

Facility Name & ID Number GLENWOOD CARE CENTER

0040394 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	203	Skilled (SNF)	203	74,095	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	203	TOTALS	203	74,095	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			6,176	6,176	8
9	SNF/PED					9
10	ICF	39,320	3,007		42,327	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,320	3,007	6,176	48,503	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.46%

D. How many bed-hold days during this year were paid by the Department? 30 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/93 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 29 and days of care provided 5,950

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **GLENWOOD CARE CENTER** # **0040394** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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	204,283	15,863	12,676	232,822		232,822	0	232,822		1
2	Food Purchase		175,808		175,808	(17,739)	158,069	(617)	157,452		2
3	Housekeeping	197,927	23,920	0	221,847		221,847	0	221,847		3
4	Laundry	60,309	14,580	0	74,889	0	74,889	0	74,889		4
5	Heat and Other Utilities			130,839	130,839		130,839	36	130,875		5
6	Maintenance	116,188	13,434	45,260	174,882		174,882	5,869	180,751		6
7	Other (specify):*			14,106	14,106		14,106	17	14,123		7
8	TOTAL General Services	578,707	243,605	202,881	1,025,193	(17,739)	1,007,454	5,305	1,012,759		8
	B. Health Care and Programs										
9	Medical Director	0		11,300	11,300		11,300	0	11,300		9
10	Nursing and Medical Records	1,870,419	68,302	64,024	2,002,745		2,002,745	(18,244)	1,984,501		10
10a	Therapy	9,587	16,144	51,574	77,305		77,305	(14,671)	62,634		10a
11	Activities	96,679	4,684	14,361	115,724		115,724	0	115,724		11
12	Social Services	250,856		0	250,856		250,856	0	250,856		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	2,227,541	89,130	141,259	2,457,930	0	2,457,930	(32,915)	2,425,015		16
	C. General Administration										
17	Administrative	103,899		0	103,899		103,899	97,750	201,649		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			233,835	233,835		233,835	(180,449)	53,386		19
20	Dues, Fees, Subscriptions & Promotions			42,361	42,361		42,361	(1,089)	41,272		20
21	Clerical & General Office Expenses	47,286	15,982	318,595	381,863		381,863	(230,726)	151,137		21
22	Employee Benefits & Payroll Taxes			475,617	475,617	17,739	493,356	0	493,356		22
23	Inservice Training & Education			0	0		0	1,937	1,937		23
24	Travel and Seminar			1,765	1,765		1,765	1,036	2,801		24
25	Other Admin. Staff Transportation			10,706	10,706		10,706	2,854	13,560		25
26	Insurance-Prop.Liab.Malpractice			110,023	110,023		110,023	1,382	111,405		26
27	Other (specify):*			0	0		0	53,354	53,354		27
28	TOTAL General Administration	151,185	15,982	1,192,902	1,360,069	17,739	1,377,808	(253,951)	1,123,857		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,957,433	348,717	1,537,042	4,843,192	0	4,843,192	(281,561)	4,561,631		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	10,847
	REPAIRS & MAINTENANCE	1,829
		0
		12,676
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	18,329
	ELECTRICITY	82,480
	WATER	30,030
	CABLE TV - LOBBY	0
		0
		130,839
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,885
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	27,316
	ELEVATOR MAINTENANCE & REPAIR	5,947
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,647
	FIRE SERVICE	4,465
		0
		0
		0
		0
		45,260
7	OTHER	
	SCAVENGER	14,106
	SECURITY SERVICE	0
		0
		0
		14,106
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	11,300
		11,300

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	812
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	1,650
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	PROGRAM CONSULTANT	61,562
		0
		64,024
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	9,146
	SPEECH THERAPY SERVICES	1,283
	OCCUPATIONAL THERAPY SERVICES	6,791
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	7,200
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	7,200
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	19,954
		51,574
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	14,361
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		14,361
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	26,144
	ADMINISTRATIVE CONSULTANTS XIX C	170,500
	PROFESSIONAL FEES XIX C	37,191
		0
		233,835
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,586
	EMPLOYEE WANT ADS XIX F	32,983
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,421
	LICENSES & PERMITS XIX F	4,195
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	418
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	150
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	300
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	209
	PATIENT BACKGROUND CHECKS XIX F	99
		0
		42,361
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,669
	EQUIPMENT REPAIR & MAINTENANCE	4,503
	OUTSIDE CLERICAL SERVICES	178,454
	PENALTIES / OVERDRAFT CHARGES VI 18	111,539
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	20,797
	MESSENGER SERVICE	1,633
		0
		318,595

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	204,000
	UNEMPLOYMENT COMPENSATION XIX D	85,578
	WORKERS COMPENSATION INSURANC XIX D	101,900
	HOSPITALIZATION INSURANCE XIX D	56,674
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	27,465
	CHICAGO HEAD TAX XIX D	0
		0
		475,617
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,672
	TRAVEL XIX G	93
		0
		1,765
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,706
		0
		10,706
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	110,023
		0
		110,023
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,537,042

GLENWOOD CARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	175,808	PATIENT MEALS	145509
LESS SALES TAX	(617)	ADD EMPLOYEE MEALS	16425
	-----		-----
NET FOOD	175,191	TOTAL MEALS/YEAR	161934
TOTAL PATIENT CENSUS	48,503	NET FOOD	175191
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	161934

TOTAL PATIENT MEALS	145509	COST PER MEAL	1.08
		TIME EMPLOYEE MEALS	16425
ADD # EMPLOYEE MEALS/DAY	45		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	17739
	-----		=====
TOTAL EMPLOYEE MEALS	16425		

Facility Name & ID Number **GLENWOOD CARE CENTER**

#0040394

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			371,935	371,935		371,935	(313,671)	58,264			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			87,634	87,634		87,634	33,981	121,615			32
33	Real Estate Taxes			91,385	91,385		91,385	4,368	95,753			33
34	Rent-Facility & Grounds			576,928	576,928		576,928	0	576,928			34
35	Rent-Equipment & Vehicles			50,262	50,262		50,262	(10,545)	39,717			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			1,178,144	1,178,144	0	1,178,144	(285,867)	892,277			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		169,063	189,396	358,459		358,459	(23,289)	335,170			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			111,143	111,143		111,143	0	111,143			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	169,063	300,539	469,602	0	469,602	(23,289)	446,313			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,957,433	517,780	3,015,725	6,490,938	0	6,490,938	(590,717)	5,900,221			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 **GLENWOOD CARE CENTER**

0040394

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(327,632)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(617)	2		13
14	Non-Care Related Interest	(49)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(111,539)	21		18
19	Entertainment	0	20		19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(2,586)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(418)	20		28
29	Other-Attach Schedule	(9,036)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (452,327)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(138,390)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (138,390)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (590,717)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

GLENWOOD CARE CENTER

ID# 0040394

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6 1
2	MARKETING SALARY	(9,036)	21 2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(9,036)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GLENWOOD CARE CENTER# 0040394

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(617)	0	0	0	0	0	0	0	0	0	0	(617)	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	36	0	0	0	0	0	0	0	0	0	36	5
6	Maintenance	0	5,869	0	0	0	0	0	0	0	0	0	5,869	6
7	Other (specify):*	0	17	0	0	0	0	0	0	0	0	0	17	7
8	TOTAL General Services	(617)	5,922	0	0	0	0	0	0	0	0	0	5,305	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	(18,244)	0	0	0	0	0	0	0	0	0	(18,244)	10
10a	Therapy	0	2,928	(17,599)	0	0	0	0	0	0	0	0	(14,671)	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	(15,316)	(17,599)	0	(32,915)	16							
	C. General Administration													
17	Administrative	0	97,750	0	0	0	0	0	0	0	0	0	97,750	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(183,700)	3,251	0	0	0	0	0	0	0	0	(180,449)	19
20	Fees, Subscriptions & Promotions	(3,454)	0	2,365	0	0	0	0	0	0	0	0	(1,089)	20
21	Clerical & General Office Expenses	(120,575)	(177,079)	66,928	0	0	0	0	0	0	0	0	(230,726)	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	1,937	0	0	0	0	0	0	0	0	1,937	23
24	Travel and Seminar	0	0	1,036	0	0	0	0	0	0	0	0	1,036	24
25	Other Admin. Staff Transportation	0	0	2,854	0	0	0	0	0	0	0	0	2,854	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,382	0	0	0	0	0	0	0	0	1,382	26
27	Other (specify):*	0	(11,413)	64,767	0	0	0	0	0	0	0	0	53,354	27
28	TOTAL General Administration	(124,029)	(274,442)	144,520	0	(253,951)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(124,646)	(283,836)	126,921	0	(281,561)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GLENWOOD CARE CENTER# 0040394

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(327,632)	0	13,961	0	0	0	0	0	0	0	0	(313,671)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(49)	0	34,030	0	0	0	0	0	0	0	0	33,981	32
33	Real Estate Taxes	0	0	4,368	0	0	0	0	0	0	0	0	4,368	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	(10,545)	0	0	0	0	0	0	0	0	(10,545)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(327,681)	0	41,814	0	(285,867)	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	(23,289)	0	0	0	0	0	0	0	0	(23,289)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	(23,289)	0	(23,289)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(452,327)	(283,836)	145,446	0	(590,717)	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
				CAREPLUS MGMT.	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB.	SKOKIE	THERAPY
SEE ATTACHED SCHEDULE						

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	10 PROGRAM CONS. FEES	\$ 61,562	CAREPLUS MANAGEMENT, INC		\$	\$ (61,562)	1
2	V	19 DATA PROCESS FEES	13,200	" "			(13,200)	2
3	V	21 CLERICAL FEES	177,079	" "			(177,079)	3
4	V	19 ADMIN. CONSULT FEES	170,500	" "			(170,500)	4
5	V	27 W/C INSURANCE	11,413	" "			(11,413)	5
6	V							6
7	V	5 UTILITIES		" "		36	36	7
8	V	6 MAINT & REPAIRS		" "		1,466	1,466	8
9	V	6 MAINTENANCE SALARIES		" "		4,403	4,403	9
10	V	7 SECURITY		" "		17	17	10
11	V	10 NURSING SALARIES		" "		43,318	43,318	11
12	V	10A THERAPY SALARIES		" "		2,928	2,928	12
13	V	17 ADMIN SALARIES		" "		97,750	97,750	13
14	Total		\$ 433,754			\$ 149,918	\$ * (283,836)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A THERAPY SERVICES	\$ 145,705	CAREPLUS REHABILITATIVE SERVICES		\$ 128,106	\$ (17,599)	15
16	V	39 ANCILLARY THERAPY	192,812	" "		169,523	(23,289)	16
17	V	35 EQUIPMENT RENT	18,648	" "			(18,648)	17
18	V	30 SL DEPRECIATION		" "		3,106	3,106	18
19	V	32 INTEREST		" "		2,482	2,482	19
20	V							20
21	V							21
22	V							22
23	V	19 PROFESSIONAL FEES		CAREPLUS MGMT, INC.		3,251	3,251	23
24	V	20 ADVERTISING		" "		2,365	2,365	24
25	V	21 TOTAL OFFICE		" "		14,424	14,424	25
26	V	21 CLERICAL SALARIES		" "		52,504	52,504	26
27	V	23 SEMINARS		" "		1,937	1,937	27
28	V	24 TRAVEL		" "		1,036	1,036	28
29	V	25 TRANSPORTATION		" "		2,854	2,854	29
30	V	26 INSURANCE		" "		1,382	1,382	30
31	V	27 EMPLOYEE BENEFITS		" "		64,767	64,767	31
32	V	30 DEPRECIATION (SL)		" "		10,855	10,855	32
33	V	33 REAL ESTATE TAX		" "		4,368	4,368	33
34	V	32 INTEREST		" "		27,624	27,624	34
35	V	32 INTEREST-TAG 18 PPTY-MTG		" "		3,664	3,664	35
36	V	32 INTEREST-CP REHAB-EQ LOAN		" "		260	260	36
37	V	35 EQUIPMENT RENT		" "		8,103	8,103	37
38	V							38
39	Total		\$ 357,165			\$ 502,611	\$ * 145,446	39

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

Facility Name & ID Number

GLENWOOD CARE CENTER

#

0040394

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	CAREPLUS MGMT ALLOCATIONS:								\$	1	
2	SHERWIN RAY	PRESIDENT	ADMIN.FINANC	25.86	SEE ATACHED	5.3		SALARY	17,535	17-7	2
3	JAKOB BAKST	DIR OPERATIONS	ADMIN,CONSUL	24.88	SCHEDULE	5.3		SALARY	17,535	17-7	3
4	JOE ZIMMERMAN	CFO	CLERICAL	0.99		5.3		SALARY	8,811	17-7	4
5	JOE ANN BREW	REGIONAL DIR	ADMINISTRAT	0.49		5.3		SALARY	7,516	17-7	5
6	JAMME O'BRIEN	REGIONAL DIR	ADMINISTRAT	0.49		5.3		SALARY	11,956	10-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 63,353		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 GLENWOOD CARE CENTER

0040394

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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 CAREPLUS MANAGEMENT
 Street Address 8320 SKOKIE BLVD.
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 329-1555
 Fax Number (847) 329-9555

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	5	UTILITIES	553,205	13	408		48,503	36	2
3	6	MAINT & REPAIRS	553,205	13	16,722		48,503	1,466	3
4	6	MAINTENANCE SALARIES	553,205	13	50,215	50,215	48,503	4,403	4
5	7	SECURITY	553,205	13	194		48,503	17	5
6	10	NURSING SALARIES	553,205	13	494,063	494,063	48,503	43,318	6
7	10A	THERAPY SALARIES	553,205	13	33,400	33,400	48,503	2,928	7
8	17	ADMIN SALARIES	553,205	13	1,114,897	1,114,897	48,503	97,750	8
9	19	PROFESSIONAL FEES	553,205	13	37,085		48,503	3,251	9
10	20	ADVERTISING	553,205	13	26,974		48,503	2,365	10
11	21	TOTAL OFFICE	553,205	13	164,515		48,503	14,424	11
12	21	CLERICAL SALARIES	553,205	13	598,842	598,842	48,503	52,504	12
13	23	SEMINARS	553,205	13	22,090		48,503	1,937	13
14	24	TRAVEL	553,205	13	11,815		48,503	1,036	14
15	25	TRANSPORTATION	553,205	13	32,553		48,503	2,854	15
16	26	INSURANCE	553,205	13	15,760		48,503	1,382	16
17	27	EMPLOYEE BENEFITS	553,205	13	738,700		48,503	64,767	17
18	30	DEPRECIATION (SL)	553,205	13	123,804		48,503	10,855	18
19	33	REAL ESTATE TAX	553,205	13	49,822		48,503	4,368	19
20	32	INTEREST	553,205	13	315,063		48,503	27,624	20
21	32	INTEREST-TAG 18 PPTY-MTG	553,205	13	41,794		48,503	3,664	21
22	32	INTEREST-CP REHAB-EQ LOAN	553,205	13	2,962		48,503	260	22
23	35	EQUIPMENT RENT	553,205	13	92,424		48,503	8,103	23
24									24
25	TOTALS				\$ 3,984,102	\$ 2,291,417		\$ 349,312	25

Facility Name & ID Number

GLENWOOD CARE CENTER

0040394

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	CIB BANK		X	CAPITAL IMPROVEMENTS		01/04	\$ 336,000	\$ 32,279	01/09	PRIME +	\$ 3,413	1						
2												2						
3												3						
4												4						
5	CAREPLUS MANAGEMENT ALLOCATION											31,548	5					
Working Capital																		
6	CAREPLUS MGMT	X		WORKING CAPITAL	DEMAND	04/95	1,300,000	1,230,364		PRIME +	83,367	6						
7	A.I. CREDIT INC		X	INSURANCE FINANCED							805	7						
8	CAREPLUS REHAB ALLOCATION:EQUIPMENT LOANS											2,482	8					
9	TOTAL Facility Related											\$ 1,636,000	\$ 1,262,643	\$ 121,615	9			
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES							49	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related											\$ 0	\$ 0	\$ 49	14			
15	TOTALS (line 9+line14)											\$ 1,636,000	\$ 1,262,643	\$ 121,664	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.)

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 2005 report.	\$	91,892	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.)	\$	91,183	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(709)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	92,094	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.	\$	91,385	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	82,562	8
	2002	88,330	9
	2003	88,012	10
	2004	90,982	11
	2005	91,183	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED

ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GLENWOOD CARE CENTER COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0040394

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>30-07-07-304-025-0000</u>	<u>NURSING HOME</u>	\$ <u>91,182.64</u>	\$ <u>91,182.64</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>91,182.64</u>	\$ <u>91,182.64</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number GLENWOOD CARE CENTER

0040394

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>75,625</u>		\$	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>75,625</u>		\$ <u>0</u>	<u>3</u>

Facility Name & ID Number GLENWOOD CARE CENTER

0040394

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		LEASEHOLD IMPROVEMENTS		1993	1,080	648	31.5	34	(614)	466	9
10		LEASEHOLD IMPROVEMENTS		1993	26,757	18,220	39	686	(17,534)	9,223	10
11		LEASEHOLD IMPROVEMENTS		1994	4,980	3,471	39	128	(3,343)	1,637	11
12		OUTLETS		1995	1,429	1,048	39	37	(1,011)	418	12
13		PAVING		1995	19,500	5,845	15	1,300	(4,545)	14,956	13
14		ROOF REPAIR		1996	2,505	1,891	39	64	(1,827)	696	14
15		ELEVATOR REPAIR		1996	7,000	5,285	39	180	(5,105)	1,936	15
16		WATER CONDITIONING SYSTEM		1996	3,486	2,632	39	89	(2,543)	953	16
17		ROOFTOP A/C UNIT		1996	5,300	4,002	39	136	(3,866)	1,366	17
18		LANDSCAPING		1996	3,554	1,303	15	237	(1,066)	2,488	18
19		EXTERIOR PLASTER/PAINT		1997	8,500	6,637	39	218	(6,419)	2,135	19
20		PLUMBING		1997	1,091	852	39	28	(824)	270	20
21		LAMINATED COUNTER TOPS		1997	5,900	4,606	39	151	(4,455)	1,389	21
22		WALK-IN COOLER		1998	9,893	7,934	39	254	(7,680)	2,275	22
23		OUTDOOR STORAGE UNIT		1998	1,200	962	39	31	(931)	275	23
24		DRAIN LINE REPAIRS		1998	6,575	5,272	39	168	(5,104)	1,476	24
25		ROOFTOP HEAT / AC UNIT		1998	5,200	4,170	39	133	(4,037)	1,092	25
26		LANDSCAPING		1998	5,883	2,943	15	392	(2,551)	3,332	26
27		ROOF & HEATING REPAIRS / FIRE SAFETY UPGRADE		1999	17,798	14,911	39	456	(14,455)	3,274	27
28		NEW SUSPENDED CELLING		2000	64,670	50,944	27.5	2,352	(48,592)	16,077	28
29		CARPET-ENTRANCE & LOBBY		2000	2,750	450	20	138	(312)	966	29
30		NEW DIALYSIS ROOM		2001	8,750	7,200	27.5	318	(6,882)	1,868	30
31		INSTALLATION WATER SYSTEM		2001	1,905	1,568	27.5	69	(1,499)	406	31
32		FIRE ALARM SYSTEM-NEW HORNS,SMOKE DETECTORS		2001	7,194	6,071	27.5	262	(5,809)	1,386	32
33		DRYWALL		2001	5,425	4,578	27.5	197	(4,381)	1,043	33
34		PASSENGER ELEVATOR-PUMPING UNIT		2001	9,700	8,274	27.5	353	(7,921)	1,780	34
35		REPLACE WATER HEATER		2001	4,411	3,763	27.5	160	(3,603)	807	35
36		ROOF REPAIR		2002	3,100	2,687	27.5	113	(2,574)	541	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 GLENWOOD CARE CENTER

0040394

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	NURSES STATION WITH SURFACE TRANSACTION TOP	2002	\$ 17,820	\$ 15,741	27.5	\$ 648	\$ (15,093)	\$ 2,727	37
38	VESTIBULE, LOBBY, DINING ROOMS - WALLCOVERING	2002	7,200	6,241	27.5	262	(5,979)	1,240	38
39	REPLACE THE ELEVATOR PUMPING UNIT	2002	4,700	4,074	27.5	171	(3,903)	819	39
40	NURSES' STATIONS-WALLCOVERING, ELECTRIC. WORK	2002	5,440	4,716	27.5	198	(4,518)	865	40
41	REPAIR PATCH AT FRONT OF BUILDING	2002	1,720	1,299	15	115	(1,184)	575	41
42	BUILD NEW WALL BETWEEN LOBBY & NURSES STATION	2002	6,930	6,100	27.5	252	(5,848)	1,082	42
43	LOBBY, VESTIBULE, CORRIDOR-FLOORING	2002	34,654	30,611	27.5	1,260	(29,351)	5,303	43
44	FACILITY DOOR	2003	3,072	2,789	27.5	112	(2,677)	396	44
45	GREASE TRAPS	2003	3,900	3,540	27.5	141	(3,399)	500	45
46	DELAYS FOR PATIO DOORS	2003	3,049	2,768	27.5	111	(2,657)	393	46
47	FENCE	2003	3,950	3,292	15	263	(3,029)	921	47
48	ROOF DRAIN	2003	1,900	1,753	27.5	69	(1,684)	216	48
49	FIRE ALARM SYSTEM	2003	6,198	5,720	27.5	225	(5,495)	703	49
50	INSTALL FIRE ALARM DEVICES	2005	6,662	6,430	27.5	232	(6,198)	464	50
51	REPLACE ROOF TOP UNIT	2005	11,450	11,259	27.5	191	(11,068)	382	51
52	SIDE WALK	2005	19,550	19,116	15	1,303	(17,813)	2,606	52
53	FURNISH AND INSTALL CEILING LIGHT FIXTURE	2005	6,150	6,141	27.5	9	(6,132)	18	53
54	FLOORING THERAPY ROOM	2006	3,962	3,962	27.5	3,962		3,962	54
55	INSTALLED ALARM	2006	3,452	3,452	27.5	3,452		3,452	55
56									56
57									57
58									58
59									59
60									60
61									61
62	RELATED PARTY ALLOCATION:								62
63	CAREPLUS MGMT								63
64	BUILDING-TAG-18 PROPERTIES	2004	56,460	1,407	39	1,407			64
65	BUILDINF IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,181	833	39	833			65
66									66
67	CAREPLUS REHAB								67
68	GENERATOR	2003	24,048	617	39	617			68
69									69
70	TOTAL (lines 4 thru 69)		\$ 499,984	\$ 320,028		\$ 24,517	\$ (295,511)	\$ 101,155	70

**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	\$ 245,891	\$ 39,933	\$ 21,939	\$ (17,994)	5-15	\$ 143,869	71
72	Current Year Purchases	14,067	14,067	704	(13,363)	10	704	72
73	Fully Depreciated Assets	32,515			0		32,515	73
74	RELATED PARTY SL DEPRECIATION		11,104	11,104	0			74
75	TOTALS	\$ 292,473	\$ 65,104	\$ 33,747	\$ (31,357)		\$ 177,088	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	FACILITY	1998 CHEVROLET VAN	2001	\$ 13,250	\$ 764	\$	\$ (764)	5	\$ 13,250	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 13,250	\$ 764	\$ 0	\$ (764)		\$ 13,250	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)	\$ 805,707	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 385,896	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,264	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (327,632)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 291,493	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: **METROPOLITAN NURSING CENTER OF JOLIET**

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: 1970	203	04/01/93	\$ 576,928	30		3
4	Additions						4
5							5
6							6
7	TOTAL	203		\$ 576,928			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **46,125** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	CAREPLUS MGMT		\$ SEE ATTACHED	\$ 4,137	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,137	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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 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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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	39-3	hrs	\$		\$ 87,710	\$		\$ 87,710	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,416			3,416	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			95,818			95,818	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				168,472		168,472	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Radiology, Laboratory Other (specify): Med.Supplies	39-3 39-2				2,452	591		2,452 591	13
14	TOTAL			\$		\$ 189,396	\$ 169,063		\$ 358,459	14

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

Facility Name & ID Number GLENWOOD CARE CENTER

0040394

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 27,498	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 70,628)	2,463,871		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,193		6
7	Other Prepaid Expenses	1,984		7
8	Accounts Receivable (owners or related parties)	734,407		8
9	Other(specify): <u>Real Estate Tax Escrow</u>	43,059		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,304,012	\$ 0	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	397,295		15
16	Equipment, at Historical Cost	305,723		16
17	Accumulated Depreciation (book methods)	(703,018)		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): <u>RENT SECURITY DEPOSIT</u>	487,200		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 487,200	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,791,212	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,250,137	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,971		28
29	Short-Term Notes Payable	2,148,546		29
30	Accrued Salaries Payable	105,995		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,912		31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,094		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,669,655	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,669,655	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ 121,557	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,791,212	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 310,586	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	112,259	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 422,845	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(301,288)	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)	\$ (301,288)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 121,557	24 *

* This must agree with page 17, line 47.

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,189,601	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,189,601	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	49	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,189,650	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,025,193	31
32	Health Care	2,457,930	32
33	General Administration	1,360,069	33
	B. Capital Expense		
34	Ownership	1,178,144	34
	C. Ancillary Expense		
35	Special Cost Centers	358,459	35
36	Provider Participation Fee	111,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,490,938	40
41	Income before Income Taxes (line 30 minus line 40)**	(301,288)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (301,288)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number GLENWOOD CARE CENTER

0040394

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	1,206	1,576	\$ 55,023	\$ 34.91	1
2	Assistant Director of Nursing	1,244	1,289	37,205	28.86	2
3	Registered Nurses	16,431	17,335	537,314	31.00	3
4	Licensed Practical Nurses	21,132	22,096	506,011	22.90	4
5	CNAs & Orderlies	69,887	73,464	717,252	9.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	496	559	9,587	17.15	8
9	Activity Director	1,072	1,111	16,141	14.53	9
10	Activity Assistants	8,947	9,366	80,538	8.60	10
11	Social Service Workers	9,148	10,315	250,856	24.32	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,152	41,426	19.25	13
14	Head Cook	6,586	7,004	66,752	9.53	14
15	Cook Helpers/Assistants	12,378	12,894	96,105	7.45	15
16	Dishwashers					16
17	Maintenance Workers	11,632	12,494	116,188	9.30	17
18	Housekeepers	19,642	21,207	197,927	9.33	18
19	Laundry	6,135	6,639	60,309	9.08	19
20	Administrator	2,807	2,807	73,489	26.18	20
21	Assistant Administrator	1,722	1,857	30,410	16.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,838	4,153	47,286	11.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,728	1,760	17,614	10.01	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	198,087	210,078	\$ 2,957,433 *	\$ 14.08	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	M	\$ 10,847	1-3	35
36	Medical Director	O	11,300	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,650	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) <u>PROGRAM CONSULTANT</u>	S	61,562	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 99,759		49

C. CONTRACT NURSES

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

Facility Name & ID Number GLENWOOD CARE CENTER

0040394

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL. ASSOC. OF HEALTHCARE \$1421
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 847 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,143
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. \$ 17,739 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ 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