

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: <u>0043935</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																
Facility Name: <u>WOOD GLEN PAVILION, LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																
Address: <u>30 WEST 300 NORTH AVENUE</u> <u>WEST CHICAGO</u> <u>60185</u> Number City Zip Code																																		
County: <u>DUPAGE</u>																																		
Telephone Number: <u>(630) 876-8100</u> Fax # <u>(630) 876-8108</u>																																		
HFS ID Number: _____																																		
Date of Initial License for Current Owners: <u>2/15/95</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>DARRYL BUEKER, CPA</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u></td></tr><tr><td>(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>DARRYL BUEKER, CPA</u> <u>PARTNER</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																					
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Type of Ownership:																																		
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In the event there are further questions about this report, please contact:																																		
Name: <u>DARRYL BUEKER</u> Telephone Number: <u>(417) 865-8701</u>																																		
Email Address: _____																																		

Facility Name & ID Number WOOD GLEN PAVILION, LLC

0043935 Report Period Beginning: 1/1/11 Ending: 12/31/11

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>69,556</u>		<u>1,449</u>	<u>71,005</u>	8
9	SNF/PED					9
10	ICF		<u>2,589</u>		<u>2,589</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>69,556</u>	<u>2,589</u>	<u>1,449</u>	<u>73,594</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.40%

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

481 (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/A

F. Does the facility maintain a daily midnight census? YES

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

YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 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 1,445

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

STATE OF ILLINOIS

Facility Name & ID Number

WOOD GLEN PAVILION, LLC

0043935

Report Period Beginning:

1/1/11

Ending:

12/31/11

Page 3

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	300,237	31,572	8,723	340,532		340,532		340,532			1
2	Food Purchase		390,706		390,706		390,706	(4,186)	386,520			2
3	Housekeeping	246,602	58,411		305,013		305,013		305,013			3
4	Laundry		25,310		25,310		25,310		25,310			4
5	Heat and Other Utilities			219,413	219,413		219,413	4,063	223,476			5
6	Maintenance	178,654		104,083	282,737		282,737	5,974	288,711			6
7	Other (specify):*											7
8	TOTAL General Services	725,493	505,999	332,219	1,563,711		1,563,711	5,851	1,569,562			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,255,370	83,884	13,822	2,353,076		2,353,076		2,353,076			10
10a	Therapy	133,092		226	133,318		133,318		133,318			10a
11	Activities	80,368	4,230	721	85,319		85,319		85,319			11
12	Social Services	283,212		585	283,797		283,797		283,797			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,752,042	88,114	51,354	2,891,510		2,891,510		2,891,510			16
	C. General Administration											
17	Administrative	250,605		636,339	886,944		886,944	(135,616)	751,328			17
18	Directors Fees											18
19	Professional Services			164,964	164,964		164,964	(15,012)	149,952			19
20	Dues, Fees, Subscriptions & Promotions			34,845	34,845		34,845	(8,130)	26,715			20
21	Clerical & General Office Expenses	217,796	16,367	89,592	323,755		323,755	68,691	392,446			21
22	Employee Benefits & Payroll Taxes			544,554	544,554		544,554		544,554			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,434	4,434		4,434	48	4,482			24
25	Other Admin. Staff Transportation			32,664	32,664		32,664	6,767	39,431			25
26	Insurance-Prop.Liab.Malpractice			172,635	172,635		172,635	30,980	203,615			26
27	Other (specify):*							25,132	25,132			27
28	TOTAL General Administration	468,401	16,367	1,680,027	2,164,795		2,164,795	(27,140)	2,137,655			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,945,936	610,480	2,063,600	6,620,016		6,620,016	(21,289)	6,598,727			29

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

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

V. COST CENTER EXPENSES (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			26,442	26,442		26,442	172,808	199,250			30
31	Amortization of Pre-Op. & Org.							307	307			31
32	Interest			38,477	38,477		38,477	263,420	301,897			32
33	Real Estate Taxes			290,020	290,020		290,020	1,636	291,656			33
34	Rent-Facility & Grounds			908,692	908,692		908,692	(908,692)				34
35	Rent-Equipment & Vehicles			37,494	37,494		37,494	1,430	38,924			35
36	Other (specify):*							3,759	3,759			36
37	TOTAL Ownership			1,301,125	1,301,125		1,301,125	(465,332)	835,793			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			76,294	76,294		76,294		76,294			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,333	113,333		113,333		113,333			42
43	Other (specify):*							(91,887)	(91,887)			43
44	TOTAL Special Cost Centers			189,627	189,627		189,627	(91,887)	97,740			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,945,936	610,480	3,554,352	8,110,768		8,110,768	(578,508)	7,532,260			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,183)	2		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	(11)	32		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	(13,764)	19		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,150)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,244)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,766)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(91,749)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (138,120)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	(440,388)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (440,388)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (578,508)		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 Yes	2 No	3 Amount	4 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

Report Period Beginning:

Ending:

ID#

0043935

1/1/11

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	\$ (4,831)	20	1
2	MISCELLANEOUS INCOME	(1,987)	21	2
3	BANK FEES	(33,680)	21	3
4	TAXES - GENERAL	(767)	21	4
5	DAMAGE/THEFT/LOSS	0	21	5
6	ADJ TO S/L	41,403	30	6
7	MARKETING SALARIES	(80,744)	43	7
8	MARKETING EMPLOYEE BENEFITS	(11,143)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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21				21
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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	(91,749)		49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		SEE PG6-SUPP				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 908,692	WOOD GLEN PAVILION REALTY, LLC		\$	(908,692)	1
2	V	30	DEPRECIATION				127,291	127,291	2
3	V	32	INTEREST				260,851	260,851	3
4	V	36	AMORTIZATION-LOAN COSTS				3,759	3,759	4
5	V	26	INSURANCE				32,487	32,487	5
6	V	19	ACCOUNTING FEES				12,500	12,500	6
7	V								7
8	V	19	PROFESSIONAL FEES	23,320	PHC CONSULTANTS, LLC		18,021	(5,299)	8
9	V								9
10	V	19	PROFESSIONAL FEES	1,055	MTS CONSULTING		1,055		10
11	V								11
12	V								12
13	V								13
14	Total			\$ 933,067			\$ 455,964	\$ * (477,103)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	HOME OFFICE	\$ 156,339	PLATINUM HEALTH CARE, LLC	100.00%	\$	\$ (156,339)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		4,063	4,063	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		5,974	5,974	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		20,723	20,723	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		6,701	6,701	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		945	945	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		103,624	103,624	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		10,517	10,517	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		48	48	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		6,767	6,767	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		(1,507)	(1,507)	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		25,132	25,132	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		2,568	2,568	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		1,430	1,430	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		307	307	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,546	1,546	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		2,580	2,580	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		1,636	1,636	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 156,339			\$ 193,054	\$ * 36,715	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BEN KLEIN	70.1	ALL FAITH PAVILION	CHICAGO	PLATINUM HEALTH	SKOKIE, IL	MANAGEMENT	1
2	MIRIAM KLEIN	4.95	BELLA VISTA CARE CENTER	PEORIA HEIGHTS	CARE, LLC			2
3	KENNETH KLEIN	2.475	CAPITOL CARE CENTER	SPRINGFIELD	WOOD GLEN PAVILION REALTY, LLC		BUILDING	3
4	RONNIE KLEIN	2.475	COLONIAL HALL CARE CENTER	PRINCETON	PHC CONSULTANTS	SKOKIE	CONSULTING	4
5	ABM LIMITED PARTNERSHIP	10.3	MORTON TERRACE CARE CENTER	MORTON	MTS CONSULTING	SKOKIE	CONSULTING	5
6	ABRAHAM STERN	4.8	MORTON VILLA CARE CENTER	MORTON				6
7	SUSAN STERN	4.9	RIVER VALLEY SUPPORTING LVG RES	KANKAKEE				7
8			RIVERSHORES CARE CENTER	MARSEILLES				8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	1	3.45	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

Ending: 12/31/11

(847) 329-7652

1	2	3	4	5	6	7	8	9		
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation		
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6		
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6				
1	5	Utilities	Patient Days	876,273	29	\$ 48,379	\$ 73,594	\$ 4,063	1	
2	6	Repairs & Maintenance	Patient Days	876,273	29	71,131	73,594	5,974	2	
3	17	Administrative Salary	Patient Days	876,273	29	246,751	246,751	73,594	20,723	3
4	19	Professional Fees	Patient Days	876,273	29	79,792	73,594	6,701	4	
5	20	Fees, Subscriptions	Patient Days	876,273	29	11,255	73,594	945	5	
6	21	Clerical Salaries	Patient Days	876,273	29	1,233,841	1,233,841	73,594	103,624	6
7	21	Office Expenses	Patient Days	876,273	29	125,226	73,594	10,517	7	
8	24	Education & Seminars	Patient Days	876,273	29	577	73,594	48	8	
9	25	Travel	Patient Days	876,273	29	80,576	73,594	6,767	9	
10	26	Insurance	Patient Days	876,273	29	(17,938)	73,594	(1,507)	10	
11	27	Employee Benefits	Patient Days	876,273	29	299,243	73,594	25,132	11	
12	30	Depreciation	Patient Days	876,273	29	30,566	73,594	2,568	12	
13	35	Equipment Rental	Patient Days	876,273	29	17,025	73,594	1,430	13	
14	31	Amortization	Patient Days	876,273	29	3,657	73,594	307	14	
15	30	Depreciation	Patient Days	876,273	29	18,405	73,594	1,546	15	
16	32	Interest	Patient Days	876,273	29	30,718	73,594	2,580	16	
17	33	Real Estate Taxes	Patient Days	876,273	29	19,475	73,594	1,636	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,298,679	\$ 1,480,592	\$ 193,054	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			X	MORTGAGE			\$					\$ 260,851	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Cole Taylor Bank		X	LINE OF CREDIT								6,488	6
7	HFG		X	LINE OF CREDIT								31,989	7
8													8
9	TOTAL Facility Related						\$					\$ 299,328	9
	B. Non-Facility Related*												
10	INTEREST INCOME OFFSET											(11)	10
11													11
12													12
13	ALLOCATION FROM PLATINUM											2,580	13
14	TOTAL Non-Facility Related						\$					\$ 2,569	14
15	TOTALS (line 9+line14)						\$					\$ 301,897	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,717 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	288,000	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.)		\$	290,020	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	2,020	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	288,000	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.		\$	290,020	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	200	113	8
		2007	252,405	9	
		2008	263,079	10	
		2009	286,692	11	
		2010	290,020	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>WOOD GLEN PAVILION, LLC</u>	COUNTY	<u>DUPAGE</u>
FACILITY IDPH LICENSE NUMBER	<u>0043935</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>DARRYL BUEKER</u>		
TELEPHONE (417) 865-8701		FAX #: (417) 865-0682	

Enter the tax index number and real estate tax assessed for 2010 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 2010.

Page 10A

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1995	1995	\$ 3,067,125	\$ 78,645	35	\$ 87,632	\$ 8,987	\$ 1,400,915	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FENCE		1998		5,042	337	15	337		4,927	9
10	FIRE ALARM		2002		44,058		20	2,203	2,203	39,213	10
11											11
12	Various		1995		25,326		20	1,266	1,266	21,002	12
13	Various		1996		16,672		20	834	834	12,717	13
14	Various		1997		20,310		20	1,016	1,016	14,768	14
15	Various		1998		22,766		20	1,138	1,138	17,462	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 LOBBY IMPROVEMENTS	1999	\$ 3,750	\$	20	\$ 188	\$ 188	\$ 2,284	37
38 WATER HEATER	1999	4,100		20	205	205	2,491	38
39 CONTRACTOR	1999	919		20	46	46	575	39
40 PUMP	1999	1,887		20	94	94	1,134	40
41 MATV SYSTEM	1999	752		20	38	38	456	41
42 PRESSURE SWITCH	1999	1,341		20	67	67	804	42
43 BOILER	1999	1,964		20	98	98	1,176	43
44 AIR CONDITIONER	1999	612		20	31	31	372	44
45 SMOKE DETECTOR	1999	3,118		20	156	156	1,872	45
46 FIRE ALARM SYSTEM	1999	693		20	35	35	519	46
47 2 WATER HEATERS	2000	8,400		20	420	420	4,970	47
48 FLOORING	2000	1,284		20	64	64	725	48
49 CARPET	2000	1,284		20	64	64	720	49
50 FLOORING	2000	3,740		20	187	187	2,104	50
51 CARPET	2000	5,225		20	261	261	2,893	51
52 FIXTURES (\$31,000 REMOVED 2008 CAP COST AUDIT)	2000							52
53 FLUID PUMP	2000	2,429		20	121	121	1,412	53
54 FLUID PUMP	2000	905		20	45	45	525	54
55 FLUID PUMP SVC	2000	2,412		20	121	121	1,391	55
56 WATER LINES & DRAIN	2001	3,870		39	99	99	1,085	56
57 BURNER PILOT & PARTS	2001	1,593		39	41	41	449	57
58 4 DUPLEX OUTLETS	2001	2,275		39	58	58	636	58
59 WATER HEATER PIPING	2001	8,997		39	231	231	2,493	59
60 FLUES - WATER BOILER	2001	3,580		39	92	92	955	60
61 BRICK WALL	2001	4,515		39	116	116	1,184	61
62 EXPANSION MODULE	2001	947		20	47	47	497	62
63 CABLES	2001	1,031		20	52	52	524	63
64 CABLE WORK	2001	767		20	38	38	383	64
65 PHONES/CABLES	2001	544		20	27	27	297	65
66 LIGHTING	2001	1,022		20	51	51	514	66
67 LAMPS (\$742 TO MME PER '08 CAP COST AUDIT)	2001			20				67
68 FIRE PUMP WORK	2001	750		20	38	38	383	68
69 HEATING/COOLING WORK	2001	649		20	32	32	323	69
70 TOTAL (lines 4 thru 69)		\$ 3,276,654	\$ 80,405		\$ 97,589	\$ 17,184	\$ 1,547,150	70

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

XI. OWNERSHIP COSTS (continued)
B. Building and Improvement Costs-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	\$ 1,547,150	1
2	<u>LIGHTING</u>	2001	903		20	45	45	461	2
3	<u>MOTOR</u>	2001	547		20	27	27	293	3
4	<u>LIGHTING ENHANCEMENT</u>	2001	903		20	45	45	476	4
5	<u>REFRIGERATOR WORK</u>	2001	1,044		20	52	52	533	5
6	<u>PIPE WORK</u>	2001	500		20	25	25	256	6
7	<u>CONCERTE ANCHOR</u>	2001	5,332		20	267	267	2,826	7
8	<u>REFRIGERATOR WORK</u>	2001	532		20	27	27	284	8
9	<u>REFRIGERATOR WORK</u>	2001	585		20	29	29	300	9
10	<u>LIGHTING</u>	2001	903		20	45	45	495	10
11	<u>LIGHTING</u>	2001	903		20	45	45	491	11
12	<u>LIGHTING</u>	2001	903		20	45	45	488	12
13	<u>LIGHTING</u>	2001	903		20	45	45	484	13
14	<u>LIGHTING</u>	2001	903		20	45	45	480	14
15	<u>PUMP</u>	2001	571		20	29	29	292	15
16	<u>HEAT PUMP MOTOR</u>	2001	1,409		20	70	70	712	16
17	<u>PLUMBING</u>	2001	1,038		20	52	52	572	17
18	<u>PATIO</u>	2002	2,250		10	225	225	2,156	18
19	<u>A/C REPAIR</u>	2002	3,529		10	353	353	3,383	19
20	<u>A/C REPAIR</u>	2002	1,305		10	131	131	1,244	20
21	<u>A/C REPAIR</u>	2002	1,240		10	124	124	1,168	21
22	<u>A/C REPAIR</u>	2002	888		10	89	89	816	22
23	<u>A/C REPAIR</u>	2002	846		10	85	85	772	23
24	<u>A/C REPAIR</u>	2002	664		10	66	66	627	24
25	<u>WATER HEATERS</u>	2002	1,700		10	170	170	1,629	25
26	<u>WATER HEATERS</u>	2002	2,460		10	246	246	2,358	26
27	<u>FREEZER REPAIR</u>	2002	587		20	29	29	290	27
28	<u>FIRE PUMP WORK</u>	2002	750		20	38	38	380	28
29	<u>SERVICE PUMP</u>	2002	540		20	27	27	270	29
30	<u>ELECTRICAL SYSTEM</u>	2002	528		20	26	26	260	30
31	<u>PIPE WORK</u>	2002	1,213		20	61	61	610	31
32	<u>LIGHTING ENHANCEMENT</u>	2002	12,442		20	622	622	6,220	32
33	<u>MAIN ENTRANCE CAMERA</u>	2003	13,445		5			13,445	33
34	TOTAL (lines 1 thru 33)		\$ 3,338,920	\$ 80,405		\$ 100,774	\$ 20,369	\$ 1,592,221	34

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

Facility Name & ID Number WOOD GLEN PAVILION, LLC

0043935

Report Period Beginning:

1/1/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 100,774	\$ 20,369	\$ 1,592,221	1
2	PROXIMITY READERS	2003	2,074		5			2,074	2
3	PROXIMITY READERS/SMART	2003	3,805		5			3,805	3
4	WALL DECORATION	2003	1,063		5			1,063	4
5	KITCHEN WORK	2003	1,454		10	145	145	1,281	5
6	CI RANG STEAM	2003	869		10	87	87	718	6
7	CI RANG STEAM	2003	2,289		10	229	229	1,889	7
8	DRAPES	2003	2,525		5			2,525	8
9	FROZEN COIL IN AIR HANDLER	2004	3,819		10	382	382	3,056	9
10	WATER HEATER	2004	8,714		10	871	871	6,823	10
11	INSTALL NEW COIL	2004	3,800		10	380	380	2,913	11
12	CONDENSING UNIT	2004	4,200		15	280	280	2,100	12
13	PLUMBING-DIALYSIS ROOM	2004	5,390		20	270	270	2,025	13
14	WATER HEATER	2004	6,748		10	675	675	5,062	14
15	SERVICE PUMP	2004	7,565		20	378	378	2,804	15
16	BOILER & STORAGE TANKS	2004	6,200		20	310	310	2,377	16
17	CHASE WALLS	2004	4,570		15	305	305	2,211	17
18	CARPETING	2004	12,311		5			12,311	18
19	HOT WATER TANK	2004	11,242		10	1,124	1,124	8,149	19
20	WATER TANK	2004	34,751		20	1,738	1,738	12,456	20
21	HOT WATER VALVE	2004	3,609		20	180	180	1,305	21
22	CARPETING	2004	28,726		5			28,726	22
23	HOT WATER BOILER	2004	7,344		20	367	367	2,569	23
24	ALUMINUM STREET SIGN DISP	2005	3,700		10	370	370	2,590	24
25	FIRE ALARMS/SMOKE DETECTORS	2005	2,134		10	213	213	1,474	25
26	TURNBURY INSULATED DOME	2005	1,545		10	155	155	1,072	26
27	STEEL PEDESTRIAN DOORS	2005	4,630		20	232	232	1,604	27
28	RED OAK UNFINISHED DOO	2005	1,580		15	105	105	718	28
29	FIRE DAMPERS	2005	5,294		10	529	529	3,571	29
30	SECURITY SYSTEM	2005	16,519		10	1,652	1,652	11,013	30
31	SMOKE DAMPER MOTORS	2005	7,524		10	752	752	5,014	31
32	ASPHALT REPLACEMENT	2005	10,862		8	1,358	1,358	8,940	32
33	SMOKE DAMPER MOTORS	2005	2,585		10	259	259	1,705	33
34	TOTAL (lines 1 thru 33)		\$ 3,558,361	\$ 80,405		\$ 114,120	\$ 33,715	\$ 1,738,163	34

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

Facility Name & ID Number WOOD GLEN PAVILION, LLC

0043935

Report Period Beginning:

1/1/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 114,120	\$ 33,715	\$ 1,738,163	1
2	BOILER REPLACEMENT	2005	18,998		20	950	950	6,017	2
3	SECURITY SYSTEM	2005	2,400		10	240	240	1,500	3
4	FIRE ALARM DEVICES INSTALL	2005	4,687		10	469	469	2,931	4
5	HOT WATER HEATER EXCHAN	2005	27,374		10	2,737	2,737	16,878	5
6	VINYL FENCE & WALK GATE	2005	3,844		10	384	384	2,368	6
7	SATELLITE TV & INTERNET (\$12,699 TO MME '08 CC AUDI	2005							7
8	DOOR HOLDERS	2006	3,324		10	332	332	1,965	8
9	HOT WATER COILS-OFFICE	2006	4,472		10	447	447	2,608	9
10	ADD CONCRETE TO PATIO	2006	8,476		15	565	565	3,202	10
11	ROOF WORK	2006	4,560		20	228	228	1,273	11
12	EGRESS DOORS	2006	1,651		10	165	165	908	12
13	DOORS	2006	1,631		10	160	160	1,631	13
14	CABLE,SPLITTERS, WALL PLA	2006	16,577		20	829	829	4,145	14
15	ALARM & SPRINKLER INSPECTION (\$3,640 REMOVED '08 C	2007							15
16	FAN COIL UNIT	2007	5,215		10	522	522	2,392	16
17	PEERLESS FENCE	2007	2,576		15	172	172	788	17
18	SEALCOATING & CRACK SEALING	2007	4,525		8	566	566	2,405	18
19	PS-35 PYROTRONICS POWER SUPPLY (41,992 REM '08 CC A	2007							19
20	DOORS	2007	2,585		10	259	259	1,058	20
21	CHILLER	2008	106,846		10	10,685	10,685	36,507	21
22	AIR HANDLER/PNEUMATIC CONTROL	2008	3,300		10	330	330	1,292	22
23	INSTALL DOORS (1ST-3RD FLOOR)	2008	2,597		10	260	260	1,018	23
24	COMDIAL MP5000	2008	14,730		10	1,473	1,473	5,769	24
25	CHILLER REPLACEMENT PROJ	2008	9,740		10	974	974	3,734	25
26	INSTALL DOORS (LINEN/GARBAGE))	2008	2,212		10	221	221	829	26
27	FIRE SPRINKLER SUBCONTRACTOR	2008	6,965		10	697	697	2,555	27
28	INSTALL NEW CONDENSER & EVAPORATOR	2008	6,191		10	619	619	2,270	28
29	SECURTY UNIT	2008	6,740		10	674	674	2,415	29
30	REPAIR FIRE PUMP RUN TIMER	2008	6,318		10	632	632	2,159	30
31	POWER SUPPLY & DOME CAMERA	2008	1,099		10	110	110	330	31
32	REPAIR/REPLACE THERMOSTATIC VALVE-HOT WATER S	2008	3,086		10	309	309	927	32
33	BOILER REPAIR	2009	33,860		10	3,386	3,386	8,042	33
34	TOTAL (lines 1 thru 33)		\$ 3,874,940	\$ 80,405		\$ 143,515	\$ 63,110	\$ 1,858,077	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 3,874,940	\$ 80,405		\$ 143,515	\$ 63,110	\$ 1,858,077	1
2	CHILLER REPLACEMENT	2009	136,577		10	13,658	13,658	35,647	2
3	REMOVE/REPLACE RUBBER WALL DETAIL	2009	2,900		10	290	290	580	3
4	INSTALL NEW DOORS & MAGNETIC CLOSERS	2009	6,987		10	699	699	1,398	4
5	BACKUP GENSET-REPLACE COOLANT, HTR HOSES, FILT	2009	1,205		10	121	121	242	5
6	PLUMBING-TWIST N CLOSE BATH WASTE	2009	1,086		10	109	109	218	6
7	ENTRY HEAT REMOVED/CLEANED BLOWERS	2009	2,547		10	255	255	510	7
8	BOILER #1 REPAIR	2009	4,138		10	414	414	828	8
9	FIRE ALARM REPAIR	2009	8,413		10	841	841	1,682	9
10	SPRINKLER REPAIR/REPLACE HEADS	2009	5,593		10	559	559	1,118	10
11	SPRINKLER INSPECTION	2009	2,282		10	228	228	456	11
12	REPAIR PLUMBING LEAKS	2009	776		10	78	78	156	12
13	PAINTING-DINING ROOM & PANTRY-CONTRACT-E&L PA	2011	5,730		5	1,146	1,146	1,146	13
14	VINYL FLOORING & BASEBOARD	2011	117,197		10	9,766	9,766	9,766	14
15	CCTV INSTALLATION	2011	14,936		5	1,494	1,494	1,494	15
16	WATER PUMP REPAIR, THERMOSTAT, HOSES & BELTS	2011	4,044		10	168	168	168	16
17				14,614			(14,614)		17
18				44,489			(44,489)		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)		\$ 4,189,351	\$ 139,508		\$ 173,341	\$ 33,833	\$ 1,913,486	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12E, Carried Forward		\$ 4,189,351	\$ 139,508		\$ 173,341	\$ 33,833	\$ 1,913,486	1
2	ALLOCATIONS FROM PLATINUM (HO):								2
3	BUILDING (CONSTRUCTED 1955; PURCH 2004)	2004	23,797						3
4	FIRE ALARM & SECURITY SYSTEM	2004	148						4
5	PAINTING	2004	160						5
6	CARPETING	2004	333						6
7	BLINDS	2004	78						7
8	BLINDS	2005	114						8
9	REMODELING-FLOORS, LIGHTS, PLUMBING & WALLS	2005	1,142						9
10	REMODELING-WALLS	2005	46						10
11	BATHROOM REMODELING	2005	114						11
12	BATHROOM REMODELING	2005	167						12
13	BATHROOM REMODELING	2006	651						13
14	WINDOWS	2006	285						14
15	TUCK POINTING	2008	96						15
16	REMODEL PARESH'S OFFICE	2008	352						16
17	HEAT EXCHANGER	2009	327						17
18	RENZOR UNIT HEATER	2009	328						18
19	RELOCATION OF STAT FOR NW UNIT HEATER	2009	65						19
20	REMODEL BOOKKEEPING OFFICE	2009	352						20
21	AWNING	2009	694						21
22	PARKING LOT REPAIR	2009	269						22
23	ROOF TOP UNIT	2010	1,385						23
24	COMPRESSOR AC UNIT	2010	186						24
25				1,160		1,160			25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,220,440	\$ 140,668		\$ 174,501	\$ 33,833	\$ 1,913,486	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 428,280	\$ 10,816	\$ 20,061	\$ 9,245		\$ 340,414	71
72	Current Year Purchases	14,494	1,734	1,734			1,734	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		2,954	2,954				74
75	TOTALS	\$ 442,774	\$ 15,504	\$ 24,749	\$ 9,245		\$ 342,148	75

D. Vehicle Costs. (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		BUS	2002	\$ 8,447	\$	\$	\$	5	\$ 8,447	76
77		GMC SIERRA	2004	30,357				4	30,357	77
78		WG VAN	2005	26,782	1,675		(1,675)	4	26,782	78
79										79
80	TOTALS			\$ 65,586	\$ 1,675	\$	\$ (1,675)		\$ 65,586	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)	\$ 5,193,800	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 157,847	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 199,250	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 41,403	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,321,220	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 21,610
- Description: Copier/printer \$12,824; Dish machine \$3,433; Med equip/beds \$1,657; Postage meter \$3,696
(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	Facility	204 Lexus GX470	\$	\$ 11,558	17
18	Facility	Honda	599.00	4,326	18
19					19
20					20
21	TOTAL		\$ 599.00	\$ 15,884	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		Facility			
		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)	\$			

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.)

12345678										
	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							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				73,304		73,304	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Ther	10a-03				226			226	12
13	Other (specify): Lab & X-ray	39-02					2,990		2,990	13
14	TOTAL			\$		\$ 226	\$ 76,294		\$ 76,520	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (7,203)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,769,332		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,787		6
7	Other Prepaid Expenses	1,867		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,858,783	\$	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	520,263		15
16	Equipment, at Historical Cost	366,120		16
17	Accumulated Depreciation (book methods)	(549,734)		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): Due Others	732,375		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,069,024	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,927,807	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 302,639	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,554,111		29
30	Accrued Salaries Payable	182,529		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	288,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	53,223		36
37	Due Others, Adv Billing	220,104		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,600,606	\$	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)	\$ 3,600,606	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,327,201	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,927,807	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 342,392	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 342,394	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,612,824	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	(628,017)	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)	\$ 984,807	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)	\$ 1,327,201	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,360,053	1
2	Discounts and Allowances for all Levels	(29,104)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,330,949	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	322,355	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 322,355	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	4,183	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	61,405	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,702	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 68,290	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	1,987	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,987	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,723,592	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,563,711	31
32	Health Care	2,891,510	32
33	General Administration	2,164,795	33
	B. Capital Expense		
34	Ownership	1,301,125	34
	C. Ancillary Expense		
35	Special Cost Centers	76,294	35
36	Provider Participation Fee	113,333	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,110,768	40
41	Income before Income Taxes (line 30 minus line 40)**	1,612,824	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,612,824	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 FILED 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.

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	1,792	2,080	\$ 130,854	\$ 62.91	1
2	Assistant Director of Nursing	5,688	6,184	242,138	39.16	2
3	Registered Nurses	22,179	23,238	746,167	32.11	3
4	Licensed Practical Nurses	10,162	10,859	297,791	27.42	4
5	CNAs & Orderlies	55,778	58,832	813,200	13.82	5
6	CNA Trainees					6
7	Licensed Therapist	508	508	27,391	53.92	7
8	Rehab/Therapy Aides	2,884	3,020	105,701	35.00	8
9	Activity Director					9
10	Activity Assistants	7,590	7,962	80,368	10.09	10
11	Social Service Workers	11,352	12,165	283,212	23.28	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,160	79,991	37.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,696	22,777	220,246	9.67	15
16	Dishwashers					16
17	Maintenance Workers	13,769	14,523	178,654	12.30	17
18	Housekeepers	26,290	28,294	246,602	8.72	18
19	Laundry					19
20	Administrator	1,920	2,080	250,605	120.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,807	6,275	217,796	34.71	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	1,952	2,230	25,220	11.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	191,327	203,187	\$ 3,945,936 *	\$ 19.42	34

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	\$ 8,723	1-03	35
36	Medical Director	Monthly	36,000	9-03	36
37	Medical Records Consultant	Quarterly	1,568	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		12,254	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	8	536	11-03	44
45	Social Service Consultant	10	585	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	197	\$ 59,666		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

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 \$19,468
- (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. \$ 12,549 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 113,333
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? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
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: _____
- (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.