

		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043935

Facility Name: WOOD GLEN NURSING & REHAB CTR

Address: 30 WEST 300 NORTH AVENUE WEST CHICAGO 60185
 Number City Zip Code

County: DUPAGE

Telephone Number: (630) 876-8100 **Fax #** (630) 876-8108

HFS ID Number: 364223866001

Date of Initial License for Current Owners: 2/15/95

Type of Ownership:

<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 _____	

In the event there are further questions about this report, please contact:
Name: DARRYL BUEKER **Telephone Number:** (417) 865-8701

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(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) 865-701</u> Fax # <u>417 865-0682</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR# 0043935 Report Period Beginning: 1/1/05 Ending: 12/31/05

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	<u>207</u>	Skilled (SNF)	<u>207</u>	<u>75,555</u>	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	<u>207</u>	TOTALS	<u>207</u>	<u>75,555</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>63,977</u>		<u>2,756</u>	<u>66,733</u>	8
9	SNF/PED					9
10	ICF		<u>3,004</u>		<u>3,004</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>63,977</u>	<u>3,004</u>	<u>2,756</u>	<u>69,737</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.30%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/AF. 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 2,756Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR** # **0043935** Report Period Beginning: **1/1/05** Ending: **12/31/05**

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	238,879	29,240	7,385	275,504		275,504		275,504		1
2	Food Purchase		297,239		297,239		297,239	(8,293)	288,946		2
3	Housekeeping	262,845	38,283		301,128		301,128		301,128		3
4	Laundry		26,475		26,475		26,475		26,475		4
5	Heat and Other Utilities			325,245	325,245		325,245	6,380	331,625		5
6	Maintenance	132,739	110,557		243,296		243,296	6,436	249,732		6
7	Other (specify):*										7
8	TOTAL General Services	634,463	501,794	332,630	1,468,887		1,468,887	4,523	1,473,410		8
	B. Health Care and Programs										
9	Medical Director			48,845	48,845		48,845		48,845		9
10	Nursing and Medical Records	1,882,376	78,263	7,632	1,968,271		1,968,271		1,968,271		10
10a	Therapy			284,137	284,137		284,137		284,137		10a
11	Activities	102,202	10,090	342	112,634		112,634		112,634		11
12	Social Services	298,149		684	298,833		298,833		298,833		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,282,727	88,353	341,640	2,712,720		2,712,720		2,712,720		16
	C. General Administration										
17	Administrative	222,360		456,800	679,160		679,160	(38,591)	640,569		17
18	Directors Fees										18
19	Professional Services			235,688	235,688		235,688	5,041	240,729		19
20	Dues, Fees, Subscriptions & Promotions			35,942	35,942		35,942	(14,200)	21,742		20
21	Clerical & General Office Expenses	244,383	32,097	134,256	410,736		410,736	(8,508)	402,228		21
22	Employee Benefits & Payroll Taxes			563,919	563,919		563,919		563,919		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,498	3,498		3,498	389	3,887		24
25	Other Admin. Staff Transportation			7,251	7,251		7,251	3,095	10,346		25
26	Insurance-Prop.Liab.Malpractice			116,732	116,732		116,732	1,120	117,852		26
27	Other (specify):*							27,326	27,326		27
28	TOTAL General Administration	466,743	32,097	1,554,086	2,052,926		2,052,926	(24,328)	2,028,598		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,383,933	622,244	2,228,356	6,234,533		6,234,533	(19,805)	6,214,728		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: 1/1/05 Ending: 12/31/05

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			38,444	38,444	38,444	145,253	183,697				30
31	Amortization of Pre-Op. & Org.						769	769				31
32	Interest			37,170	37,170	37,170	595,816	632,986				32
33	Real Estate Taxes			188,300	188,300	188,300		188,300				33
34	Rent-Facility & Grounds			1,168,712	1,168,712	1,168,712	(1,168,712)					34
35	Rent-Equipment & Vehicles			37,346	37,346	37,346		37,346				35
36	Other (specify):*											36
37	TOTAL Ownership			1,469,972	1,469,972	1,469,972	(426,874)	1,043,098				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,443		69,443	69,443		69,443				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,333	113,333	113,333		113,333				42
43	Other (specify):*						(106,189)	(106,189)				43
44	TOTAL Special Cost Centers		69,443	113,333	182,776	182,776	(106,189)	76,587				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,383,933	691,687	3,811,661	7,887,281	7,887,281	(552,868)	7,334,413				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: 1/1/05

Ending: 12/31/05

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	(268,244)	30		9
10	Interest and Other Investment Income	(79)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	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				18
19	Entertainment				19
20	Contributions	(87,725)	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	(13,244)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,689)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(138,561)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (512,605)		\$	30

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)	(40,263)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (40,263)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (552,868)		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

OHF USE ONLY					
48		49		50	51
					52

WOOD GLEN NURSING & REHAB CTR

ID# 0043935

Report Period Beginning: 1/1/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	BANK FEES	\$ (8,792)	21	1
2	TAXES - GENERAL	(694)	21	2
3	DAMAGE/THEFT/LOSS	(3,343)	21	3
4	IL COUNCIL LTC-COPE	(2,514)	20	4
5	MARKETING SALARIES	(91,021)	43	5
6	MARKETING EMPLOYEE BENEFITS	(15,168)	43	6
7	MISCELLANEOUS INCOME	(8,230)	2	7
8	BLDG-BANK CHARGES	(243)	21	8
9	REAL ESTATE TAXES	(8,556)	33	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(138,561)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/05

Ending:

12/31/05

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	(8,293)	0	0	0	0	0	0	0	0	0	0	(8,293)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	6,380	0	0	0	0	0	0	0	6,380	5
6	Maintenance	0	0	0	6,436	0	0	0	0	0	0	0	6,436	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,293)	0	0	12,816	0	4,523	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(38,591)	0	0	0	0	0	0	0	(38,591)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	5,041	0	0	0	0	0	0	0	5,041	19
20	Fees, Subscriptions & Promotions	(15,758)	0	0	1,558	0	0	0	0	0	0	0	(14,200)	20
21	Clerical & General Office Expenses	(105,486)	243	0	96,735	0	0	0	0	0	0	0	(8,508)	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	389	0	0	0	0	0	0	0	389	24
25	Other Admin. Staff Transportation	0	0	0	3,095	0	0	0	0	0	0	0	3,095	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,120	0	0	0	0	0	0	0	1,120	26
27	Other (specify):*	0	0	0	27,326	0	0	0	0	0	0	0	27,326	27
28	TOTAL General Administration	(121,244)	243	0	96,673	0	(24,328)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(129,537)	243	0	109,489	0	(19,805)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/05 Ending: 12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(268,244)	354,016	47,247	12,234	0	0	0	0	0	0	0	145,253	30
31	Amortization of Pre-Op. & Org.	0	0	0	769	0	0	0	0	0	0	0	769	31
32	Interest	(79)	457,133	118,449	20,313	0	0	0	0	0	0	0	595,816	32
33	Real Estate Taxes	(8,556)	0	0	8,556	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(564,476)	(604,236)	0	0	0	0	0	0	0	0	(1,168,712)	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	(276,879)	246,673	(438,540)	41,872	0	(426,874)	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):*	(106,189)	0	0	0	0	0	0	0	0	0	0	(106,189)	43
44	TOTAL Special Cost Centers	(106,189)	0	0	0	0	0	0	0	0	0	0	(106,189)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(512,605)	246,916	(438,540)	151,361	0	(552,868)	45						

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning:

1/1/05

Ending:

12/31/05

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 1,168,712	WOOD GLEN PAVILION REALTY, LLC		\$	\$ (1,168,712)	1
2	V	34 Rent Expense		WOOD GLEN PAVILION REALTY, LLC		604,236	604,236	2
3	V	21 Bank Charges		WOOD GLEN PAVILION REALTY, LLC		243	243	3
4	V	30 Depreciation		WOOD GLEN PAVILION REALTY, LLC		354,016	354,016	4
5	V	32 Interest		WOOD GLEN PAVILION REALTY, LLC		457,133	457,133	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,168,712			\$ 1,415,628	\$ * 246,916	14

* 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: 1/1/05 Ending: 12/31/05

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	\$ 604,236	Wood Glen Associates, LLC		\$	(604,236)	15
16	V	32 Mortgage Interest		Wood Glen Associates, LLC		118,449	118,449	16
17	V	30 Depreciation		Wood Glen Associates, LLC		47,247	47,247	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		\$ 604,236			\$ 165,696	\$ * (438,540)	39

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR# 0043935Report Period Beginning: 1/1/05Ending: 12/31/05

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	\$ 96,800	Platinum Healthcare Consultants, LLC	100.00%	\$	\$ (96,800)	15
16	V	5 Utilities		Platinum Healthcare Consultants, LLC	100.00%	6,380	6,380	16
17	V	6 Repairs & Maintenance		Platinum Healthcare Consultants, LLC	100.00%	6,436	6,436	17
18	V	17 Administrative Salary		Platinum Healthcare Consultants, LLC	100.00%	58,209	58,209	18
19	V	19 Professional Fees		Platinum Healthcare Consultants, LLC	100.00%	5,041	5,041	19
20	V	20 Fees, Subscriptions		Platinum Healthcare Consultants, LLC	100.00%	1,558	1,558	20
21	V	21 Office Expenses		Platinum Healthcare Consultants, LLC	100.00%	24,525	24,525	21
22	V	21 Clerical Salaries		Platinum Healthcare Consultants, LLC	100.00%	72,162	72,162	22
23	V	24 Education & Seminars		Platinum Healthcare Consultants, LLC	100.00%	389	389	23
24	V	25 Travel		Platinum Healthcare Consultants, LLC	100.00%	3,095	3,095	24
25	V	27 Employee Benefits		Platinum Healthcare Consultants, LLC	100.00%	27,326	27,326	25
26	V	26 Insurance		Platinum Healthcare Consultants, LLC	100.00%	1,120	1,120	26
27	V	30 Depreciation		Platinum Healthcare Consultants, LLC	100.00%	1,313	1,313	27
28	V	21 Office Expense		Platinum Healthcare Consultants, LLC	100.00%	48	48	28
29	V	31 Amortization		Platinum Healthcare Consultants, LLC	100.00%	769	769	29
30	V	30 Depreciation		Platinum Healthcare Consultants, LLC	100.00%	10,921	10,921	30
31	V	32 Interest		Platinum Healthcare Consultants, LLC	100.00%	20,313	20,313	31
32	V	33 Real Estate Taxes		Platinum Healthcare Consultants, LLC	100.00%	8,556	8,556	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 96,800			\$ 248,161	\$ * 151,361	39

* 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: 1/1/05 Ending: 12/31/05

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	5	12.50	Mgmt Fees	\$ 360,000	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	\$ 360,000		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: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Platinum Healthcare Consultants
 Street Address 7444 Long Ave.
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 329-4100
 Fax Number (847) 329-7652

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	5	Utilities	Patient Days	415,423	11	\$ 38,007	\$ 69,737	\$ 6,380	1
2	6	Repairs & Maintenance	Patient Days	415,423	11	38,341	69,737	6,436	2
3	17	Administrative Salary	Patient Days	415,423	11	346,750	346,750	58,209	3
4	19	Professional Fees	Patient Days	415,423	11	30,027	69,737	5,041	4
5	20	Fees, Subscriptions	Patient Days	415,423	11	9,282	69,737	1,558	5
6	21	Clerical Salaries	Patient Days	415,423	11	429,868	429,868	72,162	6
7	21	Office Expenses	Patient Days	415,423	11	146,099	69,737	24,526	7
8	24	Education & Seminars	Patient Days	415,423	11	2,319	69,737	389	8
9	25	Travel	Patient Days	415,423	11	18,439	69,737	3,095	9
10	27	Employee Benefits	Patient Days	415,423	11	162,778	69,737	27,326	10
11	26	Insurance	Patient Days	415,423	11	6,673	69,737	1,120	11
12	30	Depreciation	Patient Days	415,423	11	7,823	69,737	1,313	12
13	21	Office Expenses	Patient Days	415,423	11	285	69,737	48	13
14	31	Amortization	Patient Days	415,423	11	4,583	69,737	769	14
15	30	Depreciation	Patient Days	415,423	11	65,061	69,737	10,922	15
16	32	Interest	Patient Days	415,423	11	121,002	69,737	20,313	16
17	33	Real Estate Taxes	Patient Days	415,423	11	50,966	69,737	8,556	17
18	21	rounding						(2)	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,478,303	\$ 776,618	\$ 248,161	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Wood Glen Associates			Mortgage						\$ 118,449	1									
2	Wood Glen Pavillion			Mortgage						\$ 457,133	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Bank Financial		X	Line of Credit				1,200,000			\$ 37,170	6								
7											7									
8											8									
9	TOTAL Facility Related							\$ 1,200,000			\$ 612,752	9								
B. Non-Facility Related*																				
10	Interest Income		X								(79)	10								
11												11								
12	Allocation from Platinum										20,313	12								
13												13								
14	TOTAL Non-Facility Related										\$ 20,234	14								
15	TOTALS (line 9+line14)							\$ 1,200,000			\$ 632,986	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-28-401-085</u>	<u>Long Term Care</u>	\$ <u>172,299.62</u>	\$ <u>172,299.62</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>172,299.62</u>	\$ <u>172,299.62</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 original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935 Report Period Beginning:

1/1/05 Ending:

12/31/05

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, CNA 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	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:

1/1/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1995	\$ 3,067,125	\$ 42,876	35	\$ 87,632	\$ 44,756	\$ 875,123	4
5					2,765,738	97,214			(97,214)		5
6											6
7											7
8											8
	Improvement Type**										
9	FENCE			1998	5,042	162	15	336	174	2,907	9
10	FIRE ALARM			2002	44,058	3,228	20	2,203	(1,025)	25,995	10
11	BLDG IMP-REHAB			2004	55,459	775	20	2,773	1,998	3,004	11
12	FURNITURE-REHAB			2004	84,096		15	5,606	5,606	5,606	12
13	EQUIPMENT-REHAB			2004	44,249	206	15	2,950	2,744	3,196	13
14	EQUIPMENT			2005	704,614	138,884	5		(138,884)		14
15	FURNITURE			2005	411,185	82,237	5		(82,237)		15
16	LAND IMPROVEMENTS			2005	713,609	35,681	15		(35,681)		16
17											17
18											18
19	Various			1995	25,326		20	1,266	1,266	13,406	19
20	Various			1996	16,672		20	834	834	7,713	20
21	Various			1997	20,310		20	1,016	1,016	8,672	21
22	Various			1998	22,766		20	1,138	1,138	10,634	22
23											23
24	LOBBY IMPROVEMENTS			1999	3,750		20	188	188	1,156	24
25	WATER HEATER			1999	4,100		20	205	205	1,261	25
26	CONTRACTOR			1999	919		20	46	46	299	26
27	PUMP			1999	1,887		20	94	94	570	27
28	MATV SYSTEM			1999	752		20	38	38	228	28
29	PRESSURE SWITCH			1999	1,341		20	67	67	402	29
30	BOILER			1999	1,964		20	98	98	588	30
31	AIR CONDITIONER			1999	612		20	31	31	186	31
32	SMOKE DETECTOR			1999	3,118		20	156	156	936	32
33	FIRE ALARM SYSTEM			1999	693		20	35	35	309	33
34	2 WATER HEATERS			2000	8,400		20	420	420	2,450	34
35	FLOORING			2000	1,284		20	64	64	341	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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning:

1/1/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CARPET	2000	\$ 1,284	\$	20	\$ 64	\$ 64	\$ 336	37
38	FLOORING	2000	3,740		20	187	187	982	38
39	CARPET	2000	5,225		20	261	261	1,327	39
40	FIXTURES	2000	31,000		20	1,550	1,550	8,138	40
41	FLUID PUMP	2000	2,429		20	121	121	686	41
42	FLUID PUMP	2000	905		20	45	45	255	42
43	FLUID PUMP SVC	2000	2,412		20	121	121	665	43
44	WATER LINES & DRAIN	2001	3,870		39	99	99	491	44
45	BURNER PILOT & PARTS	2001	1,593		39	41	41	203	45
46	4 DUPLEX OUTLETS	2001	2,275		39	58	58	288	46
47	WATER HEATER PIPING	2001	8,997		39	231	231	1,107	47
48	FLUES - WATER BOILER	2001	3,580		39	92	92	403	48
49	BRICK WALL	2001	4,515		39	116	116	488	49
50	EXPANSION MODULE	2001	947		20	47	47	215	50
51	CABLES	2001	1,031		20	52	52	212	51
52	CABLE WORK	2001	767		20	38	38	155	52
53	PHONES/CABLES	2001	544		20	27	27	135	53
54	LIGHTING	2001	1,022		20	51	51	208	54
55	LAMPS	2001	742		20	37	37	160	55
56	FIRE PUMP WORK	2001	750		20	38	38	155	56
57	HEATING/COOLING WORK	2001	649		20	32	32	131	57
58	LIGHTING	2001	903		20	45	45	191	58
59	MOTOR	2001	547		20	27	27	131	59
60	LIGHTING ENHANCEMENT	2001	903		20	45	45	206	60
61	REFRIGERATOR WORK	2001	1,044		20	52	52	221	61
62	PIPE WORK	2001	500		20	25	25	106	62
63	CONCRETE ANCHOR	2001	5,332		20	267	267	1,224	63
64	REFRIGERATOR WORK	2001	532		20	27	27	122	64
65	REFRIGERATOR WORK	2001	585		20	29	29	126	65
66	LIGHTING	2001	903		20	45	45	225	66
67	LIGHTING	2001	903		20	45	45	221	67
68	LIGHTING	2001	903		20	45	45	218	68
69	LIGHTING	2001	903		20	45	45	214	69
70	TOTAL (lines 4 thru 69)		\$ 8,101,304	\$ 401,263		\$ 111,201	\$ (290,062)	\$ 984,927	70

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning:

1/1/05

Ending:

12/31/05

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		\$ 8,101,304	\$ 401,263		\$ 111,201	\$ (290,062)	\$ 984,927	1
2	LIGHTING	2001	903		20	45	45	210	2
3	PUMP	2001	571		20	29	29	118	3
4	HEAT PUMP MOTOR	2001	1,409		20	70	70	292	4
5	PLUMBING	2001	1,038		20	52	52	260	5
6	PATIO	2002	2,250		10	225	225	806	6
7	A/C REPAIR	2002	3,529		10	353	353	1,265	7
8	A/C REPAIR	2002	1,305		10	131	131	458	8
9	A/C REPAIR	2002	1,240		10	124	124	424	9
10	A/C REPAIR	2002	888		10	89	89	282	10
11	A/C REPAIR	2002	846		10	85	85	262	11
12	A/C REPAIR	2002	664		10	66	66	231	12
13	WATER HEATERS	2002	1,700		10	170	170	609	13
14	WATER HEATERS	2002	2,460		10	246	246	882	14
15	FREEZER REPAIR	2002	587		20	29	29	116	15
16	FIRE PUMP WORK	2002	750		20	38	38	152	16
17	SERVICE PUMP	2002	540		20	27	27	108	17
18	ELECTRICAL SYSTEM	2002	528		20	26	26	104	18
19	PIPE WORK	2002	1,213		20	61	61	244	19
20	LIGHTING ENHANCEMENT	2002	12,442		20	622	622	2,488	20
21	MAIN ENTRANCE CAMERA	2003	13,445		5	2,689	2,689	7,843	21
22	PROXIMITY READERS	2003	2,074		5	415	415	1,210	22
23	PROXIMITY READERS/SMART	2003	3,805		5	761	761	2,220	23
24	WALL DECORATION	2003	1,063		5	213	213	585	24
25	KITCHEN WORK	2003	1,454		10	145	145	411	25
26	CI RANG STEAM	2003	869		10	87	87	196	26
27	CI RANG STEAM	2003	2,289		10	229	229	515	27
28	DRAPES	2003	2,525		5	505	505	1,515	28
29	FROZEN COIL IN AIR HANDLER	2004	3,819		10	382	382	764	29
30	WATER HEATER	2004	8,714		10	871	871	1,597	30
31	INSTALL NEW COIL	2004	3,800		10	380	380	633	31
32	CONDENSING UNIT	2004	4,200		15	280	280	420	32
33	PLUMBING-DIALYSIS ROOM	2004	5,390		20	270	270	405	33
34	TOTAL (lines 1 thru 33)		\$ 8,189,614	\$ 401,263		\$ 120,916	\$ (280,347)	\$ 1,012,552	34

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning:

1/1/05

Ending:

12/31/05

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 12B, Carried Forward		\$ 8,189,614	\$ 401,263		\$ 120,916	\$ (280,347)	\$ 1,012,552	1
2	WATER HEATER	2004	6,748		10	675	675	1,012	2
3	SERVICE PUMP	2004	7,565		20	378	378	536	3
4	BOILER & STORAGE TANKS	2004	6,200		20	310	310	517	4
5	CHASE WALLS	2004	4,570		15	305	305	381	5
6	CARPETING	2004	12,311		5	2,462	2,462	3,078	6
7	HOT WATER TANK	2004	11,242		10	1,124	1,124	1,405	7
8	WATER TANK	2004	34,751		20	1,738	1,738	2,028	8
9	HOT WATER VALVE	2004	3,609		20	180	180	225	9
10	CARPETING	2004	28,726		5	5,745	5,745	7,181	10
11	HOT WATER BOILER	2004	7,344		20	367	367	367	11
12	ALUMINUM STREET SIGN DISP	2005	3,700		10	370	370	370	12
13	FIRE ALARMS/SMOKE DETECTORS	2005	2,134		10	196	196	196	13
14	TURNBURY INSULATED DOME	2005	1,545		10	142	142	142	14
15	STEEL PEDESTRIAN DOORS	2005	4,630		20	212	212	212	15
16	RED OAK UNFINISHED DOO	2005	1,580		15	88	88	88	16
17	FIRE DAMPERS	2005	5,294		10	397	397	397	17
18	SECURITY SYSTEM	2005	16,519		10	1,101	1,101	1,101	18
19	SMOKE DAMPER MOTORS	2005	7,524		10	502	502	502	19
20	ASPHALT REPLACEMENT	2005	10,862		8	792	792	792	20
21	SMOKE DAMPER MOTORS	2005	2,585		10	151	151	151	21
22	BOILER REPLACEMENT	2005	18,998		20	317	317	317	22
23	SECURITY SYSTEM	2005	2,400		10	60	60	60	23
24	FIRE ALARM DEVICES INSTALL	2005	4,687		10	117	117	117	24
25	HOT WATER HEATER EXCHAN	2005	27,374		10	456	456	456	25
26	VINYL FENCE & WALK GATE	2005	3,844		10	64	64	64	26
27	SATELLITE TV & INTERNET	2005	12,699		10	212	212	212	27
28									28
29									29
30	Allocation from Platinum		191,842	4,673		4,673		6,478	30
31									31
32									32
33				19,129			(19,129)		33
34	TOTAL (lines 1 thru 33)		\$ 8,630,897	\$ 425,065		\$ 144,050	\$ (281,015)	\$ 1,040,937	34

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/05 Ending: 12/31/05

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	\$ 278,490	\$ 8,415	\$ 20,613	\$ 12,198	10	\$ 196,310	71
72	Current Year Purchases	19,481	4,023	1,078	(2,945)	Various	1,078	72
73	Fully Depreciated Assets	1,037,039				10		73
74	Allocation from Platinum	75,617	21,566	7,561	(14,005)		16,231	74
75	TOTALS	\$ 1,410,627	\$ 34,004	\$ 29,252	\$ (4,752)		\$ 213,619	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	681	1,690	1,009	5	5,913	77
78		GMC SIERRA	2004	30,357	4,857	7,589	2,732	4	7,589	78
79		WG VAN		26,782	1,339	1,116	(223)	4	1,116	79
80	TOTALS			\$ 72,047	\$ 6,877	\$ 10,395	\$ 3,518		\$ 21,079	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)		\$ 10,578,571	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 465,946	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 183,697	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (282,249)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,275,635	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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 10,454 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			\$ <u>See Attached Schedule</u>	\$ <u>26,892</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>26,892</u>	21

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

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/05 Ending: 12/31/05

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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	10a-03	hrs	\$		\$ 146,025	\$		\$ 146,025	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			3,895			3,895	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			134,217			134,217	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 prescrpts				63,281		63,281	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	39-02					6,162		6,162	13
14	TOTAL			\$		\$ 284,137	\$ 69,443		\$ 353,580	14

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

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 15,446	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>308,251</u>)	1,782,907		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,203		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,867,556	\$	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	404,186		15
16	Equipment, at Historical Cost	259,203		16
17	Accumulated Depreciation (book methods)	(263,093)		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):	930,146		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,330,442	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,197,998	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 572,956	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,200,000		29
30	Accrued Salaries Payable	100,406		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,366		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	141,856		36
37	<u>Due Others, Advance Billing</u>	277,593		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,325,177	\$	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)	\$ 2,325,177	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 872,821	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,197,998	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 882,814	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 882,814	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,090,007	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	(1,100,000)	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)	\$ (9,993)	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)	\$ 872,821	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR**# **0043935**Report Period Beginning: **1/1/05**Ending: **12/31/05****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	\$ 9,393,007	1
2	Discounts and Allowances for all Levels	(1,350,232)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,042,775	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	832,248	6
7	Oxygen	304	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 832,552	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	86,418	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,707	19
20	Radiology and X-Ray	1,527	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 93,652	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	79	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 79	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income (offset pg 5)	8,230	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,230	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,977,288	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,468,887	31
32	Health Care	2,712,720	32
33	General Administration	2,052,926	33
B. Capital Expense			
34	Ownership	1,469,972	34
C. Ancillary Expense			
35	Special Cost Centers	69,443	35
36	Provider Participation Fee	113,333	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,887,281	40
41	Income before Income Taxes (line 30 minus line 40)**	1,090,007	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,090,007	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:

1/1/05

Ending:

12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,789	2,080	\$ 101,834	\$ 48.96	1
2	Assistant Director of Nursing	1,630	1,800	61,484	34.16	2
3	Registered Nurses	23,904	29,398	900,216	30.62	3
4	Licensed Practical Nurses	4,761	5,144	119,920	23.31	4
5	CNAs & Orderlies	49,797	54,769	698,923	12.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,919	2,120	41,510	19.58	9
10	Activity Assistants	5,577	5,765	60,691	10.53	10
11	Social Service Workers	15,616	16,901	298,149	17.64	11
12	Dietician					12
13	Food Service Supervisor	1,907	2,120	51,934	24.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,904	23,529	186,945	7.95	15
16	Dishwashers					16
17	Maintenance Workers	9,528	10,462	132,739	12.69	17
18	Housekeepers	31,438	34,231	262,845	7.68	18
19	Laundry					19
20	Administrator	1,898	2,120	222,360	104.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,923	10,903	244,383	22.41	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)					33
34	TOTAL (lines 1 - 33)	181,591	201,342	\$ 3,383,933 *	\$ 16.81	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	167	\$ 7,385	01-03	35
36	Medical Director	Monthly	48,845	09-03	36
37	Medical Records Consultant	Monthly	1,504	10-03	37
38	Nurse Consultant		(2,112)	10-03	38
39	Pharmacist Consultant	Monthly	8,240	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	342	11-03	44
45	Social Service Consultant	12	684	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	185	\$ 64,888		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	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

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

0043935

Report Period Beginning: **1/1/05**

Ending: **12/31/05**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Jeff White	Administrator		\$ 222,360	Workers' Compensation Insurance	\$ 91,354	IDPH License Fee	\$		
				Unemployment Compensation Insurance	74,124	Advertising: Employee Recruitment	2,443		
				FICA Taxes	247,062	Health Care Worker Background Check	866		
				Employee Health Insurance	66,721	(Indicate # of checks performed)			
				Employee Meals		Advertising & Marketing	13,244		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	8,992		
				401K	1,936	Licenses	7,883		
				Employee Physical Exam	60	Allocation from Platinum	1,558		
				Employee Benefits	82,662				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 222,360	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Ben Klein-Management Fees			\$ 360,000				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 360,000	TOTAL		\$	Seminar Expense	3,498	
(Attach a copy of any management service agreement)							Allocation from Platinum	389	
C. Professional Services									
Vendor/Payee	Type		Amount						
See Attached Schedule			\$ 235,688						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 235,688	TOTAL			\$	Entertainment Expense	()
(If total legal fees exceed \$2500 attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)		
							TOTAL		\$ 3,887

* Attach copy of IMRF notifications

**See instructions.

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? YES
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. \$ 1,800 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. _____
- (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 during this cost report period. \$ 113,333
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 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? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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.