

		FOR BHF USE				

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 0043935

**Facility Name:** WOOD GLEN NURSING & REHAB CTR

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

**County:** DUPAGE

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

**HFS ID Number:** 364223866001

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

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>DARRYL BUEKER, CPA</u>	
	(Firm Name & Address) <u>BKD, LLP</u> <u>P, O. BOX 1190, SPRINGFIELD, MO 65801-1190</u>	
	(Telephone) <u>( 417 ) 865-8701</u> Fax # <u>(417) 865-0682</u>	

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR# 0043935 Report Period Beginning: 1/1/07 Ending: 12/31/07

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>207</u>	Skilled (SNF)	<u>207</u>	<u>75,555</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>207</u>	TOTALS	<u>207</u>	<u>75,555</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>68,851</u>		<u>1,468</u>	<u>70,319</u>	8
9	SNF/PED					9
10	ICF		<u>2,904</u>		<u>2,904</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>68,851</u>	<u>2,904</u>	<u>1,468</u>	<u>73,223</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.91%

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

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

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

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

N/AF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 2/12/95

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

YES  Date 1994 NO 

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

YES  NO  If YES, enter number of beds certified 207 and days of care provided 1,426Medicare Intermediary ADMINISTAR FEDERAL

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR** # **0043935** Report Period Beginning: **1/1/07** Ending: **12/31/07**

**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	271,127	22,863	8,280	302,270		302,270		302,270		1
2	Food Purchase		361,506		361,506		361,506	(1,288)	360,218		2
3	Housekeeping	341,455	44,749		386,204		386,204		386,204		3
4	Laundry	514	49,435		49,949		49,949		49,949		4
5	Heat and Other Utilities			321,039	321,039		321,039	7,983	329,022		5
6	Maintenance	104,979		94,351	199,330		199,330	8,301	207,631		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>718,075</b>	<b>478,553</b>	<b>423,670</b>	<b>1,620,298</b>		<b>1,620,298</b>	<b>14,996</b>	<b>1,635,294</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			38,500	38,500		38,500		38,500		9
10	Nursing and Medical Records	2,055,513	69,442	11,993	2,136,948		2,136,948		2,136,948		10
10a	Therapy	123,950		2,459	126,409		126,409		126,409		10a
11	Activities	109,156	36,025	1,945	147,126		147,126		147,126		11
12	Social Services	371,177		336	371,513		371,513		371,513		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,659,796</b>	<b>105,467</b>	<b>55,233</b>	<b>2,820,496</b>		<b>2,820,496</b>		<b>2,820,496</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	219,241		624,000	843,241		843,241	(113,939)	729,302		17
18	Directors Fees										18
19	Professional Services			77,276	77,276		77,276	8,434	85,710		19
20	Dues, Fees, Subscriptions & Promotions			27,650	27,650		27,650	(11,938)	15,712		20
21	Clerical & General Office Expenses	312,771	14,537	85,342	412,650		412,650	63,130	475,780		21
22	Employee Benefits & Payroll Taxes			552,147	552,147		552,147		552,147		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,207	3,207		3,207		3,207		24
25	Other Admin. Staff Transportation			20,796	20,796		20,796	16,475	37,271		25
26	Insurance-Prop.Liab.Malpractice			165,624	165,624		165,624	1,153	166,777		26
27	Other (specify):*							32,655	32,655		27
28	<b>TOTAL General Administration</b>	<b>532,012</b>	<b>14,537</b>	<b>1,556,042</b>	<b>2,102,591</b>		<b>2,102,591</b>	<b>(4,030)</b>	<b>2,098,561</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,909,883</b>	<b>598,557</b>	<b>2,034,945</b>	<b>6,543,385</b>		<b>6,543,385</b>	<b>10,966</b>	<b>6,554,351</b>		<b>29</b>

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

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR #0043935 Report Period Beginning: 1/1/07 Ending: 12/31/07

## 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			53,156	53,156	53,156	134,774	187,930			30
31	Amortization of Pre-Op. & Org.						205	205			31
32	Interest			16,931	16,931	16,931	267,368	284,299			32
33	Real Estate Taxes			230,113	230,113	230,113		230,113			33
34	Rent-Facility & Grounds			1,132,084	1,132,084	1,132,084	(1,132,084)				34
35	Rent-Equipment & Vehicles			34,692	34,692	34,692	1,023	35,715			35
36	Other (specify):*						3,759	3,759			36
37	<b>TOTAL Ownership</b>			1,466,976	1,466,976	1,466,976	(724,955)	742,021			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			58,833	58,833	58,833		58,833			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			113,643	113,643	113,643		113,643			42
43	Other (specify):*						(133,229)	(133,229)			43
44	<b>TOTAL Special Cost Centers</b>			172,476	172,476	172,476	(133,229)	39,247			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,909,883	598,557	3,674,397	8,182,837	8,182,837	(847,218)	7,335,619			45

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

# 0043935

Report Period Beginning: 1/1/07

Ending: 12/31/07

**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				9
10	Interest and Other Investment Income	(25)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	2		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	(17,763)	21		18
19	Entertainment				19
20	Contributions	(10,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,885)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,823)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(103,315)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (144,321)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(702,897)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (702,897)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (847,218)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

**WOOD GLEN NURSING & REHAB CTR**

ID# 0043935

Report Period Beginning: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	BANK FEES	\$ (12,352)	21	1
2	TAXES - GENERAL	(385)	21	2
3	DAMAGE/THEFT/LOSS	0	21	3
4	IL COUNCIL LTC-COPE	(2,526)	20	4
5	MARKETING SALARIES	(87,990)	43	5
6	MARKETING EMPLOYEE BENEFITS	(12,426)	43	6
7	MISCELLANEOUS INCOME	(1,278)	2	7
8	MISCELLANEOUS INCOME	(255)	21	8
9	MISCELLANEOUS INCOME--SS SAL REIMB	(26,250)	43	9
10	MISCELLANEOUS INCOME-SS EB REIMB	(6,563)	43	10
11	ADJ TO S/L DEPR	49,693	30	11
12	REAL ESTATE TAXES	(2,983)	33	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>	(103,315)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,288)	0	0	0	0	0	0	0	0	0	0	(1,288)	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	7,983	0	0	0	0	0	0	0	0	7,983	5
6	Maintenance	0	0	8,301	0	0	0	0	0	0	0	0	8,301	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,288)</b>	<b>0</b>	<b>16,284</b>	<b>0</b>	<b>14,996</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	(113,939)	0	0	0	0	0	0	0	0	(113,939)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	8,434	0	0	0	0	0	0	0	0	8,434	19
20	Fees, Subscriptions & Promotions	(12,411)	0	473	0	0	0	0	0	0	0	0	(11,938)	20
21	Clerical & General Office Expenses	(44,078)	2,000	105,208	0	0	0	0	0	0	0	0	63,130	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	16,475	0	0	0	0	0	0	0	0	16,475	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,153	0	0	0	0	0	0	0	0	1,153	26
27	Other (specify):*	0	0	32,655	0	0	0	0	0	0	0	0	32,655	27
28	<b>TOTAL General Administration</b>	<b>(56,489)</b>	<b>2,000</b>	<b>50,459</b>	<b>0</b>	<b>(4,030)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(57,777)</b>	<b>2,000</b>	<b>66,743</b>	<b>0</b>	<b>10,966</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/07 Ending: 12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	49,693	80,920	4,161	0	0	0	0	0	0	0	0	134,774	30
31	Amortization of Pre-Op. & Org.	0	0	205	0	0	0	0	0	0	0	0	205	31
32	Interest	(25)	262,116	5,277	0	0	0	0	0	0	0	0	267,368	32
33	Real Estate Taxes	(2,983)	0	2,983	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,132,084)	0	0	0	0	0	0	0	0	0	(1,132,084)	34
35	Rent-Equipment & Vehicles	0	0	1,023	0	0	0	0	0	0	0	0	1,023	35
36	Other (specify):*	0	3,759	0	0	0	0	0	0	0	0	0	3,759	36
37	<b>TOTAL Ownership</b>	<b>46,685</b>	<b>(785,289)</b>	<b>13,649</b>	<b>0</b>	<b>(724,955)</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):*	(133,229)	0	0	0	0	0	0	0	0	0	0	(133,229)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(133,229)</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>(133,229)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(144,321)</b>	<b>(783,289)</b>	<b>80,392</b>	<b>0</b>	<b>(847,218)</b>	<b>45</b>							

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

# 0043935

Report Period Beginning:

1/1/07

Ending:

12/31/07

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENTAL INCOME	\$ 1,132,084	WOOD GLEN PAVILION REALTY, LLC		\$	\$ (1,132,084)	1
2	V	21 ADMINISTRATIVE EXPENSES		WOOD GLEN PAVILION REALTY, LLC		2,000	2,000	2
3	V	30 DEPRECIATION		WOOD GLEN PAVILION REALTY, LLC		80,920	80,920	3
4	V	32 INTEREST		WOOD GLEN PAVILION REALTY, LLC		262,116	262,116	4
5	V	36 AMORTIZATION-LOAN COSTS		WOOD GLEN PAVILION REALTY, LLC		3,759	3,759	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,132,084			\$ 348,795	\$ * (783,289)	14

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR# 0043935Report Period Beginning: 1/1/07Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Home Office	\$ 144,000	Platinum Health Care, LLC	100.00%	\$	(144,000)	15
16	V	5 Utilities		Platinum Health Care, LLC		7,983	7,983	16
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		8,301	8,301	17
18	V	17 Administrative Salary		Platinum Health Care, LLC		30,061	30,061	18
19	V	19 Professional Fees		Platinum Health Care, LLC		8,434	8,434	19
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		473	473	20
21	V	21 Clerical Salaries		Platinum Health Care, LLC		88,536	88,536	21
22	V	21 Office Expenses		Platinum Health Care, LLC		16,672	16,672	22
23	V	25 Travel		Platinum Health Care, LLC		16,475	16,475	23
24	V	26 Insurance		Platinum Health Care, LLC		1,153	1,153	24
25	V	27 Employee Benefits		Platinum Health Care, LLC		32,655	32,655	25
26	V	30 Depreciation		Platinum Health Care, LLC		1,138	1,138	26
27	V	35 Equipment Rental		Platinum Health Care, LLC		1,023	1,023	27
28	V	31 Amortization		Platinum Health Care, LLC		205	205	28
29	V	30 Depreciation		Platinum Health Care, LLC		3,023	3,023	29
30	V	32 Interest		Platinum Health Care, LLC		5,277	5,277	30
31	V	33 Real Estate Taxes		Platinum Health Care, LLC		2,983	2,983	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 144,000			\$ 224,392	\$ * 80,392	39

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/07 Ending: 12/31/07

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ben Klein	Owner	Administrative	70.10	See Attached	1	2.50	Mgmt fees	\$ 480,000	17-03	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 480,000		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/07 Ending: 12/31/07

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 Platinum Health Care, LLC  
 Street Address 7444 Long Ave.  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number ( 847 ) 329-4100  
 Fax Number ( 847 ) 329-7652

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	5	Utilities	Patient Days	445,050	11	\$ 48,520	\$ 73,223	\$ 7,983	1
2	6	Repairs & Maintenance	Patient Days	445,050	11	50,451	73,223	8,301	2
3	17	Administrative Salary	Patient Days	445,050	11	182,711	182,711	30,061	3
4	19	Professional Fees	Patient Days	445,050	11	51,264	73,223	8,434	4
5	20	Fees, Subscriptions	Patient Days	445,050	11	2,875	73,223	473	5
6	21	Clerical Salaries	Patient Days	445,050	11	538,120	538,120	88,536	6
7	21	Office Expenses	Patient Days	445,050	11	101,335	73,223	16,672	7
8	25	Travel	Patient Days	445,050	11	100,136	73,223	16,475	8
9	26	Insurance	Patient Days	445,050	11	7,006	73,223	1,153	9
10	27	Employee Benefits	Patient Days	445,050	11	198,477	73,223	32,655	10
11	30	Depreciation	Patient Days	445,050	11	6,916	73,223	1,138	11
12	35	Equipment Rental	Patient Days	445,050	11	6,218	73,223	1,023	12
13	31	Amortization	Patient Days	445,050	11	1,246	73,223	205	13
14	30	Depreciation	Patient Days	445,050	11	18,376	73,223	3,023	14
15	32	Interest	Patient Days	445,050	11	32,071	73,223	5,277	15
16	33	Real Estate Taxes	Patient Days	445,050	11	18,130	73,223	2,983	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,363,852	\$ 720,831		\$ 224,392	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1			Mortgage			\$	\$			\$ 262,116	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	LaSalle Bank		X	Line of Credit						16,931	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>					\$	\$			\$ 279,047	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(25)	10									
11											11									
12											12									
13	Allocation from Platinum									5,277	13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ 5,252	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 284,299	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 3,761 Line # 32

\* 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.)

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

# **0043935** Report Period Beginning: **1/1/07**

Ending: **12/31/07**

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2006 report.		\$ <b>180,000</b>	<b>1</b>																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <b>200,113</b>	<b>2</b>																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>20,113</b>	<b>3</b>																																	
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>210,000</b>	<b>4</b>																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>5</b>																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>6</b>																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>230,113</b>	<b>7</b>																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2002</td><td><b>161,874</b></td><td><b>8</b></td></tr> <tr><td>2003</td><td><b>156,080</b></td><td><b>9</b></td></tr> <tr><td>2004</td><td><b>172,300</b></td><td><b>10</b></td></tr> <tr><td>2005</td><td><b>190,000</b></td><td><b>11</b></td></tr> <tr><td>2006</td><td><b>200,113</b></td><td><b>12</b></td></tr> </table>	2002	<b>161,874</b>	<b>8</b>	2003	<b>156,080</b>	<b>9</b>	2004	<b>172,300</b>	<b>10</b>	2005	<b>190,000</b>	<b>11</b>	2006	<b>200,113</b>	<b>12</b>	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td><b>13</b></td><td>FROM R. E. TAX STATEMENT FOR 2006</td><td>\$</td><td><b>13</b></td></tr> <tr><td><b>14</b></td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td><b>14</b></td></tr> <tr><td><b>15</b></td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td><b>15</b></td></tr> <tr><td><b>16</b></td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td><b>16</b></td></tr> </table>	<b>FOR BHF USE ONLY</b>			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>
2002	<b>161,874</b>	<b>8</b>																																		
2003	<b>156,080</b>	<b>9</b>																																		
2004	<b>172,300</b>	<b>10</b>																																		
2005	<b>190,000</b>	<b>11</b>																																		
2006	<b>200,113</b>	<b>12</b>																																		
<b>FOR BHF USE ONLY</b>																																				
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>																																	
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>																																	
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>																																	
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>																																	

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 WOOD GLEN NURSING & REHAB CTR COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0043935

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE ( 417 ) 865-8701 FAX #: ( 417 ) 865-0682

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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>01-28-401-085</u>	<u>Long Term Care</u>	\$ <u>200,113.08</u>	\$ <u>200,113.08</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>200,113.08</u>	\$ <u>200,113.08</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 WOOD GLEN NURSING & REHAB CTR

# 0043935 Report Period Beginning:

1/1/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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

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

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1994	\$ 465,000	1
2					2
3	TOTALS			\$ 465,000	3

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

# 0043935

Report Period Beginning:

1/1/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1995	1995	\$ 3,067,125	\$	35	\$ 87,632	\$ 87,632	\$ 1,050,387	4
5				1995	2,765,738	212,104			(212,104)		5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		FENCE		1998	5,042		15	336	336	3,579	9
10		FIRE ALARM		2002	44,058		20	2,203	2,203	30,401	10
11		BLDG IMP-REHAB-ENVIRONMENTAL		1995	3,089		20	154	154	475	11
12		BLDG IMP-REHAB-ROOFING		1995	4,450		20	223	223	688	12
13		BLDG IMP-REHAB-TILES		1996	4,644		20	232	232	715	13
14		BLDG IMP-REHAB-DESIGN TECHS		1996	2,600		20	130	130	401	14
15		BLDG IMP-REHAB-PT ROOM		1997	18,496		20	925	925	2,852	15
16		BLDG IMP-REHAB-TILES ON 3RD FLOOR		1998	15,000		20	750	750	2,313	16
17		BLDG IMP-REHAB-FENCE		1999	7,180		20	359	359	1,107	17
18											18
19											19
20											20
21											21
22		EQUIPMENT		2005	704,614		5				22
23		FURNITURE		2005	411,185		5				23
24		SITE IMPROVEMENTS		2005	16,179		15				24
25		ASPHALT PAVING		2005	214,968		15				25
26		CURB/SIDEWALKS		2005	74,438		15				26
27		SITE UTILITIES		2005	117,694		15				27
28		SITE LIGHTING		2005	35,271		15				28
29		SECURITY FENCES		2005	7,158		15				29
30		FLAGPOLES/SIGNS		2005	7,206		15				30
31		LANDSCAPING/IRRIGATION		2005	201,780		15				31
32		RETAINING WALLS		2005	38,915		15				32
33						486,553			(486,553)		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

Facility Name &amp; ID Number WOOD GLEN NURSING &amp; REHAB CTR

# 0043935

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	1995	\$ 25,326	\$	20	\$ 1,266	\$ 1,266	\$ 15,938	37
38	Various	1996	16,672		20	834	834	9,381	38
39	Various	1997	20,310		20	1,016	1,016	10,704	39
40	Various	1998	22,766		20	1,138	1,138	12,910	40
41									41
42	LOBBY IMPROVEMENTS	1999	3,750		20	188	188	1,532	42
43	WATER HEATER	1999	4,100		20	205	205	1,671	43
44	CONTRACTOR	1999	919		20	46	46	391	44
45	PUMP	1999	1,887		20	94	94	758	45
46	MATV SYSTEM	1999	752		20	38	38	304	46
47	PRESSURE SWITCH	1999	1,341		20	67	67	536	47
48	BOILER	1999	1,964		20	98	98	784	48
49	AIR CONDITIONER	1999	612		20	31	31	248	49
50	SMOKE DETECTOR	1999	3,118		20	156	156	1,248	50
51	FIRE ALARM SYSTEM	1999	693		20	35	35	379	51
52	2 WATER HEATERS	2000	8,400		20	420	420	3,290	52
53	FLOORING	2000	1,284		20	64	64	469	53
54	CARPET	2000	1,284		20	64	64	464	54
55	FLOORING	2000	3,740		20	187	187	1,356	55
56	CARPET	2000	5,225		20	261	261	1,849	56
57	FIXTURES	2000	31,000		20	1,550	1,550	11,238	57
58	FLUID PUMP	2000	2,429		20	121	121	928	58
59	FLUID PUMP	2000	905		20	45	45	345	59
60	FLUID PUMP SVC	2000	2,412		20	121	121	907	60
61	WATER LINES & DRAIN	2001	3,870		39	99	99	689	61
62	BURNER PILOT & PARTS	2001	1,593		39	41	41	285	62
63	4 DUPLEX OUTLETS	2001	2,275		39	58	58	404	63
64	WATER HEATER PIPING	2001	8,997		39	231	231	1,569	64
65	FLUES - WATER BOILER	2001	3,580		39	92	92	587	65
66	BRICK WALL	2001	4,515		39	116	116	720	66
67	EXPANSION MODULE	2001	947		20	47	47	309	67
68	CABLES	2001	1,031		20	52	52	316	68
69	CABLE WORK	2001	767		20	38	38	231	69
70	TOTAL (lines 4 thru 69)		\$ 7,955,294	\$ 698,657		\$ 101,763	\$ (596,894)	\$ 1,175,657	70

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

Facility Name &amp; ID Number WOOD GLEN NURSING &amp; REHAB CTR

# 0043935

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 7,955,294	\$ 698,657		\$ 101,763	\$ (596,894)	\$ 1,175,657	1
2	PHONES/CABLES	2001	544		20	27	27	189	2
3	LIGHTING	2001	1,022		20	51	51	310	3
4	LAMPS	2001	742		20	37	37	234	4
5	FIRE PUMP WORK	2001	750		20	38	38	231	5
6	HEATING/COOLING WORK	2001	649		20	32	32	195	6
7	LIGHTING	2001	903		20	45	45	281	7
8	MOTOR	2001	547		20	27	27	185	8
9	LIGHTING ENHANCEMENT	2001	903		20	45	45	296	9
10	REFRIGERATOR WORK	2001	1,044		20	52	52	325	10
11	PIPE WORK	2001	500		20	25	25	156	11
12	CONCRETE ANCHOR	2001	5,332		20	267	267	1,758	12
13	REFRIGERATOR WORK	2001	532		20	27	27	176	13
14	REFRIGERATOR WORK	2001	585		20	29	29	184	14
15	LIGHTING	2001	903		20	45	45	315	15
16	LIGHTING	2001	903		20	45	45	311	16
17	LIGHTING	2001	903		20	45	45	308	17
18	LIGHTING	2001	903		20	45	45	304	18
19	LIGHTING	2001	903		20	45	45	300	19
20	PUMP	2001	571		20	29	29	176	20
21	HEAT PUMP MOTOR	2001	1,409		20	70	70	432	21
22	PLUMBING	2001	1,038		20	52	52	364	22
23	PATIO	2002	2,250		10	225	225	1,256	23
24	A/C REPAIR	2002	3,529		10	353	353	1,971	24
25	A/C REPAIR	2002	1,305		10	131	131	720	25
26	A/C REPAIR	2002	1,240		10	124	124	672	26
27	A/C REPAIR	2002	888		10	89	89	460	27
28	A/C REPAIR	2002	846		10	85	85	432	28
29	A/C REPAIR	2002	664		10	66	66	363	29
30	WATER HEATERS	2002	1,700		10	170	170	949	30
31	WATER HEATERS	2002	2,460		10	246	246	1,374	31
32	FREEZER REPAIR	2002	587		20	29	29	174	32
33	FIRE PUMP WORK	2002	750		20	38	38	228	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,993,099	\$ 698,657		\$ 104,397	\$ (594,260)	\$ 1,191,286	34

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

Facility Name &amp; ID Number WOOD GLEN NURSING &amp; REHAB CTR

# 0043935

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 7,993,099	\$ 698,657		\$ 104,397	\$ (594,260)	\$ 1,191,286	1
2	SERVICE PUMP	2002	540		20	27	27	162	2
3	ELECTRICAL SYSTEM	2002	528		20	26	26	156	3
4	PIPE WORK	2002	1,213		20	61	61	366	4
5	LIGHTING ENHANCEMENT	2002	12,442		20	622	622	3,732	5
6	MAIN ENTRANCE CAMERA	2003	13,445		5	2,689	2,689	13,221	6
7	PROXIMITY READERS	2003	2,074		5	415	415	2,040	7
8	PROXIMITY READERS/SMART	2003	3,805		5	761	761	3,742	8
9	WALL DECORATION	2003	1,063		5	213	213	1,011	9
10	KITCHEN WORK	2003	1,454		10	145	145	701	10
11	CI RANG STEAM	2003	869		10	87	87	370	11
12	CI RANG STEAM	2003	2,289		10	229	229	973	12
13	DRAPES	2003	2,525		5	505	505	2,525	13
14	FROZEN COIL IN AIR HANDLER	2004	3,819		10	382	382	1,528	14
15	WATER HEATER	2004	8,714		10	871	871	3,339	15
16	INSTALL NEW COIL	2004	3,800		10	380	380	1,393	16
17	CONDENSING UNIT	2004	4,200		15	280	280	980	17
18	PLUMBING-DIALYSIS ROOM	2004	5,390		20	270	270	945	18
19	WATER HEATER	2004	6,748		10	675	675	2,362	19
20	SERVICE PUMP	2004	7,565		20	378	378	1,292	20
21	BOILER & STORAGE TANKS	2004	6,200		20	310	310	1,137	21
22	CHASE WALLS	2004	4,570		15	305	305	991	22
23	CARPETING	2004	12,311		5	2,462	2,462	8,002	23
24	HOT WATER TANK	2004	11,242		10	1,124	1,124	3,653	24
25	WATER TANK	2004	34,751		20	1,738	1,738	5,504	25
26	HOT WATER VALVE	2004	3,609		20	180	180	585	26
27	CARPETING	2004	28,726		5	5,745	5,745	18,671	27
28	HOT WATER BOILER	2004	7,344		20	367	367	1,101	28
29	ALUMINUM STREET SIGN DISP	2005	3,700		10	370	370	1,110	29
30	FIRE ALARMS/SMOKE DETECTORS	2005	2,134		10	213	213	622	30
31	TURNBURY INSULATED DOME	2005	1,545		10	155	155	452	31
32	STEEL PEDESTRIAN DOORS	2005	4,630		20	232	232	676	32
33	RED OAK UNFINISHED DOO	2005	1,580		15	105	105	298	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,197,924	\$ 698,657		\$ 126,719	\$ (571,938)	\$ 1,274,926	34

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

Facility Name &amp; ID Number WOOD GLEN NURSING &amp; REHAB CTR

# 0043935

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 8,197,924	\$ 698,657		\$ 126,719	\$ (571,938)	\$ 1,274,926	1
2	FIRE DAMPERS	2005	5,294		10	529	529	1,455	2
3	SECURITY SYSTEM	2005	16,519		10	1,652	1,652	4,405	3
4	SMOKE DAMPER MOTORS	2005	7,524		10	752	752	2,006	4
5	ASPHALT REPLACEMENT	2005	10,862		8	1,358	1,358	3,508	5
6	SMOKE DAMPER MOTORS	2005	2,585		10	259	259	669	6
7	BOILER REPLACEMENT	2005	18,998		20	950	950	2,217	7
8	SECURITY SYSTEM	2005	2,400		10	240	240	540	8
9	FIRE ALARM DEVICES INSTALL	2005	4,687		10	469	469	1,055	9
10	HOT WATER HEATER EXCHAN	2005	27,374		10	2,737	2,737	5,930	10
11	VINYL FENCE & WALK GATE	2005	3,844		10	384	384	832	11
12	SATELLITE TV & INTERNET	2005	12,699		10	1,270	1,270	2,752	12
13	DOOR HOLDERS	2006	3,324		10	332	332	637	13
14	HOT WATER COILS-OFFICE	2006	4,472		10	447	447	820	14
15	ADD CONCRETE TO PATIO	2006	8,476		15	565	565	942	15
16	ROOF WORK	2006	4,560		20	228	228	361	16
17	EGRESS DOORS	2006	1,651		10	165	165	248	17
18	DOORS	2006	1,631		10	163	163	982	18
19	CABLE,SPLITTERS, WALL PLA	2006	16,577		20	829	829	829	19
20	ALARM & SPRINKLER INSPECTION	2007	3,640		10	334	334	334	20
21	FAN COIL UNIT	2007	5,215		10	304	304	304	21
22	PEERLESS FENCE	2007	2,576		15	100	100	100	22
23	SEALCOATING & CRACK SEALING	2007	4,525		8	141	141	141	23
24	PS-35 PYROTRONICS POWER SUPPLY	2007	1,992		10				24
25	DOORS	2007	2,585		10	22	22	22	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33				24,890			(24,890)		33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,371,934	\$ 723,547		\$ 140,949	\$ (582,598)	\$ 1,306,015	34

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

# 0043935

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,371,934	\$ 723,547		\$ 140,949	\$ (582,598)	\$ 1,306,015	1
2	ALLOCATIONS FROM PLATINUM (HO):								2
3	BUILDING (CONSTRUCTED 1955; PURCH 2004)	2004	46,618	1,358		1,358			3
4	FIRE ALARM & SECURITY SYSTEM	2004	291						4
5	PAINTING	2004	313						5
6	CARPETING	2004	652						6
7	BLINDS	2004	153						7
8	BLINDS	2005	224						8
9	REMODELING-FLOORS, LIGHTS, PLUMBING & WALLS	2005	2,237						9
10	REMODELING-WALLS	2005	90						10
11	BATHROOM REMODELING	2005	224						11
12	BATHROOM REMODELING	2005	327						12
13	BATHROOM REMODELING	2006	1,275						13
14	WINDOWS	2006	559						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	TOTAL (lines 1 thru 33)		\$ 8,424,897	\$ 724,905		\$ 142,307	\$ (582,598)	\$ 1,306,015	34

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	\$ 323,036	\$ 15,633	\$ 24,559	\$ 8,926	Various	\$ 243,540	71
72	Current Year Purchases	46,291	9,257	3,130	(6,127)	Various	3,130	72
73	Fully Depreciated Assets	1,165,384						73
74	Allocation from Platinum	29,524	3,479	2,803	(676)			74
75	TOTALS	\$ 1,564,235	\$ 28,369	\$ 30,492	\$ 2,123		\$ 246,670	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		FRANKS CHEVROLET	1996	\$ 6,461	\$	\$	\$	5	\$ 6,461	76
77		BUS	2002	8,447	341	845	504	5	8,447	77
78		GMC SIERRA	2004	30,357	1,748	7,590	5,842	4	24,033	78
79		WG VAN	2005	26,782	3,150	6,696	3,546	4	14,507	79
80	TOTALS			\$ 72,047	\$ 5,239	\$ 15,131	\$ 9,892		\$ 53,448	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 10,526,179	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 758,513	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 187,930	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (570,583)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,606,133	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

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

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	\$ _____

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: \$ 15,174 Description: See attached schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ <u>See attached schedule</u>	\$ <u>19,518</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <u>19,518</u>	21

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

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/07 Ending: 12/31/07

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	hrs	\$		\$ 148	\$		\$ 148	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			2,311			2,311	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				55,164		55,164	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab/X-ray	39-02					3,668		3,668	13
14	<b>TOTAL</b>			\$		\$ 2,459	\$ 58,832		\$ 61,291	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 WOOD GLEN NURSING & REHAB CTR# 0043935Report Period Beginning: 1/1/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 308,193	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>247,337</u> )	928,095		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,214		6
7	Other Prepaid Expenses	15,004		7
8	Accounts Receivable (owners or related parties)	550,000		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,886,506	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	480,151		15
16	Equipment, at Historical Cost	330,559		16
17	Accumulated Depreciation (book methods)	(377,129)		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):	(123,260)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 310,321	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,196,827	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 346,231	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	90		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	134,769		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	210,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	41,106		36
37	<u>Due Others, Adv Billing</u>	267,877		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,000,073	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,000,073	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,196,754	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,196,827	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,005,087</b>	<b>1</b>
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,005,087</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	<b>864,192</b>	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	<b>(672,525)</b>	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>191,667</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,196,754</b>	<b>24</b> *

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

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# **0043935**

Report Period Beginning: **1/1/07**

Ending: **12/31/07**

**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	\$ 8,632,892	1
2	Discounts and Allowances for all Levels	(67,503)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 8,565,389</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	370,925	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 370,925</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,953	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	64,723	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,303	19
20	Radiology and X-Ray	365	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 76,344</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	25	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 25</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc Income (offset pg 5)</b>	<b>34,346</b>	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 34,346</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 9,047,029</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,620,298	31
32	Health Care	2,820,496	32
33	General Administration	2,102,591	33
<b>B. Capital Expense</b>			
34	Ownership	1,466,976	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	58,833	35
36	Provider Participation Fee	113,643	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 8,182,837</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>864,192</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 864,192</b>	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

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

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

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Report Period Beginning:

1/1/07

Ending:

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**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	1,896	2,080	\$ 111,934	\$ 53.81	1
2	Assistant Director of Nursing	3,475	3,928	163,121	41.53	2
3	Registered Nurses	21,716	23,341	725,916	31.10	3
4	Licensed Practical Nurses	10,648	11,451	289,207	25.26	4
5	CNAs & Orderlies	53,631	57,325	765,335	13.35	5
6	CNA Trainees					6
7	Licensed Therapist	387	394	18,947	48.09	7
8	Rehab/Therapy Aides	3,115	3,418	105,003	30.72	8
9	Activity Director	1,579	1,808	41,169	22.77	9
10	Activity Assistants	6,853	7,478	67,987	9.09	10
11	Social Service Workers	18,734	21,220	371,177	17.49	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,264	63,548	28.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,385	23,893	207,579	8.69	15
16	Dishwashers					16
17	Maintenance Workers	8,051	8,510	104,979	12.34	17
18	Housekeepers	36,885	40,578	341,455	8.41	18
19	Laundry	68	68	514	7.56	19
20	Administrator	1,856	2,080	219,241	105.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,294	13,245	312,771	23.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>205,557</b>	<b>223,081</b>	<b>\$ 3,909,883 *</b>	<b>\$ 17.53</b>	<b>34</b>

\* 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	179	\$ 8,280	01-03	35
36	Medical Director	Monthly	38,500	09-03	36
37	Medical Records Consultant	Monthly	1,504	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,489	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	990	11-03	44
45	Social Service Consultant	6	336	12-03	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>202</b>	<b>\$ 60,099</b>		<b>49</b>

**C. CONTRACT NURSES**

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





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LTC \$10,678
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,138 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ 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.  
WOOD GLEN NURSING & REHAB CENTER - DDPH#40568-6.1.98
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 113,643  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? YES  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$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.