

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR# 0043935 Report Period Beginning: 1/01/08 Ending: 12/31/08

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>75,762</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>75,762</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>69,209</u>		<u>2,069</u>	<u>71,278</u>	8
9	SNF/PED					9
10	ICF		<u>2,325</u>		<u>2,325</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>69,209</u>	<u>2,325</u>	<u>2,069</u>	<u>73,603</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.15%

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

416 (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 & 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 2,043Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR** # **0043935** Report Period Beginning: **1/01/08** Ending: **12/31/08**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	262,077	26,138	8,309	296,524		296,524		296,524		1
2	Food Purchase		339,545		339,545		339,545	(3)	339,542		2
3	Housekeeping	353,094	41,261		394,355		394,355		394,355		3
4	Laundry		30,023		30,023		30,023		30,023		4
5	Heat and Other Utilities			338,936	338,936		338,936	7,735	346,671		5
6	Maintenance	115,454		116,055	231,509		231,509	9,030	240,539		6
7	Other (specify):*										7
8	TOTAL General Services	730,625	436,967	463,300	1,630,892		1,630,892	16,762	1,647,654		8
	B. Health Care and Programs										
9	Medical Director			37,000	37,000		37,000		37,000		9
10	Nursing and Medical Records	2,173,209	88,040	12,518	2,273,767		2,273,767		2,273,767		10
10a	Therapy	143,507		4,361	147,868		147,868		147,868		10a
11	Activities	80,831	18,709	1,115	100,655		100,655		100,655		11
12	Social Services	271,764		276	272,040		272,040		272,040		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,669,311	106,749	55,270	2,831,330		2,831,330		2,831,330		16
	C. General Administration										
17	Administrative	205,776		624,000	829,776		829,776	(101,211)	728,565		17
18	Directors Fees										18
19	Professional Services			150,165	150,165		150,165	(18,226)	131,939		19
20	Dues, Fees, Subscriptions & Promotions			25,263	25,263		25,263	(8,338)	16,925		20
21	Clerical & General Office Expenses	177,834	17,052	82,355	277,241		277,241	75,139	352,380		21
22	Employee Benefits & Payroll Taxes			519,573	519,573		519,573		519,573		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,151	6,151		6,151	728	6,879		24
25	Other Admin. Staff Transportation			22,405	22,405		22,405	(10,076)	12,329		25
26	Insurance-Prop.Liab.Malpractice			210,199	210,199		210,199	1,177	211,376		26
27	Other (specify):*							27,349	27,349		27
28	TOTAL General Administration	383,610	17,052	1,640,111	2,040,773		2,040,773	(33,458)	2,007,315		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,783,546	560,768	2,158,681	6,502,995		6,502,995	(16,696)	6,486,299		29

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

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR #0043935 Report Period Beginning: 1/01/08 Ending: 12/31/08

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
	D. Ownership										
30	Depreciation			52,511	52,511	52,511	138,956	191,467			30
31	Amortization of Pre-Op. & Org.						176	176			31
32	Interest			23,155	23,155	23,155	273,817	296,972			32
33	Real Estate Taxes			296,405	296,405	296,405		296,405			33
34	Rent-Facility & Grounds			1,132,084	1,132,084	1,132,084	(1,132,084)				34
35	Rent-Equipment & Vehicles			30,816	30,816	30,816	872	31,688			35
36	Other (specify):*						3,759	3,759			36
37	TOTAL Ownership			1,534,971	1,534,971	1,534,971	(714,504)	820,467			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			82,479	82,479	82,479		82,479			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			113,644	113,644	113,644		113,644			42
43	Other (specify):*						(118,729)	(118,729)			43
44	TOTAL Special Cost Centers			196,123	196,123	196,123	(118,729)	77,394			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,783,546	560,768	3,889,775	8,234,089	8,234,089	(849,929)	7,384,160			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: 1/01/08

Ending: 12/31/08

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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3)	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	(3,025)	21		18
19	Entertainment				19
20	Contributions	(13,971)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(28,312)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,217)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,068)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(105,065)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (163,661)		\$	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)	(686,268)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (686,268)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (849,929)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

WOOD GLEN NURSING & REHAB CTR

ID# 0043935

Report Period Beginning: 1/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	BANK FEES	\$ (11,870)	21 1
2	TAXES - GENERAL	0	21 2
3	DAMAGE/THEFT/LOSS	0	21 3
4	IL COUNCIL LTC - COPE	(7,246)	20 4
5	MARKETING SALARIES	(58,141)	43 5
6	MARKETING EMPLOYEE BENEFITS	(7,984)	43 6
7	MISCELLANEOUS INCOME-SS SAL REIMB	(42,083)	43 7
8	MISCELLANEOUS INCOME-SS EB REIMB	(10,521)	43 8
9	MISCELLANEOUS INCOME	(85)	21 9
10	TRAVEL - PH ECLIPSE	(18,690)	25 10
11	REAL ESTATE TAXES	(3,337)	33 11
12	ADJ. TO S/L DEPRECIATION	54,892	30 12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(105,065)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/01/08

Ending:

12/31/08

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3)	0	0	0	0	0	0	0	0	0	0	(3)	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	7,735	0	0	0	0	0	0	0	0	7,735	5
6	Maintenance	0	0	9,030	0	0	0	0	0	0	0	0	9,030	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3)	0	16,765	0	16,762	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(101,211)	0	0	0	0	0	0	0	0	(101,211)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(28,312)	0	10,086	0	0	0	0	0	0	0	0	(18,226)	19
20	Fees, Subscriptions & Promotions	(9,463)	0	1,125	0	0	0	0	0	0	0	0	(8,338)	20
21	Clerical & General Office Expenses	(40,019)	0	115,158	0	0	0	0	0	0	0	0	75,139	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	728	0	0	0	0	0	0	0	0	728	24
25	Other Admin. Staff Transportation	(18,690)	0	8,614	0	0	0	0	0	0	0	0	(10,076)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,177	0	0	0	0	0	0	0	0	1,177	26
27	Other (specify):*	0	0	27,349	0	0	0	0	0	0	0	0	27,349	27
28	TOTAL General Administration	(96,484)	0	63,026	0	(33,458)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(96,487)	0	79,791	0	(16,696)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	54,892	80,405	3,659	0	0	0	0	0	0	0	0	138,956	30
31	Amortization of Pre-Op. & Org.	0	0	176	0	0	0	0	0	0	0	0	176	31
32	Interest	0	269,352	4,465	0	0	0	0	0	0	0	0	273,817	32
33	Real Estate Taxes	(3,337)	0	3,337	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	872	0	0	0	0	0	0	0	0	872	35
36	Other (specify):*	0	3,759	0	0	0	0	0	0	0	0	0	3,759	36
37	TOTAL Ownership	51,555	(778,568)	12,509	0	(714,504)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(118,729)	0	0	0	0	0	0	0	0	0	0	(118,729)	43
44	TOTAL Special Cost Centers	(118,729)	0	0	0	0	0	0	0	0	0	0	(118,729)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(163,661)	(778,568)	92,300	0	(849,929)	45							

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning:

1/01/08

Ending:

12/31/08

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	30 DEPRECIATION		WOOD GLEN PAVILION REALTY, LLC		80,405	80,405	2
3	V	32 INTEREST		WOOD GLEN PAVILION REALTY, LLC		269,352	269,352	3
4	V	36 AMORTIZATION-LOAN COSTS		WOOD GLEN PAVILION REALTY, LLC		3,759	3,759	4
5	V							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			\$ 353,516	\$ * (778,568)	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: 1/01/08Ending: 12/31/08

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		7,735	7,735	16
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		9,030	9,030	17
18	V	17 Administrative Salary		Platinum Health Care, LLC		42,789	42,789	18
19	V	19 Professional Fees		Platinum Health Care, LLC		10,086	10,086	19
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		1,125	1,125	20
21	V	21 Clerical Salaries		Platinum Health Care, LLC		102,612	102,612	21
22	V	21 Office Expenses		Platinum Health Care, LLC		12,546	12,546	22
23	V	24 Education & Seminars		Platinum Health Care, LLC		728	728	23
24	V	25 Travel		Platinum Health Care, LLC		8,614	8,614	24
25	V	26 Insurance		Platinum Health Care, LLC		1,177	1,177	25
26	V	27 Employee Benefits		Platinum Health Care, LLC		27,349	27,349	26
27	V	30 Depreciation		Platinum Health Care, LLC		1,064	1,064	27
28	V	35 Equipment Rental		Platinum Health Care, LLC		872	872	28
29	V	31 Amortization		Platinum Health Care, LLC		176	176	29
30	V	30 Depreciation		Platinum Health Care, LLC		2,595	2,595	30
31	V	32 Interest		Platinum Health Care, LLC		4,465	4,465	31
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		3,337	3,337	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 144,000			\$ 236,300	\$ * 92,300	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: 1/01/08 Ending: 12/31/08

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		Administrative	70.10	SEE ATTACHED	3	7.50	Mgt Fees	\$ 480,000	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 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: 1/01/08 Ending: 12/31/08

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	522,253	12	\$ 54,883	\$ 73,603	\$ 7,735	1
2	6	Repairs & Maintenance	Patient Days	522,253	12	64,073	73,603	9,030	2
3	17	Administrative Salary	Patient Days	522,253	12	303,614	303,614	42,789	3
4	19	Professional Fees	Patient Days	522,253	12	71,566	73,603	10,086	4
5	20	Fees, Subscriptions	Patient Days	522,253	12	7,979	73,603	1,125	5
6	21	Clerical Salaries	Patient Days	522,253	12	728,090	728,090	102,612	6
7	21	Office Expenses	Patient Days	522,253	12	89,019	73,603	12,546	7
8	24	Education & Seminars	Patient Days	522,253	12	5,163	73,603	728	8
9	25	Travel	Patient Days	522,253	12	61,119	73,603	8,614	9
10	26	Insurance	Patient Days	522,253	12	8,354	73,603	1,177	10
11	27	Employee Benefits	Patient Days	522,253	12	194,056	73,603	27,349	11
12	30	Depreciation	Patient Days	522,253	12	7,547	73,603	1,064	12
13	35	Equipment Rental	Patient Days	522,253	12	6,184	73,603	872	13
14	31	Amortization	Patient Days	522,253	12	1,246	73,603	176	14
15	30	Depreciation	Patient Days	522,253	12	18,405	73,603	2,595	15
16	32	Interest	Patient Days	522,253	12	31,679	73,603	4,465	16
17	33	Real Estate Taxes	Patient Days	522,253	12	23,679	73,603	3,337	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,676,656	\$ 1,031,704	\$ 236,300	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			
A. Directly Facility Related																				
Long-Term																				
1			Mortgage			\$	\$			\$ 269,352	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	LaSalle Bank		X	Line of Credit						23,155	6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 292,507	9									
B. Non-Facility Related*																				
10											10									
11											11									
12	Allocation from Platinum									4,465	12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$ 4,465	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 296,972	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,860 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:

1/01/08

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

B. Real Estate Taxes

<p>Important, 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 2007 report.		\$ 210,000	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.)		\$ 252,405	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ 42,405	3																													
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 254,000	4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 296,405	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr> <td>2003</td> <td>156,080</td> <td>8</td> </tr> <tr> <td>2004</td> <td>172,300</td> <td>9</td> </tr> <tr> <td>2005</td> <td>190,000</td> <td>10</td> </tr> <tr> <td>2006</td> <td>200,113</td> <td>11</td> </tr> <tr> <td>2007</td> <td>252,405</td> <td>12</td> </tr> </table>	2003	156,080	8	2004	172,300	9	2005	190,000	10	2006	200,113	11	2007	252,405	12	<table border="1"> <tr> <td colspan="2">FOR BHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2007</td> <td>\$</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> </tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2007	\$	14	PLUS APPEAL COST FROM LINE 5	\$	15	LESS REFUND FROM LINE 6	\$	16	AMOUNT TO USE FOR RATE CALCULATION	\$
2003	156,080	8																														
2004	172,300	9																														
2005	190,000	10																														
2006	200,113	11																														
2007	252,405	12																														
FOR BHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2007	\$																														
14	PLUS APPEAL COST FROM LINE 5	\$																														
15	LESS REFUND FROM LINE 6	\$																														
16	AMOUNT TO USE FOR RATE CALCULATION	\$																														

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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>252,405.40</u>	\$ <u>252,405.40</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>252,405.40</u>	\$ <u>252,405.40</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

1/01/08 Ending:

12/31/08

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).

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:

1/01/08

Ending:

12/31/08

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	\$ 78,645	35	\$ 87,632	\$ 8,987	\$ 1,138,019	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	FENCE			1998	5,042	337	15	337		3,916	9
10	FIRE ALARM			2002	44,058		20	2,203	2,203	32,604	10
11											11
12	Various			1995	25,326		20	1,266	1,266	17,204	12
13	Various			1996	16,672		20	834	834	10,215	13
14	Various			1997	20,310		20	1,016	1,016	11,720	14
15	Various			1998	22,766		20	1,138	1,138	14,048	15
16						1,423			(1,423)		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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning:

1/01/08

Ending:

12/31/08

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	LOBBY IMPROVEMENTS	1999	\$ 3,750	\$	20	\$ 188	\$ 188	\$ 1,720	37
38	WATER HEATER	1999	4,100		20	205	205	1,876	38
39	CONTRACTOR	1999	919		20	46	46	437	39
40	PUMP	1999	1,887		20	94	94	852	40
41	MATV SYSTEM	1999	752		20	38	38	342	41
42	PRESSURE SWITCH	1999	1,341		20	67	67	603	42
43	BOILER	1999	1,964		20	98	98	882	43
44	AIR CONDITIONER	1999	612		20	31	31	279	44
45	SMOKE DETECTOR	1999	3,118		20	156	156	1,404	45
46	FIRE ALARM SYSTEM	1999	693		20	35	35	414	46
47	2 WATER HEATERS	2000	8,400		20	420	420	3,710	47
48	FLOORING	2000	1,284		20	64	64	533	48
49	CARPET	2000	1,284		20	64	64	528	49
50	FLOORING	2000	3,740		20	187	187	1,543	50
51	CARPET	2000	5,225		20	261	261	2,110	51
52	FIXTURES (\$31,000 REMOVED 2008 CAP COST AUDIT)	2000							52
53	FLUID PUMP	2000	2,429		20	121	121	1,049	53
54	FLUID PUMP	2000	905		20	45	45	390	54
55	FLUID PUMP SVC	2000	2,412		20	121	121	1,028	55
56	WATER LINES & DRAIN	2001	3,870		39	99	99	788	56
57	BURNER PILOT & PARTS	2001	1,593		39	41	41	326	57
58	4 DUPLEX OUTLETS	2001	2,275		39	58	58	462	58
59	WATER HEATER PIPING	2001	8,997		39	231	231	1,800	59
60	FLUES - WATER BOILER	2001	3,580		39	92	92	679	60
61	BRICK WALL	2001	4,515		39	116	116	836	61
62	EXPANSION MODULE	2001	947		20	47	47	356	62
63	CABLES	2001	1,031		20	52	52	368	63
64	CABLE WORK	2001	767		20	38	38	269	64
65	PHONES/CABLES	2001	544		20	27	27	216	65
66	LIGHTING	2001	1,022		20	51	51	361	66
67	LAMPS (\$742 TO MME PER '08 CAP COST AUDIT)	2001			20				67
68	FIRE PUMP WORK	2001	750		20	38	38	269	68
69	HEATING/COOLING WORK	2001	649		20	32	32	227	69
70	TOTAL (lines 4 thru 69)		\$ 3,276,654	\$ 80,405		\$ 97,589	\$ 17,184	\$ 1,254,383	70

**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:

1/01/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,276,654	\$ 80,405		\$ 97,589	\$ 17,184	\$ 1,254,383	1
2	LIGHTING	2001	903		20	45	45	326	2
3	MOTOR	2001	547		20	27	27	212	3
4	LIGHTING ENHANCEMENT	2001	903		20	45	45	341	4
5	REFRIGERATOR WORK	2001	1,044		20	52	52	377	5
6	PIPE WORK	2001	500		20	25	25	181	6
7	CONCRETE ANCHOR	2001	5,332		20	267	267	2,025	7
8	REFRIGERATOR WORK	2001	532		20	27	27	203	8
9	REFRIGERATOR WORK	2001	585		20	29	29	213	9
10	LIGHTING	2001	903		20	45	45	360	10
11	LIGHTING	2001	903		20	45	45	356	11
12	LIGHTING	2001	903		20	45	45	353	12
13	LIGHTING	2001	903		20	45	45	349	13
14	LIGHTING	2001	903		20	45	45	345	14
15	PUMP	2001	571		20	29	29	205	15
16	HEAT PUMP MOTOR	2001	1,409		20	70	70	502	16
17	PLUMBING	2001	1,038		20	52	52	416	17
18	PATIO	2002	2,250		10	225	225	1,481	18
19	A/C REPAIR	2002	3,529		10	353	353	2,324	19
20	A/C REPAIR	2002	1,305		10	131	131	851	20
21	A/C REPAIR	2002	1,240		10	124	124	796	21
22	A/C REPAIR	2002	888		10	89	89	549	22
23	A/C REPAIR	2002	846		10	85	85	517	23
24	A/C REPAIR	2002	664		10	66	66	429	24
25	WATER HEATERS	2002	1,700		10	170	170	1,119	25
26	WATER HEATERS	2002	2,460		10	246	246	1,620	26
27	FREEZER REPAIR	2002	587		20	29	29	203	27
28	FIRE PUMP WORK	2002	750		20	38	38	266	28
29	SERVICE PUMP	2002	540		20	27	27	189	29
30	ELECTRICAL SYSTEM	2002	528		20	26	26	182	30
31	PIPE WORK	2002	1,213		20	61	61	427	31
32	LIGHTING ENHANCEMENT	2002	12,442		20	622	622	4,354	32
33	MAIN ENTRANCE CAMERA	2003	13,445		5	2,689	2,689	15,910	33
34	TOTAL (lines 1 thru 33)		\$ 3,338,920	\$ 80,405		\$ 103,463	\$ 23,058	\$ 1,292,364	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:

1/01/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,338,920	\$ 80,405		\$ 103,463	\$ 23,058	\$ 1,292,364	1
2	PROXIMITY READERS	2003	2,074		5	34	34	2,074	2
3	PROXIMITY READERS/SMART	2003	3,805		5	63	63	3,805	3
4	WALL DECORATION	2003	1,063		5	52	52	1,063	4
5	KITCHEN WORK	2003	1,454		10	145	145	846	5
6	CI RANG STEAM	2003	869		10	87	87	457	6
7	CI RANG STEAM	2003	2,289		10	229	229	1,202	7
8	DRAPES	2003	2,525		5			2,525	8
9	FROZEN COIL IN AIR HANDLER	2004	3,819		10	382	382	1,910	9
10	WATER HEATER	2004	8,714		10	871	871	4,210	10
11	INSTALL NEW COIL	2004	3,800		10	380	380	1,773	11
12	CONDENSING UNIT	2004	4,200		15	280	280	1,260	12
13	PLUMBING-DIALYSIS ROOM	2004	5,390		20	270	270	1,215	13
14	WATER HEATER	2004	6,748		10	675	675	3,037	14
15	SERVICE PUMP	2004	7,565		20	378	378	1,670	15
16	BOILER & STORAGE TANKS	2004	6,200		20	310	310	1,447	16
17	CHASE WALLS	2004	4,570		15	305	305	1,296	17
18	CARPETING	2004	12,311		5	2,462	2,462	10,464	18
19	HOT WATER TANK	2004	11,242		10	1,124	1,124	4,777	19
20	WATER TANK	2004	34,751		20	1,738	1,738	7,242	20
21	HOT WATER VALVE	2004	3,609		20	180	180	765	21
22	CARPETING	2004	28,726		5	5,745	5,745	24,416	22
23	HOT WATER BOILER	2004	7,344		20	367	367	1,468	23
24	ALUMINUM STREET SIGN DISP	2005	3,700		10	370	370	1,480	24
25	FIRE ALARMS/SMOKE DETECTORS	2005	2,134		10	213	213	835	25
26	TURNBURY INSULATED DOME	2005	1,545		10	155	155	607	26
27	STEEL PEDESTRIAN DOORS	2005	4,630		20	232	232	908	27
28	RED OAK UNFINISHED DOO	2005	1,580		15	105	105	403	28
29	FIRE DAMPERS	2005	5,294		10	529	529	1,984	29
30	SECURITY SYSTEM	2005	16,519		10	1,652	1,652	6,057	30
31	SMOKE DAMPER MOTORS	2005	7,524		10	752	752	2,758	31
32	ASPHALT REPLACEMENT	2005	10,862		8	1,358	1,358	4,866	32
33	SMOKE DAMPER MOTORS	2005	2,585		10	259	259	928	33
34	TOTAL (lines 1 thru 33)		\$ 3,558,361	\$ 80,405		\$ 125,165	\$ 44,760	\$ 1,392,112	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:

1/01/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,558,361	\$ 80,405		\$ 125,165	\$ 44,760	\$ 1,392,112	1
2	BOILER REPLACEMENT	2005	18,998		20	950	950	3,167	2
3	SECURITY SYSTEM	2005	2,400		10	240	240	780	3
4	FIRE ALARM DEVICES INSTALL	2005	4,687		10	469	469	1,524	4
5	HOT WATER HEATER EXCHAN	2005	27,374		10	2,737	2,737	8,667	5
6	VINYL FENCE & WALK GATE	2005	3,844		10	384	384	1,216	6
7	SATELLITE TV & INTERNET (\$12,699 TO MME '08 CC AUDIT	2005							7
8	DOOR HOLDERS	2006	3,324		10	332	332	969	8
9	HOT WATER COILS-OFFICE	2006	4,472		10	447	447	1,267	9
10	ADD CONCRETE TO PATIO	2006	8,476		15	565	565	1,507	10
11	ROOF WORK	2006	4,560		20	228	228	589	11
12	EGRESS DOORS	2006	1,651		10	165	165	413	12
13	DOORS	2006	1,631		10	163	163	1,145	13
14	CABLE,SPLITTERS, WALL PLA	2006	16,577		20	829	829	1,658	14
15	ALARM & SPRINKLER INSPECTION (\$3,640 REMOVED '08 C	2007							15
16	FAN COIL UNIT	2007	5,215		10	522	522	826	16
17	PEERLESS FENCE	2007	2,576		15	172	172	272	17
18	SEALCOATING & CRACK SEALING	2007	4,525		8	566	566	707	18
19	PS-35 PYROTRONICS POWER SUPPLY (41,992 REM '08 CC AU	2007							19
20	DOORS	2007	2,585		10	259	259	281	20
21	CHILLER	2008	106,846		10	4,452	4,452	4,452	21
22	AIR HANDLER/PNEUMATIC CONTROL	2008	3,300		10	302	302	302	22
23	INSTALL DOORS (1ST-3RD FLOOR)	2008	2,597		10	238	238	238	23
24	CONDIAL MP5000	2008	14,730		10	1,350	1,350	1,350	24
25	CHILLER REPLACEMENT PROJ	2008	9,740		10	812	812	812	25
26	INSTALL DOORS (LINEN/GARBAGE))	2008	2,212		10	166	166	166	26
27	FIRE SPRINKLER SUBCONTRACTOR	2008	6,965		10	464	464	464	27
28	INSTALL NEW CONDENSER & EVAPORATOR	2008	6,191		10	413	413	413	28
29	SECURTY UNIT	2008	6,740		10	393	393	393	29
30	REPAIR FIRE PUMP RUN TIMER	2008	6,318		10	263	263	263	30
31	POWER SUPPLY & DOME CAMERA	2008	1,099		10				31
32	REPAIR/REPLACE THERMOSTATIC VALVE-HOT WATER S	2008	3,086		10				32
33				22,962			(22,962)		33
34	TOTAL (lines 1 thru 33)		\$ 3,841,080	\$ 103,367		\$ 143,046	\$ 39,679	\$ 1,425,953	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:

1/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,841,080	\$ 103,367		\$ 143,046	\$ 39,679	\$ 1,425,953	1
2	ALLOCATIONS FROM PLATINUM (HO):								2
3	BUILDING (CONSTRUCTED 1955; PURCH 2004)	2004	39,933						3
4	FIRE ALARM & SECURITY SYSTEM	2004	249						4
5	PAINTING	2004	268						5
6	CARPETING	2004	559						6
7	BLINDS	2004	131						7
8	BLINDS	2005	192						8
9	REMODELING-FLOORS, LIGHTS, PLUMBING & WALLS	2005	1,916						9
10	REMODELING-WALLS	2005	77						10
11	BATHROOM REMODELING	2005	192						11
12	BATHROOM REMODELING	2005	280						12
13	BATHROOM REMODELING	2006	1,092						13
14	WINDOWS	2006	479						14
15	TUCK POINTING	2008	161						15
16	REMODEL PARESH'S OFFICE	2008	591						16
17				1,188		1,188			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)		\$ 3,887,200	\$ 104,555		\$ 144,234	\$ 39,679	\$ 1,425,953	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: 1/01/08 Ending: 12/31/08

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	\$ 382,768	\$ 25,925	\$ 31,743	\$ 5,818	Various	\$ 279,575	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		2,471	2,471				74
75	TOTALS	\$ 382,768	\$ 28,396	\$ 34,214	\$ 5,818		\$ 279,575	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				5	8,447	77
78		GMC SIERRA	2004	30,357	1,749	6,324	4,575	4	30,357	78
79		WG VAN	2005	26,782	1,875	6,695	4,820	4	21,202	79
80	TOTALS			\$ 72,047	\$ 3,624	\$ 13,019	\$ 9,395		\$ 66,467	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)	\$ 4,807,015	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 136,575	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 191,467	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 54,892	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,771,995	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 16,256 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>14,560</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>14,560</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: 1/01/08 Ending: 12/31/08

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)	
TOTAL TRAINED	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	hrs	\$	5	\$ 365	\$	5	\$ 365	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		63	3,996		63	3,996	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				77,104		77,104	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Lab</u>	39-02					5,375		5,375	13
14	TOTAL			\$	68	\$ 4,361	\$ 82,479	68	\$ 86,840	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**# **0043935**Report Period Beginning: **1/01/08**

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/08**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (49,106)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>127,464</u>)	1,346,704		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,640		6
7	Other Prepaid Expenses	3,044		7
8	Accounts Receivable (owners or related parties)	545,522		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,933,804	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	649,974		15
16	Equipment, at Historical Cost	330,558		16
17	Accumulated Depreciation (book methods)	(429,640)		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):	(270,374)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 280,518	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,214,322	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 285,613	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,953		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	254,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	73,605		36
37	<u>Due Others, Adv. Billing</u>	286,021		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,039,192	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,039,192	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,175,130	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,214,322	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,196,754	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,196,755	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,039,077	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,060,702)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (21,625)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,175,130	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/01/08 Ending: 12/31/08

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,704,178	1
2	Discounts and Allowances for all Levels	(79,634)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,624,544	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	509,110	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 509,110	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,306	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	74,143	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,375	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 86,824	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		52,688	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 52,688	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,273,166	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,630,892	31
32	Health Care	2,831,330	32
33	General Administration	2,040,773	33
B. Capital Expense			
34	Ownership	1,534,971	34
C. Ancillary Expense			
35	Special Cost Centers	82,479	35
36	Provider Participation Fee	113,644	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,234,089	40
41	Income before Income Taxes (line 30 minus line 40)**	1,039,077	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,039,077	43

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

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

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

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

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

0043935

Report Period Beginning:

1/01/08

Ending:

12/31/08

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	1,477	1,662	\$ 94,414	\$ 56.81	1
2	Assistant Director of Nursing	2,966	3,208	123,902	38.62	2
3	Registered Nurses	24,071	25,981	828,227	31.88	3
4	Licensed Practical Nurses	11,147	11,802	304,961	25.84	4
5	CNAs & Orderlies	52,313	55,382	772,618	13.95	5
6	CNA Trainees					6
7	Licensed Therapist	933	985	49,569	50.32	7
8	Rehab/Therapy Aides	2,958	3,075	93,938	30.55	8
9	Activity Director					9
10	Activity Assistants	9,922	10,315	80,831	7.84	10
11	Social Service Workers	11,118	11,935	271,764	22.77	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	57,888	27.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,828	22,315	204,189	9.15	15
16	Dishwashers					16
17	Maintenance Workers	9,979	10,327	115,454	11.18	17
18	Housekeepers	37,700	40,529	353,094	8.71	18
19	Laundry					19
20	Administrator	1,872	2,080	205,776	98.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,773	6,280	177,834	28.32	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	3,560	3,899	49,087	12.59	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	198,617	211,855	\$ 3,783,546 *	\$ 17.86	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	170	\$ 8,309	01-03	35
36	Medical Director	Monthly	37,000	09-03	36
37	Medical Records Consultant	Monthly	1,536	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,982	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	1,005	11-03	44
45	Social Service Consultant	4	276	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	191	\$ 59,108		49

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	TOTAL (lines 50 - 52)		\$		53

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 \$13,538
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,639 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
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. \$ 113,644
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? _____
- 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? _____**
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.