Management, Inc.	A	32,230	32,230 18
19	V 20	Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	1,948	1,948 19
20	V 21	Clerical		Glen Health and Home Management, Inc.	A	41,006	41,006 20
21	V 22	Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	60,063	60,063 21
22	V 23	Training and Education		Glen Health and Home Management, Inc.	A	700	700 22
23	V 25	Auto Expenses		Glen Health and Home Management, Inc.	A	2,075	2,075 23
24	V 26	Insurance		Glen Health and Home Management, Inc.	A	2,370	2,370 24
25	V 32	Amortization of Mortgage Cost		Glen Health and Home Management, Inc.	A	374	374 25
26	V 30	Depreciation		Glen Health and Home Management, Inc.	A	33,411	33,411 26
27	V 32	Interest		Glen Health and Home Management, Inc.	A	35,567	35,567 27
28	V 33	Real Estate Taxes		Glen Health and Home Management, Inc.	A	12,760	12,760 28
29	V 35	Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	10,563	10,563 29
30	V 24	Travel		Glen Health and Home Management, Inc.	A	1,754	1,754 30
31	V						
32	V						
33	V			A - OWNERSHIP:			
34	V			Sidney Glenner - 41.50 %			
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 325,840			\$ 258,847 \$ *	(66,993) 39

Sum_6A

-325840
8493
15533
32230
1948
41006
60063
700
2075
2370
374
33411
35567
12760
10563
1754

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

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre # 0035014 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

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	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Administrative	\$ 1,062,480	GlenBar Management Company, Ltd.	B	\$	\$ (1,062,480)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,062,480			\$	\$ * (1,062,480)	39

Sum_6B

-1062480

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre # 0035014 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

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	4	5	6	7	8
Schedule V	Line	Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)
15	V 21	Clerical	\$	GlenBridge Real Estate & Development, L.L.C.	C	\$ 350	\$ 350
16	V 30	Depreciation		GlenBridge Real Estate & Development, L.L.C.	C	193,569	193,569
17	V 32	Interest Expense		GlenBridge Real Estate & Development, L.L.C.	C	515,387	515,387
18	V 33	Real Estate Taxes		GlenBridge Real Estate & Development, L.L.C.	C	426,303	426,303
19	V 34	Rental	2,410,443	GlenBridge Real Estate & Development, L.L.C.	C		(2,410,443)
20	V 43	Corporate Taxes		GlenBridge Real Estate & Development, L.L.C.	C	2,054	2,054
21	V 32	Interest Income		GlenBridge Real Estate & Development, L.L.C.	C	(38,244)	(38,244)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V			C - OWNERSHIP:			
28	V			Sidney Glenner - 60.00 % (constructively)			
29	V			Barry Ray - 20.00 %			
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 2,410,443			\$ 1,099,419	\$ * (1,311,024)

Sum_6C

350
193569
515387
426303
-2410443
2054
-38244

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6l, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6l, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6l, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number: Glen Bridge Nursing and Rehabilitation Centre # 0035014 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

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.

Table with 8 columns: 1 Schedule V, 2 Line, 3 Cost Per General Ledger, 4 Amount, 5 Cost to Related Organization, 6 Percent of Ownership, 7 Operating Cost of Related Organization, 8 Difference: Adjustments for Related Organization Costs (7 minus 4). Rows 15-38 are blank, row 39 is Total.

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

- 1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sidney Glenner	President	Administrative	80.00 %	104,288	13	22.00 %	Salary	\$ 30,713	Ln 17, Col 1	1
2	David Glenner	Vice-President	Administrative	0.00 %	57,938	9	23.00 %	Salary	17,063	Ln 17, Col 1	2
3	Barry Ray	Vice-President	Administrative	20.00 %	78,216	9	23.00 %	Salary	23,034	Ln 17, Col 1	3
4											4
5											5
6			See Schedule B								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 70,810		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre # 0035014 Report Period Beginning: 1/01/2000 Ending: 2/31/2000

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

Name of Related Organization Glen Health & Home Management, Inc.
 Street Address 5454 West Fargo
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 674-5454
 Fax Number (847) 674-8311

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

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					\$	\$		\$	1
2	5	Utilities	Patient Days	419,697	5	37,338	95,468	8,493	2
3	6	Repairs and Maintenance	Patient Days	419,697	5	68,287	95,468	15,533	3
4	19	Professional Fees	Patient Days	419,697	5	141,688	95,468	32,230	4
5	20	Licenses, Permits and Inspection	Patient Days	419,697	5	8,563	95,468	1,948	5
6	21	Clerical	Patient Days	419,697	5	180,270	95,468	41,006	6
7	22	Employee Benefits and Payroll	Patient Days	419,697	5	264,051	95,468	60,063	7
8	23	Training and Education	Patient Days	419,697	5	3,079	95,468	700	8
9	25	Auto Expenses	Patient Days	419,697	5	9,121	95,468	2,075	9
10	26	Insurance	Patient Days	419,697	5	10,420	95,468	2,370	10
11	32	Amortization of Mortgage Cost	Patient Days	419,697	5	1,646	95,468	374	11
12	30	Depreciation	Patient Days	419,697	5	146,881	95,468	33,411	12
13	32	Interest	Patient Days	419,697	5	156,358	95,468	35,567	13
14	33	Real Estate Taxes	Patient Days	419,697	5	56,094	95,468	12,760	14
15	35	Equipment and Vehicle Rental	Patient Days	419,697	5	46,437	95,468	10,563	15
16	24	Travel	Patient Days	419,697	5	7,709	95,468	1,754	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	1,137,942	\$	258,847	25

SEE ACCOUNTANTS' COMPILATION REPORT

[Print Preview](#)

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	LaSalle National Bank		X	Mortgage	\$92,800.00	01/04/96	\$ 9,000,000	\$ 6,541,667	12/31/2007	0.0735	\$ 505,908	1								
2	LaSalle National Bank		X	Amortization of mortgage costs							9,479	2								
3							Mortgage interest allocated from management company:				35,941	3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$92,800.00		\$ 9,000,000	\$ 6,541,667			\$ 551,328	9								
B. Non-Facility Related*																				
10									Interest income offset:		(241,453)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (241,453)	14								
15	TOTALS (line 9+line14)						\$ 9,000,000	\$ 6,541,667			\$ 309,875	15								

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	474,000	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.)	\$	444,303	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(29,697)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	456,000	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.)	\$	0	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. 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 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	426,303	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	397,142	8
	1996	393,772	9
	1997	404,786	10
	1998	439,085	11
	1999	444,303	12
<u>See Attached Schedule H For Calculation Of 2000 Real Estate Tax Accrual.</u>			
	13	FROM R. E. TAX STATEMENT FOR 1999	\$ 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,058 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories Three

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 ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	58,949	1989	\$ 263,180	1
2	Allocated from Management Company:			22,390	2
3	TOTALS	58,949		\$ 285,570	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre

0035014

Report Period Beginning:

1/01/2000 Ending:

12/31/2000

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Bed* 302	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		1989	1971	\$ 6,703,340	\$	35	\$ 191,524	\$ 191,524	\$ 2,234,447	4
5										5
6	Mgt Comp:			476,295			10,797	10,797		6
7										7
8										8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Building Improvements		1989	66,436		35	1,898	1,898	22,145	9
10	Building Improvements		1990	7,195		35	206	206	2,400	10
11	Building Improvements		1990	3,885		35	111	111	1,184	11
12	Building Improvements		1990	35,167	1,172	10	1,172		35,167	12
13	Building Improvements		1991	8,342	834	10	834		8,064	13
14	Building Improvements		1991	12,621		10	1,262	1,262	12,200	14
15	Building Improvements		1992	78,993	7,899	10	7,899		68,462	15
16	Building Improvements		1993	5,350		10	535	535	4,102	16
17	Building Improvements		1993	109,105	10,910	10	10,910		83,647	17
18	Land Improvements		1993	45,615	3,041	15	3,041		23,314	18
19	Building Improvements		1993	53,394	5,339	10	5,339		35,596	19
20	Land Improvements		1993	10,717	714	15	714		4,763	20
21	Building Improvements		1995	29,767	2,976	10	2,976		16,868	21
22	Electrical wiring work to 2nd floor from basement		1996	23,000	2,300	10	2,300		10,733	22
23	Dialysis room construction		1996	7,439	744	10	744		3,472	23
24	Fireplace construction		1996	1,065	106	10	106		496	24
25	Mounted door alarm system and wiring		1996	2,505	251	10	251		1,170	25
26	PVC hand rail and wall bumper		1997	4,968	497	10	497		1,822	26
27	Window treatments		1997	2,226	223	10	223		816	27
28	Walls, cabinets and tub		1997	5,520	552	10	552		2,024	28
29	Cabinets, sink and lighting		1997	4,571	457	10	457		1,676	29
30	Walls, platform and ramp		1997	9,286	929	10	929		3,405	30
31	Window treatments		1997	2,394	239	10	239		878	31
32	Cabinets and cubicles		1997	9,631	963	10	963		3,532	32
33	Cabinets		1997	2,500	250	10	250		917	33
34	Base covers		1997	630	63	10	63		231	34
35										35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 40,459		\$ 246,792	\$ 206,333	\$ 2,583,531	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

0035014

Report Period Beginning:

1/01/2000 Ending: 12/31/2000

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Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	Doors		1997		1,950	195	10	195		715	9
10	Sink		1997		2,236	224	10	224		820	10
11	Fire alarm improvement		1997		1,975	198	10	198		724	11
12	Walls and doors		1997		2,480	248	10	248		909	12
13	80 ton compressor		1998		20,800	2,080	10	2,080		5,547	13
14	Telephone system improvements		1998		2,503	250	10	250		668	14
15	Carpeting, window treatments, mini-blinds		1998		20,703	2,070	10	2,070		3,450	15
16	Handrail/bumper corner guard installation		1998		4,200	420	10	420		700	16
17	Cove base installation		1998		2,508	251	10	251		418	17
18	Handrail/bumper corner guard installation, accent rails		1999		11,401	1,140	10	1,140		1,900	18
19	Mini-blinds		1999		3,963	396	10	396		660	19
20	Carpeting, cove base installation		1999		14,797	1,480	10	1,480		2,466	20
21	Amtico, cove base installation		1999		5,616	562	10	562		936	21
22	Carpeting, cove base installation		1999		1,634	163	10	163		272	22
23	Wallpaper		1999		10,900	1,090	10	1,090		1,817	23
24	Handrail/bumper corner guard installation, accent rails		1999		11,401	1,140	10	1,140		1,900	24
25	Insurance claim: boiler		1999		(19,000)	(1,900)	10	(1,900)		(3,167)	25
26	Panel interior, interior mat installation		1999		2,468	247	10	247		411	26
27	Install alarms for ventilators		1999		1,560	156	10	156		260	27
28	Install handrails and bumper chair rails		1999		4,600	460	10	460		767	28
29	Carpeting		1999		4,497	450	10	450		750	29
30	Lighting improvements on the 5th floor		1998		4,635	463	10	463		772	30
31	Install new braille signs/slots		1999		2,135	213	10	213		231	31
32	Installation of mini-blinds		1999		3,476	348	10	348		377	32
33	Installation of handrails, bumpers, corner guards, chair rails		1999		5,500	550	10	550		596	33
34	Tube bundles for heat exchanger		1999		3,382	338	10	338		366	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 13,232		\$ 13,232	\$	\$ 25,265	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

0035014

Report Period Beginning:

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Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		Install new tubes & door gaskets on boiler	1999	1999	7,400	740	10	740		802	9
10		Install new motor, drain valve, drain hoses on washer	1999	1999	1,903	190	10	190		206	10
11		Cove base installation, floor patches, vinyl tiles & powerbond	1999	1999	11,459	573	10	573		573	11
12		Cove base installation	2000	2000	3,267	163	10	163		163	12
13		Cove base installation	2000	2000	1,939	97	10	97		97	13
14		Installation of fire dampers & exhaust fan	2000	2000	2,773	139	10	139		139	14
15		New interior for kitchen panel	2000	2000	2,630	132	10	132		132	15
16		Electrical work for 6 dialysis chairs	2000	2000	3,975	199	10	199		199	16
17		Install exhaust fan, ductwork, exhaust grilles, & fire-rated door	2000	2000	2,560	128	10	128		128	17
18		Ductwork fabrication and installation	2000	2000	4,120	206	10	206		206	18
19		Plumbing project	2000	2000	14,517	726	10	726		726	19
20		Carpeting, floor patches	1999	1999	2,969	297	10	297		495	20
21		4 custom nurses stations	2000	2000	10,025	501	10	501		501	21
22		4 custom nurses stations	2000	2000	33,284	1,664	10	1,664		1,664	22
23		5 sinks in nurses station	2000	2000	1,642	82	10	82		82	23
24		Fire alarm system	2000	2000	3,324	166	10	166		166	24
25		Cove base & vinyl installation, floor patches	2000	2000	2,705	135	10	135		135	25
26		Install door restrictors, emergency lights & telephones on elevator	2000	2000	11,500	575	10	575		575	26
27		Dura glide 3000 single slide door packages	2000	2000	12,218	611	10	611		611	27
28											28
29											29
30		Allocated from Management Company - See Attached Detail:			1,119						30
31											31
32											32
33											33
34											34
35											35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 7,324		\$ 7,324	\$	\$ 7,600	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Print Preview

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre # 0035014 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 436,123	\$ 61,188	\$ 61,178	\$ (10)	10 years	\$ 168,816	37
38	Current Year Purchases	81,639	4,082	4,082		10 years	4,082	38
39	Fully Depreciated Assets	541,319	1,122	1,122		5 years	541,319	39
40	Allocated from Mgt Co:	170,252					61,574	40
41	TOTALS	\$ 1,229,333	\$ 66,392	\$ 66,382	\$ (10)		\$ 775,791	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Care	1986 Dodge Van	1989	\$ 8,480	\$ 0	\$ 0	\$	5 years	\$ 8,480	42
43										43
44	Allocated from Management Company:			14,995		3,047	3,047	5 years	11,716	44
45										45
46	TOTALS			\$ 23,475	\$	\$ 3,047	\$ 3,047		\$ 20,196	46

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$	#VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	127,407	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$	336,777	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	209,370	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$	3,412,383	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: See Schedule VII, Page 6

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Date of Lease	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. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A.

9. Option to Buy: YES NO Terms: N/A*

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: \$ 12,777 Description: Copier \$7,920, Ice-maker \$2,040, Postage meter \$607, Mgt Co. allocation \$2,210

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>Allocated from Management Company:</u>			<u>8,353</u>	18
19					19
20					20
21	TOTAL		\$	\$ 8,353	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. /2001 \$ _____
13. /2002 \$ _____
14. /2003 \$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>* It is the policy of this facility to hire only certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	1 2 3 4			
	Facility		Contract	Total
	Drop-outs	Completed		
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 Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre# 0035014 Report Period Beginning:

1/01/2000 Ending: 12/31/2000

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

	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	Ln10a,Col 2&3	hrs	\$	2,018	\$ 70,738	\$ 361	2,018	\$ 71,099	1
2	Licensed Speech and Language Development Therapist	Ln 10a,Col 3	hrs		1,509	53,104		1,509	53,104	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln10a,Col 2&3	hrs		5,125	179,577	68	5,125	179,645	4
5	Physician Care	Ln 39, Col 3	visits			557			557	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescripts				129,179		129,179	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Ln 39, Col 5					52,738		52,738	12
13	Other (specify): <u>Respiratory Therapy</u>	Ln 39, Col 3 Ln 10a, Col 1,3	1768 hrs	28,903	1,412	10,012 48,306		1,412	10,012 77,209	13
14	TOTAL			\$ 28,903	10,065	\$ 362,294	\$ 182,346	10,065	\$ 573,543	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre # 0035014 Report Period Beginning: 1/01/2000 Ending: 12/31/2000
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,099,192	\$ 2,741,477	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 342,000)	3,457,975	3,457,975	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	104,413	104,413	6
7	Other Prepaid Expenses	820,810	783,001	7
8	Accounts Receivable (owners or related parties)	26,958	26,958	8
9	Other(specify): <u>Employee Loans Receivable</u>	62,997	61,142	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,572,345	\$ 7,174,966	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	375,000	375,000	12
13	Land		285,570	13
14	Buildings, at Historical Cost		7,179,635	14
15	Leasehold Improvements, at Historical Cost	713,366	809,971	15
16	Equipment, at Historical Cost	567,229	1,252,808	16
17	Accumulated Depreciation (book methods)	(562,282)	(3,412,383)	17
18	Deferred Charges		78,847	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Mortgage Costs (Net)</u>		66,354	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,093,313	\$ 6,635,802	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,665,658	\$ 13,810,768	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 31,637	\$ 31,637	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	141,117	141,117	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	182,851	182,851	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,319	3,319	31
32	Accrued Real Estate Taxes(Sch.IX-B)		456,000	32
33	Accrued Interest Payable		41,403	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	Other Current Liabilities(specify):			
36	<u>See Attached Schedule E:</u>	760,097	760,097	36
37	<u>Other Accrued Expenses</u>	44,337	44,337	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,163,358	\$ 1,660,761	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,541,667	40
41	Bonds Payable			41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,541,667	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,163,358	\$ 8,202,428	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,502,300	\$ 5,608,340	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,665,658	\$ 13,810,768	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Print Preview

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre

0035014

Report Period Beginning: 1/01/2000

Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,684,578	1
2	Restatements (describe):		2
3	Prior Period Adjustments:	742,979	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,427,557	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(575,257)	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	(1,350,000)	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)	\$ (1,925,257)	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)	\$ 5,502,300	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Bridge Nursing and Rehabilitation Centre # 0035014 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,240,937	1
2	Discounts and Allowances for all Levels	(1,701,740)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,539,197	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	798,056	6
7	Oxygen	284,087	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,082,143	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	139,299	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	143,395	19
20	Radiology and X-Ray	3,948	20
21	Other Medical Services	369,911	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 656,553	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	203,209	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 203,209	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Private/Public Aid Bedhold	8,034	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,034	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,489,136	30

Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 1,860,539	31
32	Health Care	5,055,338	32
33	General Administration	3,119,817	33
B. Capital Expense			
34	Ownership	2,530,807	34
C. Ancillary Expense			
35	Special Cost Centers	305,096	35
36	Provider Participation Fee	192,796	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,064,393	40
41	Income before Income Taxes (line 30 minus line 40)**	(575,257)	41
42	Income Taxes	0	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	\$ (575,257)	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.

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

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

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Facility Name & ID Number **Glen Bridge Nursing and Rehabilitation Centre**
 XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

0035014

Report Period Beginning: **1/01/2000**

Ending:

12/31/2000

(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	2,368	2,452	\$ 85,707	\$ 34.95	1
2	Assistant Director of Nursing	4,508	4,757	123,973	26.06	2
3	Registered Nurses	52,763	56,294	1,264,039	22.45	3
4	Licensed Practical Nurses	19,916	20,724	393,113	18.97	4
5	Nurse Aides & Orderlies	145,590	153,439	1,550,779	10.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,961	2,103	28,903	13.74	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	16,772	17,566	134,354	7.65	10
11	Social Service Workers	9,637	10,483	119,774	11.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,937	6,428	59,501	9.26	14
15	Cook Helpers/Assistants	35,719	36,618	272,186	7.43	15
16	Dishwashers					16
17	Maintenance Workers	7,762	8,483	94,373	11.12	17
18	Housekeepers	25,860	27,493	205,335	7.47	18
19	Laundry	11,628	12,034	85,792	7.13	19
20	Administrator	2,912	2,961	88,960	30.04	20
21	Assistant Administrator	1,926	2,075	33,758	16.27	21
22	Other Administrative	1,612	1,612	70,810	43.93	22
23	Office Manager					23
24	Clerical	14,289	14,289	460,818	32.25	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	3,158	3,407	45,344	13.31	31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	7,830	8,075	75,674	9.37	33
34	TOTAL (lines 1 - 33)	372,148	391,293	\$ 5,193,193 *	\$ 13.27	34

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

** See instructions.

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	Monthly	\$ 15,803	Ln 1,Col 3	35
36	Medical Director	Monthly	24,600	Ln 9,Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,745	Ln 10,Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	58	2,520	Ln 11,Col 3	44
45	Social Service Consultant	137	5,728	Ln 12,Col 3	45
46	Other(specify)				46
47	Religious Consultant	16	200	Ln 15,Col 3	47
48	Medical Librarian	64	2,640	Ln 10,Col 3	48
49	TOTAL (lines 35 - 48)	275	\$ 53,236		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,425	\$ 89,709	Ln 10,Col 3	50
51	Licensed Practical Nurses	5,417	162,197	Ln 10,Col 3	51
52	Nurse Aides	10,506	134,509	Ln 10,Col 3	52
53	TOTAL (lines 50 - 52)	18,348	\$ 386,415		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

	1	2	3	4	6									7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year															
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005							
1	Painting & Decorating	April 1996	\$ 8,462	3 years	\$ 2,821	\$ 2,821	\$ 1,410	\$	\$	\$	\$	\$	\$							
2	Blower assembly repair	October 1996	3,780	3 years	1,260	1,260	1,155													
3	Asphalt sealing repairs	June 1997	2,510	3 years	418	837	837	418												
4	Painting & Decorating	1997	48,982	3 years	8,164	16,327	16,327	8,164												
5	Painting & Decorating	1998	38,785	3 years		6,464	12,928	12,928	6,465											
6	Repairs & Maintenance	1998	16,205	3 years		2,701	5,402	5,402	2,700											
7	Painting & Decorating	1999	42,539	3 years			7,090	14,180	14,180	7,089										
8	Painting & Decorating	2000	58,096	3 years				9,683	19,365	19,365	9,683									
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 219,359		\$ 12,663	\$ 30,410	\$ 45,149	\$ 50,775	\$ 42,710	\$ 26,454	\$ 9,683	\$	\$							

SEE ACCOUNTANTS' COMPILATION REPORT

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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. Illinois Council on Long Term Care \$12,757
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,812 Line 10
- (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. N/A
- (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 of Public Aid during this cost report period. \$ 165,348
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, 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. \$ 26,935 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? Yes
 - d. Have vehicle usage logs been maintained? Yes
 - 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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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 \$2500, 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.

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