



Facility Name & ID Number Oak Glen Home

# 0012252 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 N/A

	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	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	10,764	540	3,195	14,499	8	
9	SNF/PED					9	
10	ICF	36,588	10,743	368	47,699	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	47,352	11,283	3,563	62,198	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.55%

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

Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 09/01/1972

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 20 and days of care provided 3,195

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 11/30/2007 Fiscal Year: 11/30/2007

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

Facility Name & ID Number Oak Glen Home # 0012252 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
	<b>A. General Services</b>										
1	Dietary	552,701	55,812	17,315	625,828		625,828	625,828		1	
2	Food Purchase		437,412		437,412		437,412	437,412		2	
3	Housekeeping	271,606	33,861	3,780	309,247		309,247	309,247		3	
4	Laundry	208,733	44,449	465	253,647		253,647	253,647		4	
5	Heat and Other Utilities			258,341	258,341		258,341	258,341		5	
6	Maintenance	266,626	61,003	31,522	359,151		359,151	359,151		6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	1,299,666	632,537	311,423	2,243,626		2,243,626	2,243,626		8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			17,447	17,447		17,447	17,447		9	
10	Nursing and Medical Records	3,433,303	187,888	15,101	3,636,292		3,636,292	3,636,292		10	
10a	Therapy	149,089	4,361	468,081	621,531		621,531	621,531		10a	
11	Activities	161,811		803	162,614		162,614	162,614		11	
12	Social Services	88,787	5,976	675	95,438		95,438	95,438		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	3,832,990	198,225	502,107	4,533,322		4,533,322	4,533,322		16	
	<b>C. General Administration</b>										
17	Administrative	124,543			124,543		124,543	124,543		17	
18	Directors Fees							9,867	9,867	18	
19	Professional Services			683	683		683	381,793	382,476	19	
20	Dues, Fees, Subscriptions & Promotions			7,322	7,322		7,322	7,322	7,322	20	
21	Clerical & General Office Expenses	131,460	11,982	41,465	184,907		184,907	(7,275)	177,632	21	
22	Employee Benefits & Payroll Taxes			1,852,569	1,852,569		1,852,569	88,503	1,941,072	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			5,250	5,250		5,250	5,250	5,250	24	
25	Other Admin. Staff Transportation			2,822	2,822		2,822	2,822	2,822	25	
26	Insurance-Prop.Liab.Malpractice			186	186		186	186	186	26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	256,003	11,982	1,910,297	2,178,282		2,178,282	472,888	2,651,170	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,388,659	842,744	2,723,827	8,955,230		8,955,230	472,888	9,428,118	29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Oak Glen Home

#0012252

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			131,891	131,891		131,891	(65,799)	66,092			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							616	616			34
35	Rent-Equipment & Vehicles			75,385	75,385		75,385		75,385			35
36	Other (specify):* <b>Donated Goods</b>							5,564	5,564			36
37	<b>TOTAL Ownership</b>			207,276	207,276		207,276	(59,619)	147,657			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,343	621	135,964		135,964		135,964			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,138	134,138		134,138		134,138			42
43	Other (specify):* <b>Non-allowable Cos</b>		9,542	2,994,554	3,004,096		3,004,096	(3,004,096)				43
44	<b>TOTAL Special Cost Centers</b>		144,885	3,129,313	3,274,198		3,274,198	(3,004,096)	270,102			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,388,659	987,629	6,060,416	12,436,704		12,436,704	(2,590,827)	9,845,877			45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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	(65,799)	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				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,275)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(3,004,096)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (3,077,170)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*	5,564	36	32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	480,779	Vari	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 486,343		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,590,827)		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		x		45
46	Other-Attach Schedule		x		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Oak Glen Home

ID# 0012252

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs - Part A	\$ (9,455)	43	1
2	X-Rays - Part A	(1,280)	43	2
3	Offset Transfers to Other Funds	(2,983,819)	43	3
4	Marketing Expenses	(9,542)	43	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>	(3,004,096)		49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oak Glen Home# 0012252

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Services</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>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	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</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>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	9,867	0	0	0	0	0	0	0	0	0	9,867	18
19	Professional Services	0	381,793	0	0	0	0	0	0	0	0	0	381,793	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(7,275)	0	0	0	0	0	0	0	0	0	0	(7,275)	21
22	Employee Benefits & Payroll Taxes	0	88,503	0	0	0	0	0	0	0	0	0	88,503	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(7,275)</b>	<b>480,163</b>	<b>0</b>	<b>472,888</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(7,275)</b>	<b>480,163</b>	<b>0</b>	<b>472,888</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oak Glen Home

# 0012252

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(65,799)	0	0	0	0	0	0	0	0	0	0	(65,799)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	616	0	0	0	0	0	0	0	0	0	616	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	5,564	0	0	0	0	0	0	0	0	0	0	5,564	36
37	<b>TOTAL Ownership</b>	<b>(60,235)</b>	<b>616</b>	<b>0</b>	<b>(59,619)</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):*	(3,004,096)	0	0	0	0	0	0	0	0	0	0	(3,004,096)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(3,004,096)</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>(3,004,096)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(3,071,606)</b>	<b>480,779</b>	<b>0</b>	<b>(2,590,827)</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
Rock Island County	100	Oak Glen Home	Coal Valley	N/A		

**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	18 Welfare Committee	\$	Rock Island County	100.00%	\$ 9,867	\$ 9,867	1
2	V	19 Risk Management		Rock Island County	100.00%	196,573	196,573	2
3	V	19 General Management		Rock Island County	100.00%	11,728	11,728	3
4	V	19 Auditor		Rock Island County	100.00%	19,276	19,276	4
5	V	19 Purchasing		Rock Island County	100.00%	6,275	6,275	5
6	V	34 County Buildings		Rock Island County	100.00%	616	616	6
7	V	19 Information Systems		Rock Island County	100.00%	49,987	49,987	7
8	V	19 Treasurer		Rock Island County	100.00%	303	303	8
9	V	19 County Board		Rock Island County	100.00%	97,652	97,652	9
10	V	19 States Attorney/County Clerk		Rock Island County	100.00%	0		10
11	V	26 Property Insurance		Rock Island County	100.00%	0		11
12	V	22 Worker's Comp		Rock Island County	100.00%	56,913	56,913	12
13	V	22 Unemployment Comp		Rock Island County	100.00%	31,590	31,590	13
14	Total		\$			\$ 480,779	\$ *	480,779 14

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

Facility Name &amp; ID Number

Oak Glen Home

# 0012252

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	KAREN CALVILLO	CHAIR, NUR HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	\$ 1,619	18	1
2	STEVE BALLARD	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	810	18	2
3	JOHN BRANDMEYER	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	759	18	3
4	DON JACOBS	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,214	18	4
5	KEN MARANDA	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	2,429	18	5
6	STEVE MEERSMAN	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,518	18	6
7	HARRY PEREZ	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,518	18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,867		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home

# 0012252 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 ROCK ISLAND COUNTY  
 Street Address 11210 95TH STREET  
 City / State / Zip Code COAL VALLEY, IL 61240  
 Phone Number ( 309) 558-3585  
 Fax Number ( 309) 558-3516

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	18	Welfare Committee	Cost Allocation Study	100	\$ 9,867	\$	100	\$ 9,867	1
2	19	Risk Management	Cost Allocation Study	100	196,573		100	196,573	2
3	19	General Management	Cost Allocation Study	100	11,728		100	11,728	3
4	19	Auditor	Cost Allocation Study	100	19,276		100	19,276	4
5	19	Purchasing	Cost Allocation Study	100	6,275		100	6,275	5
6	34	County Buildings	Cost Allocation Study	100	616		100	616	6
7	19	Information Systems	Cost Allocation Study	100	49,987		100	49,987	7
8	19	Treasurer	Cost Allocation Study	100	303		100	303	8
9	19	County Board	Cost Allocation Study	100	97,652		100	97,652	9
10	19	States Attorney/County Clerk	Cost Allocation Study	100	0		100	0	10
11	26	Property Insurance	Cost Allocation Study	100	0		100	0	11
12	22	Worker's Comp	Actual Cost	100	56,913		100	56,913	12
13	22	Unemployment Comp	Actual Cost	100	31,590		100	31,590	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				\$ 480,779	\$		\$ 480,779	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home

# 0012252

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2	N/A																			
3																				
4																				
5																				
<b>Working Capital</b>																				
6																				
7																				
8																				
9	<b>TOTAL Facility Related</b>					\$	\$		\$											
<b>B. Non-Facility Related*</b>																				
10																				
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$											
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$											

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.     \$ None                      Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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.		\$	N/A	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.)	2006	\$		2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	8
	2003	9
	2004	10
	2005	11
	2006	12

County Facility

<b>FOR BHF USE ONLY</b>			
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:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Oak Glen Home COUNTY Rock Island County

FACILITY IDPH LICENSE NUMBER 0012252

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE (     ) FAX #: (     )

**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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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        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 Oak Glen Home

# 0012252

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 92,498 B. General Construction Type: Exterior Brick Frame Block & Brick Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>Acres 280</u>	<u>1917</u>	<u>\$ 18,526</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>280</b>		<b>\$ 18,526</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Oak Glen Home

# 0012252

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	245	1954	1954	\$ 436,798	\$		\$	\$	\$ 436,798	4
5		1966	1966	3,438					3,438	5
6		1967	1967	601,561					601,561	6
7		1969	1969	176,656					176,656	7
8		1972	1972	20,431					20,431	8
	<b>Improvement Type**</b>									
9	Water System		1969	174,960					174,960	9
10	Mutiple Improvements		1984	84,571		25	3,382	3,382	79,413	10
11	Reroof work project		1986	6,350		VARI			6,350	11
12	Caninet work & blacktop		1987	36,101		VARI	392	392	36,101	12
13	Remodeled front entrance		1989	22,670		25	907	907	16,399	13
14	Reroofing Job		1990	16,161		20	808	808	13,872	14
15	Handicap feat. added to elevator		1992	6,989		20	349	349	5,270	15
16	Install of firestorm roof system		1993	16,131		VARI	806	806	11,828	16
17	Chimney Repair & roof work		1995	59,404		VARI	2,970	2,970	36,854	17
18	Asbestos & Replacement Windows		1997	14,800		VARI	740	740	7,657	18
19	Roofing & painting water tower		1998	106,570		VARI	1,829	1,829	87,064	19
20	Driveway & Sidewalks		1999	22,375		8	2,331	2,331	22,375	20
21	Gutters and Boiler Stack		2003	58,868		VARI	5,342	5,342	23,904	21
22	New Roof on Boiler Room		2004	25,970		10	2,597	2,597	9,167	22
23	STAIR RAILING RENOVATION		2005	34,069		15	2,263	2,263	6,048	23
24	PELLA WINDOWS		2005	36,425		15	2,420	2,420	5,860	24
25	RENOVATION WORK FOR ALZHEIMERS WING		2005	186,657		15	12,504	12,504	28,059	25
26	Life Safety Work		2006	34,863		10	3,486	3,486	3,765	26
27	Smoke & Fire Dampers		2007	109,000		20	5,495	5,495	5,495	27
28										28
29										29
30										30
31	Cash Basis Expense for current year				131,891			(131,891)		31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	2,291,818	\$	131,891	\$	48,621	\$	(83,270)	\$	1,819,325	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oak Glen Home

# 0012252

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 101,604	\$	\$ 16,958	\$ 16,958	VARIOUS	\$ 85,521	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	314,882				VARIOUS	314,882	73
74								74
75	TOTALS	\$ 416,486	\$	\$ 16,958	\$ 16,958		\$ 400,403	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	Patient Care	Ford, Diesel Bus, 1994	1994	\$ 26,111	\$	\$	\$	5	\$ 26,111	76
77	Patient Care	Ford, Taurus, 2002	2002	15,400		513	513	5	15,400	77
78	Patient Care	Chevy, Lumina, 1996	1996	14,536				5		78
79	Patient Care	Carprice, Wagon 1993	1993	14,797				10		79
80	TOTALS			\$ 70,844	\$	\$ 513	\$ 513		\$ 41,511	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)	\$ 2,797,674	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 131,891	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,092	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (65,799)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,261,239	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	Non-Patient Care Vehicles	\$ 69,752	\$	\$ 69,752	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 69,752	\$	\$ 69,752	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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	County Buildings			616			6
7	TOTAL			\$ 616			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 \_\_\_\_\_.

N/A

N/A

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ 75,385 Description: Nursing Equip 70088 (Oxygen & Concentrator); Maintenance 5086; Soc Ser 60; Misc 151

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	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>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	L10A, C3	hrs	\$	2,704	\$ 196,010	\$	2,704	\$ 196,010	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,503	84,067		1,503	84,067	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C2&3	hrs		3,340	188,004	4,361	3,340	192,365	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				135,343		135,343	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Ambulance</u>	L39, C3				621			621	13
14	<b>TOTAL</b>			\$	7,547	\$ 468,702	\$ 139,704	7,547	\$ 608,406	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.

SEE ACCOUNTANTS' COMPILATION REPORT



Oak Glen Home  
Provider #: 0012252  
12/1/2006 to 11/30/2007

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
Other Current Liabilities - Line 36		
Due to Other Funds	257,282	257,282
Due to Other Gov't. Units	298,940	298,940
Unclaimed Voucher Checks	2,911	2,911
Unclaimed Payroll Checks	123	123
	<u>559,256</u>	<u>559,256</u>

SEE ACCOUNTANTS' COMPILATION REPORT

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,689,753</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Prior Year Adjustment</b>	<b>(289,686)</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>1,400,067</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>941,364</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>941,364</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>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,341,431</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 11,134,156	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,134,156	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	232,016	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 232,016	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	2,092	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	25,648	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	17,935	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,071	21
22	Laundry	10,973	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 67,719	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	86,369	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 86,369	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>See Sch 19A</u>	1,857,808	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,857,808	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,378,068	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,243,626	31
32	Health Care	4,533,322	32
33	General Administration	2,178,282	33
	<b>B. Capital Expense</b>		
34	Ownership	207,276	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	3,140,060	35
36	Provider Participation Fee	134,138	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,436,704	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	941,364	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 941,364	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. Combined filing with County

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

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

**Champaign County Nursing Home**

**Provider #: 0001636**

**12/1/2006 to 11/30/2007**

**Schedule 19A**

XVII. Income Statement

Line 28 Other Income(specify):

<u>Description</u>	<u>Amount</u>
Transfer from Nursing Home	1,855,717
Sales of Junk or Salvage	32
Farm Tax Revenue	2,059
Total - Line 28	<u><u>1,857,808</u></u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Oak Glen Home

# 0012252

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	1,548	1,768	\$ 39,847	\$ 22.54	1
2	Assistant Director of Nursing	1,784	2,226	53,758	24.15	2
3	Registered Nurses	14,353	16,272	360,777	22.17	3
4	Licensed Practical Nurses	55,678	64,010	1,115,609	17.43	4
5	CNAs & Orderlies	135,323	150,790	1,813,473	12.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,205	8,706	149,089	17.12	8
9	Activity Director	1,768	2,213	46,527	21.02	9
10	Activity Assistants	7,642	8,937	115,284	12.90	10
11	Social Service Workers	4,946	5,792	88,787	15.33	11
12	Dietician					12
13	Food Service Supervisor	3,290	4,217	72,579	17.21	13
14	Head Cook	8,077	9,214	128,556	13.95	14
15	Cook Helpers/Assistants	28,231	32,071	351,566	10.96	15
16	Dishwashers					16
17	Maintenance Workers	11,745	14,267	266,626	18.69	17
18	Housekeepers	15,953	20,151	271,606	13.48	18
19	Laundry	14,650	17,208	208,733	12.13	19
20	Administrator	1,795	2,179	68,590	31.48	20
21	Assistant Administrator	1,608	2,131	55,953	26.26	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,769	9,850	131,460	13.35	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	3,112	3,635	49,839	13.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	327,477	375,637	\$ 5,388,659 *	\$ 14.35	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	441	\$ 15,409	L1 C3	35
36	Medical Director	12 Months	17,447	L9 C5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12 Months	1,140	L10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	803	L12 C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	454	\$ 34,799		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Trudy Whittington	Administrator		\$ 68,590	Workers' Compensation Insurance	\$ 56,913	IDPH License Fee	\$ 1,990	
Sheryl Thomas	Asst. Administrator		55,953	Unemployment Compensation Insurance	31,590	Advertising: Employee Recruitment		
				FICA Taxes	397,770	Health Care Worker Background Check		
				Employee Health Insurance	970,497	(Indicate # of checks performed 40 )	475	
				Employee Meals		Patient Background Checks	142 1,700	
				Illinois Municipal Retirement Fund (IMRF)*	459,580	CHNA Dues	1,810	
				Work Fitness	3,909	Subscriptions, Dues, & Fees	1,347	
				Other Benefits	20,813			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 124,543	TOTAL (agree to Schedule V, line 22, col.8)		\$ 7,322		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	5,250
							See attached schedule	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Entertainment Expense	( )
C. Professional Services							(agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount				TOTAL	\$ 5,250
Ramirez Consulting	Consulting		\$ 683					
See Sch 21A								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 683					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Oak Glen Home**

**Provider #: 0012252**  
**12/1/2006 to 11/30/2007**

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Brought forward from page 21 683

Vendor

Type

Total agreeing to Schedule V, Line 19, Col 3 683

County Allocated Expenses (See Page 8)

Risk Management 196,573

General Management 11,728

Auditor 19,276

Purchasing 6,275

Information Systems 49,987

Treasurer 303

County Board 97,652

Total (agree to Schedule V, line 19, column 8) 382,476

**SEE ACCOUNTANTS' COMPILATION REPORT**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A						N/A					
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home# 0012252Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? 1680  
If YES, give association name and amount. COUNTY NURSING HOME ASSOC - 1810
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,224 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 134,138  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audited Statements not issued yet
- (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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees