

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB

0032839 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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		Intermediate (ICF)			3
4	92	Intermediate/DD	92	33,580	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			3,880	3,880	8
9	SNF/PED					9
10	ICF	44,488	2,313	2,870	49,671	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,488	2,313	6,750	53,551	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.74%

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 9/1/1987

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/1/1987 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 3,880

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **GLENWOOD HEALTHCARE & REHAB** # **0032839** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	227,794	22,580	10,192	260,566		260,566		260,566		1
2	Food Purchase		230,831		230,831		230,831	(431)	230,400		2
3	Housekeeping	189,717	53,622		243,339		243,339		243,339		3
4	Laundry	93,969	33,870		127,839		127,839		127,839		4
5	Heat and Other Utilities			166,898	166,898		166,898	2,028	168,926		5
6	Maintenance	68,678	47,829	15,766	132,273		132,273		132,273		6
7	Other (specify):*			10,504	10,504		10,504		10,504		7
8	TOTAL General Services	580,158	388,732	203,360	1,172,250		1,172,250	1,597	1,173,847		8
	B. Health Care and Programs										
9	Medical Director			12,200	12,200		12,200		12,200		9
10	Nursing and Medical Records	2,014,933	177,769	138,143	2,330,845		2,330,845	55,771	2,386,616		10
10a	Therapy	33,941	4,467	12,404	50,812		50,812		50,812		10a
11	Activities	128,572	9,858		138,430		138,430		138,430		11
12	Social Services	71,674		5,810	77,484		77,484		77,484		12
13	CNA Training										13
14	Program Transportation			17,032	17,032		17,032		17,032		14
15	Other (specify):* nursing bene alloc							10,036	10,036		15
16	TOTAL Health Care and Programs	2,249,120	192,094	185,589	2,626,803		2,626,803	65,807	2,692,610		16
	C. General Administration										
17	Administrative	146,047		136,896	282,943		282,943	(72,521)	210,422		17
18	Directors Fees										18
19	Professional Services			130,912	130,912		130,912	(84,741)	46,171		19
20	Dues, Fees, Subscriptions & Promotions			53,833	53,833		53,833	(29,268)	24,565		20
21	Clerical & General Office Expenses	131,086	39,347	204,766	375,199		375,199	(5,109)	370,090		21
22	Employee Benefits & Payroll Taxes			511,110	511,110		511,110	29,065	540,175		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,533	10,533		10,533	8,307	18,840		24
25	Other Admin. Staff Transportation			267	267		267	19,361	19,628		25
26	Insurance-Prop.Liab.Malpractice			237,490	237,490		237,490	10,717	248,207		26
27	Other (specify):* admin bene alloc							11,584	11,584		27
28	TOTAL General Administration	277,133	39,347	1,285,807	1,602,287		1,602,287	(112,605)	1,489,682		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,106,411	620,173	1,674,756	5,401,340		5,401,340	(45,201)	5,356,139		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	9,407
	REPAIRS & MAINTENANCE	785
		0
		10,192
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	43,993
	ELECTRICITY	75,946
	WATER	44,401
	CABLE TV - LOBBY	2,558
		0
		166,898
6	MAINTENANCE	
	GROUNDS MAINTENANCE	8,708
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	3,117
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,685
	FIRE SERVICE	1,256
		0
		0
		0
		0
		15,766
7	OTHER	
	SCAVENGER	10,504
	SECURITY SERVICE	0
		0
		0
		10,504
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,200
		12,200

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	115,020
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	19,832
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,671
	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
		138,143
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	9,766
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	2,638
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		12,404
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	5,810
		0
		5,810
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	17,032
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	136,896
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	11,182
	ADMINISTRATIVE CONSULTANTS XIX C	44,892
	PROFESSIONAL FEES XIX C	74,838
		0
		130,912
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	24,346
	EMPLOYEE WANT ADS XIX F	12,329
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,575
	LICENSES & PERMITS XIX F	5,549
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	4,922
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,556
	PATIENT BACKGROUND CHECKS XIX F	2,556
		53,833
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	8
	OUTSIDE CLERICAL SERVICES	168,252
	PENALTIES / OVERDRAFT CHARGES VI 18	21,915
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	692
	TELEPHONE	11,657
	MESSENGER SERVICE/POSTAGE	2,242
		0
		204,766

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	242,065
	UNEMPLOYMENT COMPENSATION XIX D	65,573
	WORKERS COMPENSATION INSURANC XIX D	123,777
	HOSPITALIZATION INSURANCE XIX D	70,531
	EMPLOYEE BENEFITS - OTHER XIX D	1,576
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	7,588
	CHICAGO HEAD TAX XIX D	0
		0
		511,110
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	5,709
	TRAVEL XIX G	4,824
		10,533
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	267
		267
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	237,490
		237,490
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,674,756

**GLENWOOD HEALTHCARE & REHAB
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	230,831
LESS SALES TAX	<u>(431)</u>
NET FOOD	230,400

TOTAL PATIENT CENSUS	53,551
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	160,653

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	160,653
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	160,653

NET FOOD	230,400
DIVIDE TOTAL MEALS/YEAR	<u>160,653</u>

COST PER MEAL	1.43
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			49,843	49,843		49,843	153,230	203,073		30
31	Amortization of Pre-Op. & Org.							24,533	24,533		31
32	Interest			55,811	55,811		55,811	449,983	505,794		32
33	Real Estate Taxes			407,750	407,750		407,750		407,750		33
34	Rent-Facility & Grounds			482,435	482,435		482,435	(470,365)	12,070		34
35	Rent-Equipment & Vehicles			43,754	43,754		43,754		43,754		35
36	Other (specify):* STORAGE			1,192	1,192		1,192	84	1,276		36
37	TOTAL Ownership			1,040,785	1,040,785		1,040,785	157,465	1,198,250		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		121,821	305,145	426,966		426,966		426,966		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			100,740	100,740		100,740		100,740		42
43	Other (specify):*	77,212			77,212		77,212	(77,212)			43
44	TOTAL Special Cost Centers	77,212	121,821	405,885	604,918		604,918	(77,212)	527,706		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,183,623	741,994	3,121,426	7,047,043		7,047,043	35,052	7,082,095		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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF 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	7,842	30		9
10	Interest and Other Investment Income	(17)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(431)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(21,915)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(24,346)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,922)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (43,789)		\$	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)	200,735		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 200,735		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 156,946		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 HEALTHCARE & REHAB

ID# 0032839

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	LEGAL FEES	(44,682)	19	2
3	MARKETING SALARY	(77,212)	43	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	(121,894)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB# 0032839

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(431)	0	0	0	0	0	0	0	0	0	0	(431)	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	2,028	0	0	0	0	0	0	0	0	2,028	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(431)	0	2,028	0	1,597	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	55,771	0	0	0	0	0	0	0	0	55,771	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	10,036	0	0	0	0	0	0	0	0	10,036	15
16	TOTAL Health Care and Programs	0	0	65,807	0	65,807	16							
	C. General Administration													
17	Administrative	0	(136,896)	64,375	0	0	0	0	0	0	0	0	(72,521)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(44,682)	(44,892)	4,833	0	0	0	0	0	0	0	0	(84,741)	19
20	Fees, Subscriptions & Promotions	(29,268)	0	0	0	0	0	0	0	0	0	0	(29,268)	20
21	Clerical & General Office Expenses	(21,915)	(167,400)	184,206	0	0	0	0	0	0	0	0	(5,109)	21
22	Employee Benefits & Payroll Taxes	0	0	29,065	0	0	0	0	0	0	0	0	29,065	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,307	0	0	0	0	0	0	0	0	8,307	24
25	Other Admin. Staff Transportation	0	0	19,361	0	0	0	0	0	0	0	0	19,361	25
26	Insurance-Prop.Liab.Malpractice	0	0	10,717	0	0	0	0	0	0	0	0	10,717	26
27	Other (specify):*	0	0	11,584	0	0	0	0	0	0	0	0	11,584	27
28	TOTAL General Administration	(95,865)	(349,188)	332,448	0	(112,605)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(96,296)	(349,188)	400,283	0	(45,201)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	7,842	140,359	5,029	0	0	0	0	0	0	0	0	153,230	30
31	Amortization of Pre-Op. & Org.	0	24,533	0	0	0	0	0	0	0	0	0	24,533	31
32	Interest	(17)	450,000	0	0	0	0	0	0	0	0	0	449,983	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(482,435)	12,070	0	0	0	0	0	0	0	0	(470,365)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	84	0	0	0	0	0	0	0	0	84	36
37	TOTAL Ownership	7,825	132,457	17,183	0	157,465	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(77,212)	0	0	0	0	0	0	0	0	0	0	(77,212)	43
44	TOTAL Special Cost Centers	(77,212)	0	0	0	0	0	0	0	0	0	0	(77,212)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(165,683)	(216,731)	417,466	0	35,052	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BKKPG
					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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$ 136,896	CETIFIED HEALTH MANAGEMENT		\$	\$ (136,896)	1
2	V	21 BOOKKEEPING	168,252				(168,252)	2
3	V	19 ADMIN CONSULTING FEES	44,892				(44,892)	3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	482,435	GLENWOOD HEALTHCARE LLC			(482,435)	7
8	V	21 OFFICE EXPENSE				852	852	8
9	V	30 DEPRECIATION				140,359	140,359	9
10	V	31 AMORTIZATION				24,533	24,533	10
11	V	32 INTEREST				450,000	450,000	11
12	V							12
13	V							13
14	Total		\$ 832,475			\$ 615,744	\$ * (216,731)	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		" " "		2,028		16
17	V	6 MAINTENANCE		" " "		0		17
18	V	10 NURSING/MEDICAL RECORDS		" " "		55,771		18
19	V	15 NURSING BENEFITS		" " "		10,036		19
20	V	17 ADMIN SALARIES		" " "		64,375		20
21	V	19 PROFESSIONAL FEES		" " "		4,833		21
22	V	20 FEES, SUBSCRIPTIONS		" " "		0		22
23	V	21 OFFICE EXP		" " "		184,206		23
24	V	22 EMPLOYEE BENEFITS		" " "		29,065		24
25	V	24 TRAVEL/SEMINAR		" " "		8,307		25
26	V	25 TRANSPORTATION		" " "		19,361		26
27	V	26 INSURANCE		" " "		10,717		27
28	V	27 ADMIN BENEFITS		" " "		11,584		28
29	V	30 DEPRECIATION		" " "		5,029		29
30	V	32 INTEREST		" " "		0		30
31	V	34 OFFICE RENT		" " "		12,070		31
32	V	36 EQUIPMENT RENTAL		" " "		84		32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 417,466	\$ *	417,466 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: 01/01/2007 Ending: 12/31/2007

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			ALLOC SALA	\$ 61,896	17-7	1
2	HOWARD GELLER		ADMINISTRATION		SEE ATTACHED SCHEDULE			ALLOC FEES	15,000	17-7	2
3	HOWARD GELLER		ADMINISTRATION		SEE ATTACHED SCHEDULE			DIRECT FEES	60,000	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 136,896		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:

01/01/2007

Ending: 2/31/2007

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 CERTIFIED HEALTH MANAGEMENT
 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	3	HOUSEKEEPING	PER PATIENT DAY	4	\$ 0	\$	53,551	\$ 0	1
2	5	ELECTRIC/GAS	" " "	4	6,050		53,551	2,028	2
3	6	MAINTENANCE	" " "	4	0		53,551	0	3
4	10	NURSING/MEDICAL RECORDS	" " "	4	166,338	166,338	53,551	55,771	4
5	15	NURSING BENEFITS	" " "	4	29,933		53,551	10,036	5
6	17	ADMIN SALARIES	" " "	4	192,000	192,000	53,551	64,375	6
7	19	PROFESSIONAL FEES	" " "	4	14,414		53,551	4,833	7
8	20	FEES, SUBSCRIPTIONS	" " "	4	0		53,551	0	8
9	21	OFFICE EXP	" " "	4	549,397	481,726	53,551	184,206	9
10	22	EMPLOYEE BENEFITS	" " "	4	86,688		53,551	29,065	10
11	24	TRAVEL/SEMINAR	" " "	4	24,776		53,551	8,307	11
12	25	TRANSPORTATION	" " "	4	57,744		53,551	19,361	12
13	26	INSURANCE	" " "	4	31,963		53,551	10,717	13
14	27	ADMIN BENEFITS	" " "	4	34,551		53,551	11,584	14
15	30	DEPRECIATION	" " "	4	15,000		53,551	5,029	15
16	32	INTEREST	" " "	4	0		53,551	0	16
17	34	OFFICE RENT	" " "	4	36,000		53,551	12,070	17
18	36	EQUIPMENT RENTAL	" " "	4	250		53,551	84	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,245,104	\$ 840,064		\$ 417,466	25

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB

0032839

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 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

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	\$ 140,359	\$	1	\$ 140,359	1
2	31	AMORTIZATION		1	24,533		1	24,533	2
3	32	INTEREST		1	450,000		1	450,000	3
4	21	OFFICE EXPENSE		1	852		1	852	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				\$ 615,744	\$		\$ 615,744	25

Facility Name & ID Number

GLENWOOD HEALTHCARE & REHAB

0032839

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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							\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6	BANK FINANCIAL		X	WORKING CAPITAL							PRIME+	47,007						
7	INS FINANCING		X									8,804						
8																		
9	TOTAL Facility Related						\$	\$				\$ 55,811						
	B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES														
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$	\$				\$ 55,811						

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 2006 report.		\$	399,910	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.)		\$	196,035	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(203,875)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	611,625	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.		\$	407,750	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	430,062	8
	2003	376,473	9
	2004	380,219	10
	2005	392,071	11
	2006	392,071	12

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 2006 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>32-10-201-009-000</u>	<u>NURSING HOME</u>	\$ <u>392,071.00</u>	\$ <u>392,071.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 HEALTHCARE & REHAB

0032839

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>1999</u>	<u>\$ 322,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 322,000	3

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

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$	\$ 1,263,231	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		LEASEHOLD IMPROVEMENTS		1988	20,662	656	30	689	33	13,124	9
10		LEASEHOLD IMPROVEMENTS		1989	4,071	129	30	136	7	2,516	10
11		LEASEHOLD IMPROVEMENTS		1990	28,171	894	30	939	45	16,433	11
12		LEASEHOLD IMPROVEMENTS		1991	31,712	1,007	30	1,057	50	17,441	12
13		LEASEHOLD IMPROVEMENTS		1992	10,071	320	30	336	16	5,208	13
14		LEASEHOLD IMPROVEMENTS		1993	4,810	153	30	160	7	2,383	14
15		LEASEHOLD IMPROVEMENTS		1994	17,744	455	39	455	(0)	5,687	15
16		LIGHT FIXTURES, ROOM SIGNS, HAND RAILS		1995	6,343	163	39	163	(0)	2,253	16
17		HEATING/AIR CONDITIONING		1995	12,515	320	39	321	1	4,427	17
18		NURSING STATION		1995	10,384	266	39	266	0	3,580	18
19		SPRINKLER/LANUDRY VENTILATION REPAIR		1995	2,360	61	39	61	(0)	807	19
20		LAMPS, VIDEO CAMERA, PANIC DEVICE, WATER COOLER		1996	3,650	94	39	94	(0)	1,189	20
21		EXIT & OUTDOOR SIGNS		1996	4,237	109	39	109	(0)	1,354	21
22		WINDOWS, DOORS, CEILING TILES/CARPET		1996	25,090	643	39	643	0	7,847	22
23		HVAC WIRING REPAIR		1996	1,540	39	39	39	0	479	23
24		TIME CLOCKS,HEAT & COOL UNITS		1997	7,022	180	39	180	0	1,898	24
25		NURSE STATION		1997	5,615	144	39	144	(0)	1,518	25
26		FLOOR/CEILING TILES, COUNTER & CABINETS		1997	21,659	556	39	555	(1)	5,925	26
27		DOORS, LIGHTS, SIGHNS		1997	14,825	380	39	380	0	4,078	27
28		BURNERS & ELECTRICAL FOR WASHER		1997	1,964	50	39	50	0	527	28
29		SIGNS, PATIO SURFACE		1998	6,994	466	15	466	0	4,427	29
30		WINDOWS & INSTALLATION		1998	18,944	486	39	486	(0)	4,840	30
31		KITCHEN REMODEL		1998	50,500	1,295	39	1,295	(0)	12,898	31
32		ELECTRIC WORK		1998	7,545	193	39	193	0	1,842	32
33		CARPET, WALLPAPER, HANDRAIL, BUMPER GUARD		1998	79,382	2,036	39	2,035	(1)	18,847	33
34		GENERATOR		1999	56,533	1,450	39	1,450	(0)	12,991	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 & ID Number GLENWOOD HEALTHCARE & REHAB

0032839

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$ 3,212	37
38	VINYL FLOORING AND TILES	1999	5,505	141	39	141	0	1,193	38
39	ROOF AND TUCKPOINT	1999	59,360	1,522	39	1,522	0	12,748	39
40	AIR CONDITIONER/COMPRESSOR	2000	9,868		7	705	705	10,573	40
41	ROOF REPAIR	2000	3,750	136	27.5	136	0	1,060	41
42	VINYL TILE/COVE BASE	2000	19,277	701	27.5	701	(0)	5,394	42
43	ALARM WORK	2000	3,848	140	27.5	140	(0)	1,006	43
44	DRAPERIES	2001	1,750	64	27.5	64	(0)	440	44
45	ELECTRICAL WORK	2001	5,550	201	27.5	202	1	1,338	45
46	TILE	2002	13,079	476	27.5	476	(0)	2,559	46
47	TILE	2003	13,545	493	27.5	493	(0)	2,197	47
48	WALL AC UNITS	2003	1,246	45	27.5	45	0	201	48
49	WALL CASE FOR AC	2003	622	23	27.5	23	(0)	102	49
50	WALL CASE FOR AC	2003	631	23	27.5	23	(0)	103	50
51	WALL CASE FOR AC	2003	607	22	27.5	22	0	98	51
52	SHINGLES	2003	700	25	27.5	25	0	112	52
53	COVE BASE	2003	939	34	27.5	34	0	152	53
54	WALL AC UNITS	2003	1,223	44	27.5	44	0	196	54
55	WALL AC UNITS	2003	2,113	77	27.5	77	(0)	343	55
56	WINDOW TREATMENTS	2003	24,200	2,788	5	4,840	2,052	21,780	56
57	LANDSCAPING	2003	16,500	1,100	15	1,100		4,767	57
58	ELECTRICAL WORK	2004	2,400	87	27.5	87	0	348	58
59	DOOR REPLACEMENT	2004	537	20	27.5	20	(0)	70	59
60	ROOF REPAIR	2004	6,900	251	27.5	251	(0)	878	60
61	DINING ROOM DOOR CONTROL UNIT	2004	1,317	48	27.5	48	(0)	168	61
62	FRONT DOOR CONTROL UNIT	2004	1,318	48	27.5	48	(0)	168	62
63	COVE BASE	2004	1,087	40	27.5	40	(0)	140	63
64	RESIDENT DOORS REFINISHED/INSTALLED	2004	5,500	200	27.5	200		700	64
65	WALLPAPER REMOVAL/INSTALL	2004	11,251	409	27.5	409	0	1,432	65
66	KICK PLATES	2004	2,453	89	27.5	89	0	312	66
67	WALL AC UNITS	2004	2,291	83	27.5	83	0	291	67
68	WALLPAPER REMOVAL/INSTALL	2004	10,928	397	27.5	397	0	1,390	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,173,311	\$ 163,007		\$ 165,922	\$ 2,915	\$ 1,493,221	70

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

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB

0032839

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,173,311	\$ 163,007		\$ 165,922	\$ 2,915	\$ 1,493,221	1
2	WALL AC UNITS	2005	10,799	2,073	5	2,160	87	4,320	2
3	EXHAUST/VENTALATION REPAIRS	2005	24,873	904	27.5	904	0	2,260	3
4	LANDSCAPING RENOVATION	2005	2,800	187	15	187	(0)	467	4
5	RESIDENT DOOR REFINISHED/INSTALLED	2005	16,539	601	27.5	601	0	1,503	5
6	SIDEWALK INSTALLATION	2005	4,350	290	15	290		725	6
7	SMOKE DETECTOR UPGRADE/INSTALL	2005	3,250	118	27.5	118	0	295	7
8	ROOFTOP HEATING/COOLING UNITS	2006	15,903	578	27.5	578	0	867	8
9	NURSE CALL SYSTEM UPGRADE	2006	1,032	38	27.5	38	(0)	57	9
10	AUTOMATIC DOORS FOR LOBBY	2006	6,299	229	27.5	229	0	344	10
11	WALLCOVERING/BLINDS	2007	9,914	134	39	279	145	279	11
12	PAGING SYSTEM/PHONE LINES	2007	2,234	46	39	93	47	93	12
13	ASPHALT PKG LOT	2007	3,231	45	39	94	49	94	13
14	CIRCUIT BOARD/COOLING UNIT	2007	2,033	20	39	42	22	42	14
15	FENCE - FRONT OF BUILDING	2007	2,726	38	39	80	42	80	15
16	OVEN MOTOR	2007	1,181	14	39	30	16	30	16
17	ROOF REPAIR/REPL	2007	8,544	210	39	427	217	427	17
18	EXHAUST FAN SMK RM	2007	2,800	69	39	140	71	140	18
19	HEAT EXCHANGER ROOF TOP UNIT	2007	3,390	83	39	170	87	170	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	TOTAL (lines 1 thru 33)		\$ 6,295,209	\$ 168,684		\$ 172,383	\$ 3,699	\$ 1,505,415	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	\$ 349,716	\$ 18,067	\$ 24,133	\$ 6,066	5-7	\$ 257,609	71
72	Current Year Purchases	23,610	3,451	1,528	(1,923)	5	1,528	72
73	Fully Depreciated Assets	125,423					125,423	73
74			5,029	5,029				74
75	TOTALS	\$ 498,749	\$ 26,547	\$ 30,690	\$ 4,143		\$ 384,560	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 7,115,958	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 195,231	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 203,073	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,842	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,889,975	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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: \$ **43,754** 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	TOTAL		\$ _____	\$ _____	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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 133,312	\$		\$ 133,312	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,453			7,453	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			164,380			164,380	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				114,431		114,431	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/xrays						7,390		7,390	13
14	TOTAL			\$		\$ 305,145	\$ 121,821		\$ 426,966	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>123,657</u>)	1,289,303		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	100,348		6
7	Other Prepaid Expenses	142,682		7
8	Accounts Receivable (owners or related parties)	8,323		8
9	Other(specify): <u>r/e tax escrow</u>	532,725		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,073,381	\$	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	814,917		15
16	Equipment, at Historical Cost	541,606		16
17	Accumulated Depreciation (book methods)	(734,695)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 621,828	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,695,209	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 698,968	\$	26
27	Officer's Accounts Payable	44,320		27
28	Accounts Payable-Patient Deposits	13,000		28
29	Short-Term Notes Payable	1,030,979		29
30	Accrued Salaries Payable	213,882		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,101		31
32	Accrued Real Estate Taxes(Sch.IX-B)	611,625		32
33	Accrued Interest Payable	12,491		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)	\$ 2,646,366	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	238,216		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)	\$ 238,216	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,884,582	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (189,373)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,695,209	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 236,974	1
2	Restatements (describe):		2
3	bad debt adj		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 236,974	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(426,347)	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)	\$ (426,347)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (189,373)	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	\$ 6,301,586	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,301,586	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	366,687	6
7	Oxygen	9,000	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 375,687	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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17	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)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,677,290	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,172,250	31
32	Health Care	2,626,803	32
33	General Administration	1,602,287	33
	B. Capital Expense		
34	Ownership	1,040,785	34
	C. Ancillary Expense		
35	Special Cost Centers	504,178	35
36	Provider Participation Fee	100,740	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	56,594	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,103,637	40
41	Income before Income Taxes (line 30 minus line 40)**	(426,347)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (426,347)	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: 01/01/2007

Ending: 12/31/2007

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	1,958	2,080	\$ 75,157	\$ 36.13	1
2	Assistant Director of Nursing	607	615	15,357	24.97	2
3	Registered Nurses	480	480	14,418	30.04	3
4	Licensed Practical Nurses	37,849	38,743	1,012,318	26.13	4
5	CNAs & Orderlies	84,658	88,338	841,283	9.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,035	2,323	33,941	14.61	8
9	Activity Director	2,749	2,821	39,431	13.98	9
10	Activity Assistants	8,517	10,081	89,141	8.84	10
11	Social Service Workers	4,263	4,583	71,674	15.64	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,080	40,416	19.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,559	7,211	76,875	10.66	15
16	Dishwashers	11,264	12,245	110,503	9.02	16
17	Maintenance Workers	3,632	3,885	68,678	17.68	17
18	Housekeepers	17,934	19,330	189,717	9.81	18
19	Laundry	10,236	11,022	93,969	8.53	19
20	Administrator	2,056	2,080	67,116	32.27	20
21	Assistant Administrator	2,888	3,200	78,931	24.67	21
22	Other Administrative					22
23	Office Manager	3,837	4,160	86,926	20.90	23
24	Clerical	4,412	4,532	44,160	9.74	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	2,267	2,563	44,017	17.17	31
32	Other Health Care <u>care plan</u>	780	780	12,383	15.88	32
33	Other(specify) <u>marketing</u>	1,848	2,080	77,212	37.12	33
34	TOTAL (lines 1 - 33)	212,765	225,232	\$ 3,183,623 *	\$ 14.13	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	\$ 9,407	1-3	35
36	Medical Director	O	12,200	9-3	36
37	Medical Records Consultant	N	1,671	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	9,766	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		2,638	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	5,810	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 43,112		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,518	\$ 73,620	10-3	50
51	Licensed Practical Nurses	968	41,400	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	2,486	\$ 115,020		53

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB

0032839

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. _____
- (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 _____ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ 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? 100% of line
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 \$5,000, 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