

		FOR BHF USE					

LL1

**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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

<p><b>I. IDPH Facility ID Number:</b> <u>0032839</u></p> <p><b>Facility Name:</b> <u>GLENWOOD HEALTHCARE &amp; REHAB</u></p> <p><b>Address:</b> <u>19330 SOUTH COTTAGE GROVE</u> <u>GLENWOOD</u> <u>60425</u>  Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>(847) 674-4700</u> <b>Fax #</b> <u>(847) 674-4733</u></p> <p><b>HFS ID Number:</b> <u>36-3532094</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>9/1/1987</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  Name: <u>DON FIETS</u> Telephone Number: <u>(847) 674-4700 X40</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>BRADLEY ALTER</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>SECRETARY</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) _____</td> <td>Fax # ( ) _____</td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001  Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>BRADLEY ALTER</u>			(Title) <u>SECRETARY</u>		<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) _____	Fax # ( ) _____
<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																																								
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																								
	<input checked="" type="checkbox"/> "Sub-S" Corp.																																									
	<input type="checkbox"/> Limited Liability Co.																																									
	<input type="checkbox"/> Trust																																									
	<input type="checkbox"/> Other _____																																									
<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____																																								
	(Type or Print Name) <u>BRADLEY ALTER</u>																																									
	(Title) <u>SECRETARY</u>																																									
<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____																																								
	(Print Name and Title) _____																																									
	(Firm Name & Address) _____																																									
	(Telephone) _____	Fax # ( ) _____																																								

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB

# 0032839 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	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	184	TOTALS	184	67,160	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	2,604		3,447	6,051	8
9	SNF/PED					9
10	ICF	39,719	3,628	3,586	46,933	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,323	3,628	7,033	52,984	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.89%

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)

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 09/01/87

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 09/01/87 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 19 and days of care provided 3,447

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 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
	<b>A. General Services</b>										
1	Dietary	217,346	15,925	11,371	244,642		244,642	0	244,642		1
2	Food Purchase		209,920		209,920	0	209,920	(426)	209,494		2
3	Housekeeping	176,638	46,457	0	223,095		223,095	0	223,095		3
4	Laundry	94,093	33,568	325	127,986	0	127,986	0	127,986		4
5	Heat and Other Utilities			142,085	142,085		142,085	1,754	143,839		5
6	Maintenance	86,849	33,670	18,677	139,196		139,196	1,720	140,916		6
7	Other (specify):*			9,255	9,255		9,255	0	9,255		7
8	<b>TOTAL General Services</b>	574,926	339,540	181,713	1,096,179	0	1,096,179	3,048	1,099,227		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		24,125	24,125		24,125	0	24,125		9
10	Nursing and Medical Records	1,772,092	150,188	123,433	2,045,713		2,045,713	32,584	2,078,297		10
10a	Therapy	31,449	3,729	15,181	50,359		50,359	0	50,359		10a
11	Activities	139,989	3,139	0	143,128		143,128	0	143,128		11
12	Social Services	67,219		3,132	70,351		70,351	0	70,351		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			1,300	1,300		1,300	0	1,300		14
15	Other (specify):*			0	0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	2,010,749	157,056	167,171	2,334,976	0	2,334,976	32,584	2,367,560		16
	<b>C. General Administration</b>										
17	Administrative	186,850		88,035	274,885		274,885	(9,722)	265,163		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			119,407	119,407		119,407	(78,291)	41,116		19
20	Dues, Fees, Subscriptions & Promotions			22,150	22,150		22,150	(13,154)	8,996		20
21	Clerical & General Office Expenses	110,003	27,373	236,453	373,829		373,829	(52,795)	321,034		21
22	Employee Benefits & Payroll Taxes			549,848	549,848	0	549,848	22,442	572,290		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			1,621	1,621		1,621	7,848	9,469		24
25	Other Admin. Staff Transportation			9,779	9,779		9,779	12,565	22,344		25
26	Insurance-Prop.Liab.Malpractice			165,314	165,314		165,314	25,167	190,481		26
27	Other (specify):* <b>Marketing/Bad Debt</b>	23,757		156,000	179,757		179,757	(179,757)	0		27
28	<b>TOTAL General Administration</b>	320,610	27,373	1,348,607	1,696,590	0	1,696,590	(265,697)	1,430,893		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,906,285	523,969	1,697,491	5,127,745	0	5,127,745	(230,065)	4,897,680		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	11,101
	REPAIRS & MAINTENANCE	270
		0
		11,371
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	325
		0
		325
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	50,383
	ELECTRICITY	61,855
	WATER	28,369
	CABLE TV - LOBBY	1,478
		0
		142,085
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	6,615
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	8,113
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,309
	FIRE SERVICE	1,640
		0
		0
		0
		0
		18,677
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	9,255
	SECURITY SERVICE	0
		0
		0
		9,255
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	24,125
		24,125

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	83,493
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	36,118
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	248
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,954
	PHARMACY CONSULTANT XVIII B 39-2	1,620
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		123,433
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	7,685
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	5,353
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	2,143
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		15,181
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,132
		0
		3,132
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	1,300
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	88,035
<b>18</b>	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	11,831
	ADMINISTRATIVE CONSULTANTS XIX C	45,606
	PROFESSIONAL FEES XIX C	61,970
		0
		119,407
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	8,634
	EMPLOYEE WANT ADS XIX F	5,706
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,720
	LICENSES & PERMITS XIX F	1,570
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	4,520
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		22,150
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	3,211
	OUTSIDE CLERICAL SERVICES	177,438
	PENALTIES / OVERDRAFT CHARGES VI 18	38,919
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	3,824
	TELEPHONE	11,548
	MESSENGER SERVICE/postage	1,513
		0
		236,453

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	218,640
	UNEMPLOYMENT COMPENSATION XIX D	67,769
	WORKERS COMPENSATION INSURANC XIX D	137,543
	HOSPITALIZATION INSURANCE XIX D	117,317
	EMPLOYEE BENEFITS - OTHER XIX D	501
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	8,078
	CHICAGO HEAD TAX XIX D	0
		0
		549,848
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	190
	TRAVEL XIX G	1,431
		1,621
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	9,779
		9,779
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	165,314
		165,314
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	156,000
		156,000

GRAND TOTAL COLUMN 3 OTHER

1,697,491

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

TOTAL FOOD PURCHASE	209,920	PATIENT MEALS	158952
LESS SALES TAX	(426)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	209,494	TOTAL MEALS/YEAR	158952
TOTAL PATIENT CENSUS	52,984	NET FOOD	209494
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	158952
	-----		
TOTAL PATIENT MEALS	158952	COST PER MEAL	1.32
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number **GLENWOOD HEALTHCARE & REHAB**

#0032839

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	
	<b>D. Ownership</b>											
30	Depreciation			50,044	50,044		50,044	190,489	240,533			30
31	Amortization of Pre-Op. & Org.			0	0		0	24,533	24,533			31
32	Interest			61,459	61,459		61,459	461,109	522,568			32
33	Real Estate Taxes			404,157	404,157		404,157	0	404,157			33
34	Rent-Facility & Grounds			578,922	578,922		578,922	(570,146)	8,776			34
35	Rent-Equipment & Vehicles			54,423	54,423		54,423	0	54,423			35
36	Other (specify):* <b>storage</b>			528	528		528	0	528			36
37	<b>TOTAL Ownership</b>			1,149,533	1,149,533	0	1,149,533	105,985	1,255,518			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		109,234	299,158	408,392		408,392	0	408,392			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			100,740	100,740		100,740	0	100,740			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	109,234	399,898	509,132	0	509,132	0	509,132			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,906,285	633,203	3,246,922	6,786,410	0	6,786,410	(124,080)	6,662,330			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	32,894	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	(426)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(38,919)	21		18
19	Entertainment	0	20		19
20	Contributions	0	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	(156,000)	27		24
25	Fund Raising, Advertising and Promotional	(8,634)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,520)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (175,605)		\$ 0	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	113,961		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 113,961		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (61,644)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0032839

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	LEGAL FEES	(38,679)	19	2
3	MARKETING SALARY	(23,757)	27	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	<b>Total</b>	(62,436)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB# 0032839

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	(426)	0	0	0	0	0	0	0	0	0	0	(426)	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	1,754	0	0	0	0	0	0	0	0	1,754	5
6	Maintenance	0	0	1,720	0	0	0	0	0	0	0	0	1,720	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(426)</b>	<b>0</b>	<b>3,474</b>	<b>0</b>	<b>3,048</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	32,584	0	0	0	0	0	0	0	0	32,584	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>32,584</b>	<b>0</b>	<b>32,584</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	(88,035)	78,313	0	0	0	0	0	0	0	0	(9,722)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(38,679)	(45,606)	5,994	0	0	0	0	0	0	0	0	(78,291)	19
20	Fees, Subscriptions & Promotions	(13,154)	0	0	0	0	0	0	0	0	0	0	(13,154)	20
21	Clerical & General Office Expenses	(38,919)	(175,608)	161,732	0	0	0	0	0	0	0	0	(52,795)	21
22	Employee Benefits & Payroll Taxes	0	0	22,442	0	0	0	0	0	0	0	0	22,442	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7,848	0	0	0	0	0	0	0	0	7,848	24
25	Other Admin. Staff Transportation	0	0	12,565	0	0	0	0	0	0	0	0	12,565	25
26	Insurance-Prop.Liab.Malpractice	0	0	25,167	0	0	0	0	0	0	0	0	25,167	26
27	Other (specify):*	(179,757)	0	0	0	0	0	0	0	0	0	0	(179,757)	27
28	<b>TOTAL General Administration</b>	<b>(270,509)</b>	<b>(309,249)</b>	<b>314,061</b>	<b>0</b>	<b>(265,697)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(270,935)</b>	<b>(309,249)</b>	<b>350,119</b>	<b>0</b>	<b>(230,065)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	32,894	152,675	4,920	0	0	0	0	0	0	0	0	190,489	30
31	Amortization of Pre-Op. & Org.	0	24,533	0	0	0	0	0	0	0	0	0	24,533	31
32	Interest	0	461,109	0	0	0	0	0	0	0	0	0	461,109	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(578,922)	8,776	0	0	0	0	0	0	0	0	(570,146)	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	<b>TOTAL Ownership</b>	<b>32,894</b>	<b>59,395</b>	<b>13,696</b>	<b>0</b>	<b>105,985</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(238,041)</b>	<b>(249,854)</b>	<b>363,815</b>	<b>0</b>	<b>(124,080)</b>	<b>45</b>							

**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 SCHEDULE		SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BKKPG/MGMT
				GLENWOOD TERRACE LLC	SKOKIE	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 88,035	CERTIFIED HEALTH MANAGEMENT		\$	\$	(88,035) 1
2	V	21 BOOKKEEPING	177,438					(177,438) 2
3	V	19 ADMIN CONSULTING FEES	45,606					(45,606) 3
4	V							
5	V							
6	V							
7	V	34 RENT	578,922	GLENWOOD TERRACE LLC				(578,922) 7
8	V	21 OFFICE EXPENSE				1,830		1,830 8
9	V	30 DEPRECIATION				152,675		152,675 9
10	V	31 AMORTIZATION				24,533		24,533 10
11	V	32 INTEREST				461,109		461,109 11
12	V							
13	V							
14	Total		\$ 890,001			\$ 640,147	\$ *	(249,854) 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	3 HOUSEKEEPING	\$	CERTIFIED HEALTH MANAGEMENT		\$ 0	\$	15
16	V	5 ELECTRIC/GAS		" " "		1,754		1,754 16
17	V	6 MAINTENANCE		" " "		1,720		1,720 17
18	V	10 NURSING/MEDICAL RECORDS		" " "		32,584		32,584 18
19	V	17 ADMIN SALARIES		" " "		78,313		78,313 19
20	V	19 PROFESSIONAL FEES		" " "		5,994		5,994 20
21	V	20 FEES, SUBSCRIPTIONS		" " "		0		0 21
22	V	21 OFFICE EXP		" " "		161,732		161,732 22
23	V	22 EMPLOYEE BENEFITS		" " "		22,442		22,442 23
24	V	24 TRAVEL/SEMINAR		" " "		7,848		7,848 24
25	V	25 TRANSPORTATION		" " "		12,565		12,565 25
26	V	26 INSURANCE		" " "		25,167		25,167 26
27	V	30 DEPRECIATION		" " "		4,920		4,920 27
28	V	32 INTEREST		" " "		0		0 28
29	V	34 OFFICE RENT		" " "		8,776		8,776 29
30	V	36 EQUIPMENT RENTAL		" " "		0		0 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		\$			\$ 363,815	\$ *	363,815 39

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

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 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	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	\$ 71,630	17-3	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	\$ 71,630		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 HEALTHCARE & REHAB**

# **0032839**

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

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

Name of Related Organization CERTIFIED HEALTH MANAGEMENT  
 Street Address 3865 OAKTON SUITE 200  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

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	3	HOUSEKEEPING	PER PATIENT DAY	199,244	8	\$ 0	52,984	\$ 0	1
2	5	ELECTRIC/GAS	" " "	199,244	8	6,594	52,984	1,754	2
3	6	MAINTENANCE	" " "	199,244	8	6,467	52,984	1,720	3
4	10	NURSING/MEDICAL RECORDS	" " "	199,244	8	122,529	52,984	32,584	4
5	17	ADMIN SALARIES	" " "	199,244	8	294,492	52,984	78,313	5
6	19	PROFESSIONAL FEES	" " "	199,244	8	22,540	52,984	5,994	6
7	20	FEES, SUBSCRIPTIONS	" " "	199,244	8		52,984	0	7
8	21	OFFICE EXP	" " "	199,244	8	608,185	52,984	161,732	8
9	22	EMPLOYEE BENEFITS	" " "	199,244	8	84,392	52,984	22,442	9
10	24	TRAVEL/SEMINAR	" " "	199,244	8	29,513	52,984	7,848	10
11	25	TRANSPORTATION	" " "	199,244	8	47,249	52,984	12,565	11
12	26	INSURANCE	" " "	199,244	8	94,640	52,984	25,167	12
13	30	DEPRECIATION	" " "	199,244	8	18,500	52,984	4,920	13
14	32	INTEREST	" " "	199,244	8	0	52,984	0	14
15	34	OFFICE RENT	" " "	199,244	8	33,000	52,984	8,776	15
16	36	EQUIPMENT RENTAL	" " "	199,244	8	0	52,984	0	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,368,101	\$ 962,154	\$ 363,815	25

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB

# 0032839

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 GLENWOOD HEALTHCARE LLC  
 Street Address 3856 OAKTON SUITE 200  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

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	30	DEPRECIATION	DIRECT COSTS	1	1	\$ 152,675	\$ 1	\$ 152,675	1
2	31	AMORTIZATION		1	1	24,533	1	24,533	2
3	32	INTEREST		1	1	461,109	1	461,109	3
4	21	OFFICE EXPENSE		1	1	1,830	1	1,830	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 640,147	\$	\$ 640,147	25

Facility Name & ID Number

**GLENWOOD HEALTHCARE & REHAB**

# **0032839**

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	2	3	4	5	6		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6	<b>BANKFINANCIAL</b>		<b>X</b>	<b>WORKING CAPITAL</b>	<b>DEMAND</b>				<b>PRIME+</b>	<b>57,688</b>	6							
7	<b>INS FINANCING</b>		<b>X</b>							<b>3,771</b>	7							
8											8							
9	<b>TOTAL Facility Related</b>					\$	<b>0</b>	\$	<b>0</b>	\$	<b>61,459</b>	9						
<b>B. Non-Facility Related*</b>																		
10	<b>IRS, IDR, ETC</b>		<b>X</b>	<b>LATE FEES</b>							10							
11											11							
12											12							
13											13							
14	<b>TOTAL Non-Facility Related</b>					\$	<b>0</b>	\$	<b>0</b>	\$	<b>0</b>	14						
15	<b>TOTALS (line 9+line14)</b>					\$	<b>0</b>	\$	<b>0</b>	\$	<b>61,459</b>	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.		\$	<b>387,824</b>	<b>1</b>
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.)		\$	<b>392,071</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>4,247</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>399,910</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>404,157</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2001</b>	<b>430,062</b>	<b>8</b>
	<b>2002</b>	<b>430,062</b>	<b>9</b>
	<b>2003</b>	<b>376,473</b>	<b>10</b>
	<b>2004</b>	<b>380,219</b>	<b>11</b>
	<b>2005</b>	<b>392,071</b>	<b>12</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

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

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

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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 HEALTHCARE & REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0032839

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE ( 847 ) 674-4700 X40 FAX #: ( 847 ) 674-4733

**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>32-10-201-009-0000</u>	<u>NURSING HOME</u>	\$ <u>392,071.00</u>	\$ <u>392,071.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>392,071.00</u>	\$ <u>392,071.00</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.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 98,010 B. General Construction Type: Exterior BRICK 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).

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>1999</u>	<u>\$ 322,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 322,000</b>	<b>3</b>

Facility Name & ID Number **GLENWOOD HEALTHCARE & REHAB**# **0032839**

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	184		1999		\$ 5,474,000	\$ 140,359	39	\$ 140,359	\$ (0)	\$ 1,122,872	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		LEASEHOLD IMPROVEMENTS		1988	20,662	656	30	689	33	12,435	9
10		LEASEHOLD IMPROVEMENTS		1989	4,071	129	30	136	7	2,380	10
11		LEASEHOLD IMPROVEMENTS		1990	28,171	894	30	939	45	15,494	11
12		LEASEHOLD IMPROVEMENTS		1991	31,712	1,007	30	1,057	50	16,384	12
13		LEASEHOLD IMPROVEMENTS		1992	10,071	320	30	336	16	4,872	13
14		LEASEHOLD IMPROVEMENTS		1993	4,810	153	30	160	7	2,223	14
15		LEASEHOLD IMPROVEMENTS		1994	17,744	455	39	455	(0)	5,232	15
16		LIGHT FIXTURES, ROOM SIGNS, HAND RAILS		1995	6,343	163	39	163	(0)	2,090	16
17		HEATING/AIR CONDITIONING		1995	12,515	320	39	321	1	4,106	17
18		NURSING STATION		1995	10,384	266	39	266	0	3,314	18
19		SPRINKLER/LANUDRY VENTILATION REPAIR		1995	2,360	61	39	61	(0)	746	19
20		LAMPS, VIDEO CAMERA, PANIC DEVICE, WATER COOLER		1996	3,650	94	39	94	(0)	1,095	20
21		EXIT & OUTDOOR SIGNS		1996	4,237	109	39	109	(0)	1,245	21
22		WINDOWS, DOORS, CEILING TILES/CARPET		1996	25,090	643	39	643	0	7,204	22
23		HVAC WIRING REPAIR		1996	1,540	39	39	39	0	440	23
24		TIME CLOCKS,HEAT & COOL UNITS		1997	7,022	180	39	180	0	1,718	24
25		NURSE STATION		1997	5,615	144	39	144	(0)	1,374	25
26		FLOOR/CEILING TILES, COUNTER & CABINETS		1997	21,659	556	39	555	(1)	5,370	26
27		DOORS, LIGHTS, SIGHNS		1997	14,825	380	39	380	0	3,698	27
28		BURNERS & ELECTRICAL FOR WASHER		1997	1,964	50	39	50	0	477	28
29		SIGNS, PATIO SURFACE		1998	6,994	466	15	466	0	3,961	29
30		WINDOWS & INSTALLATION		1998	18,944	486	39	486	(0)	4,354	30
31		KITCHEN REMODEL		1998	50,500	1,295	39	1,295	(0)	11,603	31
32		ELECTRIC WORK		1998	7,545	193	39	193	0	1,649	32
33		CARPET, WALLPAPER, HANDRAIL, BUMPER GUARD		1998	79,382	2,036	39	2,035	(1)	16,812	33
34		GENERATOR		1999	56,533	1,450	39	1,450	(0)	11,541	34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number GLENWOOD HEALTHCARE &amp; REHAB

# 0032839

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	HEAT AND AIR CONDITIONER	1999	\$ 14,673	\$ 376	39	\$ 376	\$ 0	\$ 2,836	37
38	VINYL FLOORING AND TILES	1999	5,505	141	39	141	0	1,052	38
39	ROOF AND TUCKPOINT	1999	59,360	1,522	39	1,522	0	11,226	39
40	AIR CONDITIONER/COMPRESSOR	2000	9,868	401	7	1,410	1,009	9,868	40
41	ROOF REPAIR	2000	3,750	136	27.5	136	0	924	41
42	VINYL TILE/COVE BASE	2000	19,277	701	27.5	701	(0)	4,693	42
43	ALARM WORK	2000	3,848	140	27.5	140	(0)	866	43
44	DRAPERIES	2001	1,750	64	27.5	64	(0)	376	44
45	ELECTRICAL WORK	2001	5,550	201	27.5	202	1	1,136	45
46	TILE	2002	13,079	476	27.5	476	(0)	2,083	46
47	TILE	2003	13,545	493	27.5	493	(0)	1,704	47
48	WALL AC UNITS	2003	1,246	45	27.5	45	0	156	48
49	WALL CASE FOR AC	2003	622	23	27.5	23	(0)	79	49
50	WALL CASE FOR AC	2003	631	23	27.5	23	(0)	80	50
51	WALL CASE FOR AC	2003	607	22	27.5	22	0	76	51
52	SHINGLES	2003	700	25	27.5	25	0	87	52
53	COVE BASE	2003	939	34	27.5	34	0	118	53
54	WALL AC UNITS	2003	1,223	44	27.5	44	0	152	54
55	WALL AC UNITS	2003	2,113	77	27.5	77	(0)	266	55
56	WINDOW TREATMENTS	2003	24,200	2,788	5	4,840	2,052	16,940	56
57	LANDSCAPING	2003	16,500	1,100	15	1,100		3,667	57
58	ELECTRICAL WORK	2004	2,400	87	27.5	87	0	261	58
59	DOOR REPLACEMENT	2004	537	20	27.5	20	(0)	50	59
60	ROOF REPAIR	2004	6,900	251	27.5	251	(0)	627	60
61	DINING ROOM DOOR CONTROL UNIT	2004	1,317	48	27.5	48	(0)	120	61
62	FRONT DOOR CONTROL UNIT	2004	1,318	48	27.5	48	(0)	120	62
63	COVE BASE	2004	1,087	40	27.5	40	(0)	100	63
64	RESIDENT DOORS REFINISHED/INSTALLED	2004	5,500	200	27.5	200		500	64
65	WALLPAPER REMOVAL/INSTALL	2004	11,251	409	27.5	409	0	1,023	65
66	KICK PLATES	2004	2,453	89	27.5	89	0	223	66
67	WALL AC UNITS	2004	2,291	83	27.5	83	0	208	67
68	WALLPAPER REMOVAL/INSTALL	2004	10,928	397	27.5	397	0	993	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,173,311	\$ 163,408		\$ 166,627	\$ 3,219	\$ 1,327,299	70

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

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,173,311	\$ 163,408		\$ 166,627	\$ 3,219	\$ 1,327,299	1
2	WALL AC UNITS	2005	10,799	3,456	5	2,160	(1,296)	2,160	2
3	EXHAUST/VENTALATION REPAIRS	2005	24,873	904	27.5	904	0	1,356	3
4	LANDSCAPING RENOVATION	2005	2,800	187	15	187	(0)	280	4
5	RESIDENT DOOR REFINISHED/INSTALLED	2005	16,539	601	27.5	601	0	902	5
6	SIDEWALK INSTALLATION	2005	4,350	290	15	290		435	6
7	SMOKE DETECTOR UPGRADE/INSTALL	2005	3,250	118	27.5	118	0	177	7
8	ROOFTOP HEATING/COOLING UNITS	2006	15,903	263	27.5	289	26	289	8
9	NURSE CALL SYSTEM UPGRADE	2006	1,032	15	27.5	19	4	19	9
10	AUTOMATIC DOORS FOR LOBBY	2006	6,299	109	27.5	115	6	115	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,259,156	\$ 169,351		\$ 171,310	\$ 1,959	\$ 1,333,032	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 331,609	\$ 14,933	\$ 49,127	\$ 34,194	5-7	\$ 233,114	71
72	Current Year Purchases	18,107	3,621	362	(3,259)	5	362	72
73	Fully Depreciated Assets	125,423			0		125,423	73
74	related co alloc		19,734	19,734	0			74
75	TOTALS	\$ 475,139	\$ 38,288	\$ 69,223	\$ 30,935		\$ 358,899	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 7,056,295	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 207,639	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 240,533	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,894	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,691,932	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	<b>TOTAL</b>				\$ _____			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: \$ **54,423** 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			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	<b>TOTAL</b>		\$ _____	\$ _____	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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
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	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 146,065	\$		\$ 146,065	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			8,170			8,170	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			144,923			144,923	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				103,821		103,821	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/xray						5,413		5,413	13
14	<b>TOTAL</b>			\$		\$ 299,158	\$ 109,234		\$ 408,392	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 HEALTHCARE & REHAB

# 0032839

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	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>227,876</u> )	1,903,335		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,560		6
7	Other Prepaid Expenses	35,361		7
8	Accounts Receivable (owners or related parties)	(338,117)		8
9	Other(specify): <u>RE TAX ESCROW</u>	399,912		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,077,051	\$ 0	10
	<b>B. Long-Term Assets</b>			
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	785,157		15
16	Equipment, at Historical Cost	517,997		16
17	Accumulated Depreciation (book methods)	(684,851)		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): _____			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 618,303	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,695,354	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,045,012	\$	26
27	Officer's Accounts Payable	44,320		27
28	Accounts Payable-Patient Deposits	13,000		28
29	Short-Term Notes Payable	757,264		29
30	Accrued Salaries Payable	162,362		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,639		31
32	Accrued Real Estate Taxes(Sch.IX-B)	399,910		32
33	Accrued Interest Payable	12,873		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	_____			36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,458,380	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,458,380	\$ 0	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 236,974	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,695,354	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(48,249)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(48,249)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>285,223</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>285,223</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>236,974</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,690,554	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,690,554	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	377,659	6
7	Oxygen	3,408	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 381,067	8
	<b>C. Other Operating Revenue</b>		
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 12	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,071,633	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,096,179	31
32	Health Care	2,334,976	32
33	General Administration	1,696,590	33
	<b>B. Capital Expense</b>		
34	Ownership	1,149,533	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	408,392	35
36	Provider Participation Fee	100,740	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,786,410	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	285,223	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 285,223	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 HEALTHCARE & REHAB

# 0032839

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	2,032	2,080	\$ 73,081	\$ 35.14	1
2	Assistant Director of Nursing	1,576	1,656	43,777	26.44	2
3	Registered Nurses	336	416	10,317	24.80	3
4	Licensed Practical Nurses	30,270	31,046	774,510	24.95	4
5	CNAs & Orderlies	84,715	88,062	795,684	9.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,914	2,202	31,449	14.28	8
9	Activity Director	244	244	2,684	11.00	9
10	Activity Assistants	13,347	14,530	137,305	9.45	10
11	Social Service Workers	4,191	4,431	67,219	15.17	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	42,115	20.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,397	8,163	79,828	9.78	15
16	Dishwashers	10,319	11,379	95,403	8.38	16
17	Maintenance Workers	4,787	5,027	86,849	17.28	17
18	Housekeepers	16,246	17,386	176,638	10.16	18
19	Laundry	11,547	12,298	94,093	7.65	19
20	Administrator	1,960	2,080	82,022	39.43	20
21	Assistant Administrator	3,968	4,160	104,828	25.20	21
22	Other Administrative					22
23	Office Manager	4,224	4,416	73,083	16.55	23
24	Clerical	3,515	3,619	36,920	10.20	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	2,596	2,940	47,382	16.12	31
32	Other Health C: Care Plan Coord	1,614	1,622	27,341	16.86	32
33	Other(specify) <u>Marketing</u>	1,672	1,680	23,757	14.14	33
34	TOTAL (lines 1 - 33)	210,462	221,517	\$ 2,906,285 *	\$ 13.12	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	\$ 11,101	1-3	35
36	Medical Director	O	24,125	9-3	36
37	Medical Records Consultant	N	1,954	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,620	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		2,143	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	3,132	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 44,075		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,675	\$ 79,216	10-3	50
51	Licensed Practical Nurses	118	4,277	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	1,793	\$ 83,493		53





Facility Name &amp; ID Number GLENWOOD HEALTHCARE &amp; REHAB

# 0032839

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 100,740  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ 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