

		FOR OHF USE				

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

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>0043935</u></p> <p>Facility Name: <u>WOOD GLEN NURSING & REHAB CTR</u></p> <p>Address: <u>30 WEST 300 NORTH AVE</u> <u>WEST CHICAGO</u> <u>60185</u> Number City Zip Code</p> <p>County: <u>DUPAGE</u></p> <p>Telephone Number: <u>(630) 876-8100</u> Fax # <u>(630) 876-8108</u></p> <p>IDPA ID Number: <u>364223866001</u></p> <p>Date of Initial License for Current Owners: <u>2/15/95</u></p> <p>Type of Ownership:</p> <table border="0"> <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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" 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>DARRYL BUEKER</u> Telephone Number: <u>(417) 865-8701</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 type="checkbox"/> "Sub-S" Corp.			<input checked="" 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>1/1/03</u> to <u>12/31/03</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 722">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 722 1281 828"></td> <td data-bbox="1281 722 1921 766">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1144 766 1281 828"></td> <td data-bbox="1281 766 1921 810">(Title) _____</td> </tr> <tr> <td data-bbox="1144 828 1281 1042">Paid Preparer</td> <td data-bbox="1281 828 1921 888">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 888 1281 1042"></td> <td data-bbox="1281 888 1921 932">(Print Name and Title) <u>DARRYL BUEKER, CPA</u></td> </tr> <tr> <td data-bbox="1144 932 1281 1042"></td> <td data-bbox="1281 932 1921 1011">(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u></td> </tr> <tr> <td data-bbox="1144 1011 1281 1042"></td> <td data-bbox="1281 1011 1921 1042">(Telephone) <u>(417) 865-8701</u> Fax # <u>417 865-0682</u></td> </tr> </table> <p>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) _____ (Date) _____		(Print Name and Title) <u>DARRYL BUEKER, CPA</u>		(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u>		(Telephone) <u>(417) 865-8701</u> Fax # <u>417 865-0682</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935 Report Period Beginning: 1/1/03 Ending: 12/31/03

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	207	Skilled (SNF)	207	75,555	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,555	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	46,210	25	2,185	48,420	8
9	SNF/PED					9
10	ICF		4,992		4,992	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,210	5,017	2,185	53,412	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.69%

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)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 2/21/95

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1994 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 157 and days of care provided 2,185

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/03 Fiscal Year: 12/31/03

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/03 Ending: 12/31/03**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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
	A. General Services										
1	Dietary	225,541	17,634	7,801	250,976		250,976		250,976		1
2	Food Purchase		233,776		233,776		233,776	(109)	233,667		2
3	Housekeeping	222,409	17,732		240,141		240,141	363	240,504		3
4	Laundry		11,678		11,678		11,678		11,678		4
5	Heat and Other Utilities			307,477	307,477		307,477	605	308,082		5
6	Maintenance	126,222		103,610	229,832		229,832	529	230,361		6
7	Other (specify):*										7
8	TOTAL General Services	574,172	280,820	418,888	1,273,880		1,273,880	1,388	1,275,268		8
	B. Health Care and Programs										
9	Medical Director			26,800	26,800		26,800		26,800		9
10	Nursing and Medical Records	1,639,499	56,317	27,378	1,723,194		1,723,194	(7,200)	1,715,994		10
10a	Therapy			204,899	204,899		204,899		204,899		10a
11	Activities	97,390	15,961	13,675	127,026		127,026		127,026		11
12	Social Services	152,289		1,610	153,899		153,899		153,899		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,889,178	72,278	274,362	2,235,818		2,235,818	(7,200)	2,228,618		16
	C. General Administration										
17	Administrative	86,292		252,500	338,792		338,792	(55,392)	283,400		17
18	Directors Fees										18
19	Professional Services			71,001	71,001		71,001	15,216	86,217		19
20	Dues, Fees, Subscriptions & Promotions			28,619	28,619		28,619	(13,312)	15,307		20
21	Clerical & General Office Expenses	181,776	25,371	93,798	300,945		300,945	8,884	309,829		21
22	Employee Benefits & Payroll Taxes			379,591	379,591		379,591		379,591		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,330	1,330		1,330	213	1,543		24
25	Other Admin. Staff Transportation			18,373	18,373		18,373	1,247	19,620		25
26	Insurance-Prop.Liab.Malpractice			67,450	67,450		67,450	1,746	69,196		26
27	Other (specify):*							9,302	9,302		27
28	TOTAL General Administration	268,068	25,371	912,662	1,206,101		1,206,101	(32,096)	1,174,005		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,731,418	378,469	1,605,912	4,715,799		4,715,799	(37,908)	4,677,891		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR** #0043935 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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	
	D. Ownership											
30	Depreciation			18,481	18,481		18,481	111,838	130,319			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,770	44,770		44,770	214,846	259,616			32
33	Real Estate Taxes			133,551	133,551		133,551	28,323	161,874			33
34	Rent-Facility & Grounds			982,215	982,215		982,215	(974,498)	7,717			34
35	Rent-Equipment & Vehicles			32,164	32,164		32,164		32,164			35
36	Other (specify):*											36
37	TOTAL Ownership			1,211,181	1,211,181		1,211,181	(619,491)	591,690			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			75,637	75,637		75,637		75,637			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,334	113,334		113,334		113,334			42
43	Other (specify):*	82,610		11,481	94,091		94,091	(94,091)				43
44	TOTAL Special Cost Centers	82,610		200,452	283,062		283,062	(94,091)	188,971			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,814,028	378,469	3,017,545	6,210,042		6,210,042	(751,490)	5,458,552			45

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

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR**

0043935

Report Period Beginning: **1/1/03**

Ending: **12/31/03**

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	16,045	30		9
10	Interest and Other Investment Income	(34)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(109)	02		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	(35,031)	21		18
19	Entertainment				19
20	Contributions	(3,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,663)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(136,002)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (170,294)		\$	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)	(581,196)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (581,196)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (751,490)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

WOOD GLEN NURSING & REHAB CTR

ID# 0043935

Report Period Beginning: 1/1/03

Ending: 12/31/03

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	BANK FEES	\$ (12,993)	21	1
2	TAXES-GENERAL	(6,912)	21	2
3	DAMAGE/THEFT/LOSS	(1,664)	21	3
4	IL COUNCIL LTC -COPE	(2,829)	20	4
5	MARKETING SALARIES	(82,610)	43	5
6	MARKETING EMPLOYEE BENEFITS	(11,481)	43	6
7	BLDG-BANK CHARGES	(23)	21	7
8	BLDG-OTHER INTEREST	(4,000)	32	8
9	BLDG-ACCOUNTING	(2,743)	19	9
10	BLDG-OFFICE EXPENSES	(115)	21	10
11	BLDG-REPLACEMENT/FRANCHISE TAX	(7,439)	21	11
12	REAL ESTATE ACCRUAL ADJUSTMENT	7,086	33	12
13	MISCELLANEOUS INCOME	(7,200)	10	13
14	MISCELLANEOUS INCOME	(3,079)	21	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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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	(136,002)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935 Report Period Beginning:

1/1/03

Ending:

12/31/03

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(109)	0	0	0	0	0	0	0	0	0	0	(109)	2
3	Housekeeping	0	0	0	363	0	0	0	0	0	0	0	363	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	605	0	0	0	0	0	0	0	605	5
6	Maintenance	0	0	0	529	0	0	0	0	0	0	0	529	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(109)	0	0	1,497	0	1,388	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	(7,200)	0	0	0	0	0	0	0	0	0	0	(7,200)	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	(7,200)	0	0	0	0	0	0	0	0	0	0	(7,200)	16
	C. General Administration													
17	Administrative	0	0	0	(55,392)	0	0	0	0	0	0	0	(55,392)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,743)	0	2,743	15,216	0	0	0	0	0	0	0	15,216	19
20	Fees, Subscriptions & Promotions	(14,492)	0	0	1,180	0	0	0	0	0	0	0	(13,312)	20
21	Clerical & General Office Expenses	(70,756)	23	7,554	72,063	0	0	0	0	0	0	0	8,884	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	213	0	0	0	0	0	0	0	213	24
25	Other Admin. Staff Transportation	0	0	0	1,247	0	0	0	0	0	0	0	1,247	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,746	0	0	0	0	0	0	0	1,746	26
27	Other (specify):*	0	0	0	9,302	0	0	0	0	0	0	0	9,302	27
28	TOTAL General Administration	(87,991)	23	10,297	45,575	0	(32,096)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(95,300)	23	10,297	47,072	0	(37,908)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR** # **0043935** Report Period Beginning: **1/1/03** Ending: **12/31/03**

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

	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	16,045	0	91,102	4,691	0	0	0	0	0	0	0	111,838 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(4,034)	0	218,880	0	0	0	0	0	0	0	0	214,846 32
33	Real Estate Taxes	7,086	0	21,237	0	0	0	0	0	0	0	0	28,323 33
34	Rent-Facility & Grounds	0	(151,110)	(831,105)	7,717	0	0	0	0	0	0	0	(974,498) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	19,097	(151,110)	(499,886)	12,408	0	(619,491) 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):*	(94,091)	0	0	0	0	0	0	0	0	0	0	(94,091) 43
44	TOTAL Special Cost Centers	(94,091)	0	0	0	0	0	0	0	0	0	0	(94,091) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(170,294)	(151,087)	(489,589)	59,480	0	(751,490) 45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

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	34 Rental Income	\$ 982,215	Wood Glen Pavillion Realty, LLC		\$	(982,215)
2	V	34 Rent Expense		Wood Glen Pavillion Realty, LLC		831,105	831,105
3	V	21 Bank Charges		Wood Glen Pavillion Realty, LLC		23	23
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 982,215			\$ 831,128	\$ * (151,087)

* 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	34 Rental Income	\$ 831,105	Wood Glen Associates, LLC		\$	\$ (831,105)
16	V	32 Mortgage Interest		Wood Glen Associates, LLC		214,880	214,880
17	V	32 Other Interest		Wood Glen Associates, LLC		4,000	4,000
18	V	19 Accounting		Wood Glen Associates, LLC		2,743	2,743
19	V	21 Office Expenses		Wood Glen Associates, LLC		115	115
20	V	21 Replacement/Franchise Tax		Wood Glen Associates, LLC		7,439	7,439
21	V	33 Real Estate Taxes		Wood Glen Associates, LLC		21,237	21,237
22	V	30 Depreciation		Wood Glen Associates, LLC		91,102	91,102
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 831,105			\$ 341,516	\$ * (489,589)

* 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	17 Home Office	\$ 67,500	Platinum Healthcare Consultants, LLC	100.00%	\$	\$ (67,500)
16	V	3 Housekeeping		Platinum Healthcare Consultants, LLC	100.00%	363	363
17	V	5 Utilities		Platinum Healthcare Consultants, LLC	100.00%	605	605
18	V	6 Repairs & Maintenance		Platinum Healthcare Consultants, LLC	100.00%	529	529
19	V	17 Administrative Salary		Platinum Healthcare Consultants, LLC	100.00%	12,108	12,108
20	V	19 Professional Fees		Platinum Healthcare Consultants, LLC	100.00%	15,216	15,216
21	V	20 Fees, Subscriptions		Platinum Healthcare Consultants, LLC	100.00%	1,180	1,180
22	V	21 Office Expenses		Platinum Healthcare Consultants, LLC	100.00%	17,782	17,782
23	V	21 Clerical Salaries		Platinum Healthcare Consultants, LLC	100.00%	54,281	54,281
24	V	24 Education & Seminars		Platinum Healthcare Consultants, LLC	100.00%	213	213
25	V	25 Travel		Platinum Healthcare Consultants, LLC	100.00%	1,247	1,247
26	V	27 Employee Benefits		Platinum Healthcare Consultants, LLC	100.00%	9,302	9,302
27	V	26 Insurance		Platinum Healthcare Consultants, LLC	100.00%	1,746	1,746
28	V	30 Depreciation		Platinum Healthcare Consultants, LLC	100.00%	4,691	4,691
29	V	34 Office Rent		Platinum Healthcare Consultants, LLC	100.00%	7,717	7,717
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 67,500			\$ 126,980	\$ * 59,480

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/03 Ending: 12/31/03

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	Ben Klein	Owner	Administrative	70.10%	See Attached	6	12.50%	Mgmt Fees	\$ 185,000	17-03	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13	TOTAL								\$ 185,000		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 WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/03 Ending: 12/31/03

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 Platinum Healthcare Consultants, LLC
 Street Address 640 E Pearson
 City / State / Zip Code Des Plaines, IL 60016
 Phone Number (847) 699-7500
 Fax Number (847) 699-8148

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)	
1	3	Housekeeping	Patient Days	449,397	13	\$ 3,053	\$ 53,412	\$ 363	1
2	5	Utilities	Patient Days	449,397	13	5,094	53,412	605	2
3	6	Repairs & Maintenance	Patient Days	449,397	13	4,450	53,412	529	3
4	17	Administrative Salary	Patient Days	449,397	13	101,878	101,878	12,108	4
5	19	Professional Fees	Patient Days	449,397	13	128,024	53,412	15,216	5
6	20	Fees, Subscriptions	Patient Days	449,397	13	9,928	53,412	1,180	6
7	21	Office Expenses	Patient Days	449,397	13	149,610	53,412	17,782	7
8	21	Clerical Salaries	Patient Days	449,397	13	456,710	456,710	54,281	8
9	24	Education & Seminars	Patient Days	449,397	13	1,795	53,412	213	9
10	25	Travel	Patient Days	449,397	13	10,496	53,412	1,247	10
11	25	Travel	Direct Cost		1	5,331			11
12	27	Employee Benefits	Patient Days	449,397	13	78,263	53,412	9,302	12
13	26	Insurance	Patient Days	449,397	13	14,694	53,412	1,746	13
14	30	Depreciation	Patient Days	449,397	13	6,154	53,412	731	14
15	34	Office Rent	Patient Days	449,397	13	64,933	53,412	7,717	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,040,413	\$ 558,588	\$ 123,020	25

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/03 Ending: 12/31/03

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	Name of Lender	2		3	4	5	6		7	8	9	10						
			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		Manifest Group		X	Equipment			\$	\$ 8,676			\$	3,250	1					
2		Wood Glen Associates	X		Mortgage								214,880	2					
3														3					
4														4					
5														5					
		Working Capital																	
6		Bank One		X	Line of Credit								18,840	6					
7		Bank Financial		X	Line of Credit				584,141				22,680	7					
8														8					
9		TOTAL Facility Related					\$	\$ 592,817				\$	259,650	9					
		B. Non-Facility Related*																	
10		Interest Income		X									(34)	10					
11														11					
12														12					
13														13					
14		TOTAL Non-Facility Related					\$	\$				\$	(34)	14					
15		TOTALS (line 9+line14)					\$	\$ 592,817				\$	259,616	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

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

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

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR**# **0043935** Report Period Beginning: **1/1/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2002 report.		\$	150,000	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.)		\$	161,874	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	11,874	3
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	150,000	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.)		\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	161,874	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1998	140,459	8	
		1999	135,204	9	
		2000	137,845	10	
		2001	164,639	11	
		2002	161,874	12	
FOR OHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2002	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOOD GLEN NURSING & REHAB CTR COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0043935

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>01-28-401-007</u>	<u>Long Term Care</u>	\$ <u>161,873.94</u>	\$ <u>161,873.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>161,873.94</u>	\$ <u>161,873.94</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 & 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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

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	Facility		1994	\$ 465,000	1
2					2
3	TOTALS			\$ 465,000	3

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR# 0043935

Report Period Beginning:

1/1/03

Ending:

12/31/03**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				1995	\$ 3,067,125	\$ 78,644	35	\$ 87,632	\$ 8,988	\$ 699,859	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		FENCE		1998	5,042	314	15	336	22	2,235	9
10		FIRE ALARM		2002	44,058	12,144	20	2,203	(9,941)	21,589	10
11											11
12											12
13		Various		1995	25,326		20	1,266	1,266	10,874	13
14		Various		1996	16,672		20	834	834	6,045	14
15		Various		1997	20,310		20	1,016	1,016	6,640	15
16		Various		1998	22,766		20	1,138	1,138	8,358	16
17											17
18		LOBBY IMPROVEMENTS		1999	3,750		20	188	188	780	18
19		WATER HEATER		1999	4,100		20	205	205	851	19
20		CONTRACTOR		1999	919		20	46	46	207	20
21		PUMP		1999	1,887		20	94	94	382	21
22		MATV SYSTEM		1999	752		20	38	38	152	22
23		PRESSURE SWITCH		1999	1,341		20	67	67	268	23
24		BOILER		1999	1,964		20	98	98	392	24
25		AIR CONDITIONER		1999	612		20	31	31	124	25
26		SMOKE DETECTOR		1999	3,118		20	156	156	624	26
27		FIRE ALARM SYSTEM		1999	693		20	35	35	239	27
28		2 WATER HEATERS		2000	8,400		20	420	420	1,610	28
29		FLOORING		2000	1,284		20	64	64	213	29
30		CARPET		2000	1,284		20	64	64	208	30
31		FLOORING		2000	3,740		20	187	187	608	31
32		CARPET		2000	5,225		20	261	261	805	32
33		FIXTURES		2000	31,000		20	1,550	1,550	5,038	33
34		FLUID PUMP		2000	2,429		20	121	121	444	34
35		FLUID PUMP		2000	905		20	45	45	165	35
36											36

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

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

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning:

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Ending:

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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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	FLUID PUMP SVC	2000	\$ 2,412	\$	20	\$ 121	\$ 121	\$ 423	37	
38	WATER LINES & DRAIN	2001	3,870		39	99	99	293	38	
39	BURNER PILOT & PARTS	2001	1,593		39	41	41	121	39	
40	4 DUPLEX OUTLETS	2001	2,275		39	58	58	172	40	
41	WATER HEATER PIPING	2001	8,997		39	231	231	645	41	
42	FLUES - WATER BOILER	2001	3,580		39	92	92	219	42	
43	BRICK WALL	2001	4,515		39	116	116	256	43	
44	EXPANSION MODULE	2001	947		20	47	47	121	44	
45	CABLES	2001	1,031		20	52	52	108	45	
46	CABLE WORK	2001	767		20	38	38	79	46	
47	PHONES/CABLES	2001	544		20	27	27	81	47	
48	LIGHTING	2001	1,022		20	51	51	106	48	
49	LAMPS	2001	742		20	37	37	86	49	
50	FIRE PUMP WORK	2001	750		20	38	38	79	50	
51	HEATING/COOLING WORK	2001	649		20	32	32	67	51	
52	LIGHTING	2001	903		20	45	45	101	52	
53	MOTOR	2001	547		20	27	27	77	53	
54	LIGHTING ENHANCEMENT	2001	903		20	45	45	116	54	
55	REFRIGERATOR WORK	2001	1,044		20	52	52	117	55	
56	PIPE WORK	2001	500		20	25	25	56	56	
57	CONCRETE ANCHOR	2001	5,332		20	267	267	690	57	
58	REFRIGERATOR WORK	2001	532		20	27	27	68	58	
59	REFRIGERATOR WORK	2001	585		20	29	29	68	59	
60	LIGHTING	2001	903		20	45	45	135	60	
61	LIGHTING	2001	903		20	45	45	131	61	
62	LIGHTING	2001	903		20	45	45	128	62	
63	LIGHTING	2001	903		20	45	45	124	63	
64	LIGHTING	2001	903		20	45	45	120	64	
65	PUMP	2001	571		20	29	29	60	65	
66	HEAT PUMP MOTOR	2001	1,409		20	70	70	152	66	
67	PLUMBING	2001	1,038		20	52	52	156	67	
68	PATIO	2002	2,250		10	225	225	356	68	
69	A/C REPAIR	2002	3,529		10	353	353	559	69	
70	TOTAL (lines 4 thru 69)		\$ 3,332,054	\$ 91,102		\$ 100,646	\$ 9,544	\$ 774,780	70	

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

STATE OF ILLINOIS

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning:

1/1/03

Ending:

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12/31/03

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 3,332,054	\$ 91,102		\$ 100,646	\$ 9,544	\$ 774,780		1
2	A/C REPAIR	2002 1,305		10	131	131	196		2
3	A/C REPAIR	2002 1,240		10	124	124	176		3
4	A/C REPAIR	2002 888		10	89	89	104		4
5	A/C REPAIR	2002 846		10	85	85	92		5
6	A/C REPAIR	2002 664		10	66	66	99		6
7	WATER HEATERS	2002 1,700		10	170	170	269		7
8	WATER HEATERS	2002 2,460		10	246	246	390		8
9	FREEZER REPAIR	2002 587		20	29	29	58		9
10	FIRE PUMP WORK	2002 750		20	38	38	76		10
11	SERVICE PUMP	2002 540		20	27	27	54		11
12	ELECTRICAL SYSTEM	2002 528		20	26	26	52		12
13	PIPE WORK	2002 1,213		20	61	61	122		13
14	LIGHTING ENHANCEMENT	2002 12,442		20	622	622	1,244		14
15	MAIN ENTRANCE CAMERA	2003 13,445		5	2,465	2,465	2,465		15
16	PROXIMITY READERS	2003 2,074		5	380	380	380		16
17	PROXIMITY READERS/SMART	2003 3,805		5	698	698	698		17
18	WALL DECORATION	2003 1,063		5	159	159	159		18
19	KITCHEN WORK	2003 1,454		10	121	121	121		19
20	CI RANG STEAM	2003 869		10	22	22	22		20
21	CI RANG STEAM	2003 2,289		10	57	57	57		21
22	DRAPES	2003 2,525		5	505	505	505		22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	BOOK DEPRECIATION		5,425			(5,425)			33
34	TOTAL (lines 1 thru 33)	\$ 3,384,741	\$ 96,527		\$ 106,767	\$ 10,240	\$ 782,119		34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 243,612	\$ 8,924	\$ 20,779	\$ 11,855	10	\$ 157,139	71
72	Current Year Purchases	7,242	4,132	353	(3,779)	Various	353	72
73	Fully Depreciated Assets	1,037,039				10		73
74	Allocation from Platinum	7,315	4,691	731	(3,960)		839	74
75	TOTALS	\$ 1,295,208	\$ 17,747	\$ 21,863	\$ 4,116		\$ 158,331	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		FRANKS CHEVROLET	1996	\$ 6,461	\$	\$	\$	5	\$ 6,461	76
77		BUS	2002	8,447		1,689	1,689	5	2,534	77
78										78
79										79
80	TOTALS			\$ 14,908	\$	\$ 1,689	\$ 1,689		\$ 8,995	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,159,857	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 114,274	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 130,319	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,045	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 949,445	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: _____
 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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5			Allocation from Platinum Healthcare		7,717			5
6								6
7	TOTAL				\$ 7,717			7

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.	/2004	\$ _____
13.	/2005	\$ _____
14.	/2006	\$ _____

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: \$ 14,739 Description: See attached schedule

(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	2001 Jeep	\$ 540.00	\$ 6,480	17
18	Facility	2000 Nissan	650.00	3,250	18
19	Facility	2002 Mercury	633.29	7,694	19
20					20
21	TOTAL		\$ 1,823.29	\$ 17,424	21

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

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

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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)

		Facility			
		1	2	3	4
		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	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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Units	Cost						
					Units	Cost								
1	Licensed Occupational Therapist	10a-03	hrs	\$				\$ 96,812	\$		\$	96,812	1	
2	Licensed Speech and Language Development Therapist	10a-03	hrs					8,114					8,114	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a-03	hrs					99,972					99,972	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39-02	# of prescripts							67,039			67,039	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify): Lab/X-ray									8,598			8,598	13
14	TOTAL			\$				\$ 204,898	\$	75,637	\$		\$ 280,535	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning: 1/1/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(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	\$ 4,614	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 232,429)	1,290,269		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	40,978		6
7 Other Prepaid Expenses	2,521		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,338,382	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cost	128,824		15
16 Equipment, at Historical Cost	154,947		16
17 Accumulated Depreciation (book methods)	(145,051)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):	838,344		23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 977,064	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,315,446	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 413,518	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	592,817		29
30 Accrued Salaries Payable	61,454		30
31 Accrued Taxes Payable (excluding real estate taxes)	26,448		31
32 Accrued Real Estate Taxes(Sch.IX-B)	150,000		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 Accrued Expenses	52,725		36
37 Due Others, Advance Billing	298,285		37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,595,247	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,595,247	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 720,195	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,315,442	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 453,538	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 453,538	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	266,657	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 266,657	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)	\$ 720,195	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning: 1/1/03

Ending:

12/31/03

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	\$ 6,873,753	1
2	Discounts and Allowances for all Levels	(1,105,500)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,768,253	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	632,284	6
7	Oxygen	7,789	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 640,073	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	50,010	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,010	19
20	Radiology and X-Ray	1,128	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 57,148	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	34	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income (offset pg 5 except \$912 state tax refund)	11,191	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,191	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,476,699	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,273,880	31
32	Health Care	2,235,818	32
33	General Administration	1,206,101	33
B. Capital Expense			
34	Ownership	1,211,181	34
C. Ancillary Expense			
35	Special Cost Centers	169,728	35
36	Provider Participation Fee	113,334	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,210,042	40
41	Income before Income Taxes (line 30 minus line 40)**	266,657	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 266,657	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

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

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning: 1/1/03

Ending:

12/31/03

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	2,016	2,080	\$ 86,203	\$ 41.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,170	31,066	902,534	29.05	3
4	Licensed Practical Nurses	1,096	1,100	24,401	22.18	4
5	Nurse Aides & Orderlies	48,212	49,326	626,361	12.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,989	2,093	37,102	17.73	9
10	Activity Assistants	7,485	7,631	60,288	7.90	10
11	Social Service Workers	10,674	10,821	152,289	14.07	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,164	44,148	20.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,459	24,128	181,392	7.52	15
16	Dishwashers					16
17	Maintenance Workers	7,839	8,184	126,222	15.42	17
18	Housekeepers	30,454	31,507	222,409	7.06	18
19	Laundry					19
20	Administrator	1,976	2,120	86,292	40.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,553	9,826	181,777	18.50	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					31
32	Other Health Care(specify)					32
33	Other(specify)	2,760	2,832	82,610	29.17	33
34	TOTAL (lines 1 - 33)	179,715	184,878	\$ 2,814,028 *	\$ 15.22	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	178	\$ 7,801	01-03	35
36	Medical Director	Monthly	26,800	09-03	36
37	Medical Records Consultant	Monthly	3,464	10-03	37
38	Nurse Consultant	Monthly	16,874	10-03	38
39	Pharmacist Consultant	Monthly	7,040	10-03	39
40	Physical Therapy Consultant	30	1,276	10a-03	40
41	Occupational Therapy Consultant	23	961	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	74	10a-03	43
44	Activity Consultant	42	2,262	11-03	44
45	Social Service Consultant	29	1,610	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	304	\$ 68,162		49

C. CONTRACT NURSES

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

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR**# **0043935**

Report Period Beginning:

1/1/03

Ending:

12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. IL COUNCIL LTC \$10,619
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,437 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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
WOOD GLEN NURSING & REHAB CENTER - DDPH #40568-6.1.98
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 113,334
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 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. \$ 0 Has any meal income been offset against related costs? N/A 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. \$
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? NA
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.
- (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.