

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 NSG & REHAB CTR</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</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 W 300 NORTH AVE</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:																																		
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td></tr><tr><td>☐</td><td>Charitable Corp.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td colspan="2">IRS Exemption Code _____</td></tr></table>	☐	VOLUNTARY, NON-PROFIT	☐	Charitable Corp.	☐	Trust	IRS Exemption Code _____		<table><tr><td>☐</td><td>PROPRIETARY</td></tr><tr><td>☐</td><td>Individual</td></tr><tr><td>☐</td><td>Partnership</td></tr><tr><td>☐</td><td>Corporation</td></tr><tr><td>☐</td><td>"Sub-S" Corp.</td></tr><tr><td>☒</td><td>Limited Liability Co.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	PROPRIETARY	☐	Individual	☐	Partnership	☐	Corporation	☐	"Sub-S" Corp.	☒	Limited Liability Co.	☐	Trust	☐	Other _____	<table><tr><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>State</td></tr><tr><td>☐</td><td>County</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	GOVERNMENTAL	☐	State	☐	County	☐	Other _____
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In the event there are further questions about this report, please contact:																																		
Name: <u>PAMELA PHILLIPS</u> Telephone Number: <u>(417) 865-8701</u>																																		
Email Address: _____																																		

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

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>68,342</u>		<u>1,858</u>	<u>70,200</u>	8
9	SNF/PED					9
10	ICF		<u>3,672</u>		<u>3,672</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>68,342</u>	<u>3,672</u>	<u>1,858</u>	<u>73,872</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 97.51%

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

452 (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?

YESG. 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 1994NO ☐

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 1,688Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

	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	306,278	31,594	8,652	346,524		346,524		346,524			1
2	Food Purchase		419,321		419,321		419,321	(3,033)	416,288			2
3	Housekeeping	250,769	41,110		291,879		291,879		291,879			3
4	Laundry		25,504		25,504		25,504		25,504			4
5	Heat and Other Utilities			229,907	229,907		229,907	3,584	233,491			5
6	Maintenance	169,737		128,897	298,634		298,634	5,397	304,031			6
7	Other (specify):*											7
8	TOTAL General Services	726,784	517,529	367,456	1,611,769		1,611,769	5,948	1,617,717			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,387,345	68,201	14,872	2,470,418		2,470,418		2,470,418			10
10a	Therapy	139,546		598	140,144		140,144		140,144			10a
11	Activities	66,110	4,087	942	71,139		71,139		71,139			11
12	Social Services	268,192			268,192		268,192		268,192			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,861,193	72,288	52,412	2,985,893		2,985,893		2,985,893			16
	C. General Administration											
17	Administrative	247,466		684,039	931,505		931,505	(181,220)	750,285			17
18	Directors Fees											18
19	Professional Services			170,662	170,662		170,662	11,017	181,679			19
20	Dues, Fees, Subscriptions & Promotions			26,991	26,991		26,991	(11,518)	15,473			20
21	Clerical & General Office Expenses	212,117	18,765	92,740	323,622		323,622	66,302	389,924			21
22	Employee Benefits & Payroll Taxes			528,942	528,942		528,942		528,942			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,617	1,617		1,617	637	2,254			24
25	Other Admin. Staff Transportation			17,236	17,236		17,236	4,793	22,029			25
26	Insurance-Prop.Liab.Malpractice			193,978	193,978		193,978	928	194,906			26
27	Other (specify):*							25,364	25,364			27
28	TOTAL General Administration	459,583	18,765	1,716,205	2,194,553		2,194,553	(83,697)	2,110,856			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,047,560	608,582	2,136,073	6,792,215		6,792,215	(77,749)	6,714,466			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			79,196	79,196		79,196	130,456	209,652			30
31	Amortization of Pre-Op. & Org.							171	171			31
32	Interest			47,120	47,120		47,120	259,851	306,971			32
33	Real Estate Taxes			327,219	327,219		327,219	1,415	328,634			33
34	Rent-Facility & Grounds			904,837	904,837		904,837	(904,398)	439			34
35	Rent-Equipment & Vehicles			43,849	43,849		43,849	1,506	45,355			35
36	Other (specify):*							3,759	3,759			36
37	TOTAL Ownership			1,402,221	1,402,221		1,402,221	(507,240)	894,981			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			84,828	84,828		84,828		84,828			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			882,286	882,286		882,286		882,286			42
43	Other (specify):*							(93,503)	(93,503)			43
44	TOTAL Special Cost Centers			967,114	967,114		967,114	(93,503)	873,611			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,047,560	608,582	4,505,408	9,161,550		9,161,550	(678,492)	8,483,058			45

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

		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	(2,989)	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	(40)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	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	(715)	21		18
19	Entertainment				19
20	Contributions	(2,275)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,740)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,767)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(146,452)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (162,022)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(516,470)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (516,470)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (678,492)		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

STATE OF ILLINOIS
WOOD GLEN NSG & REHAB CTR

Report Period Beginning: ID# 0043935
Ending: 1/1/12
12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	IL COUNCIL LTC - COPE	\$ (7,654)	20	1
2	BANK FEES	(31,251)	21	2
3	DAMAGE/THEFT/LOSS	(60)	21	3
4	ADJ TO S/L	(13,984)	30	4
5	MARKETING SALARIES	(82,720)	43	5
6	MARKETING EMPLOYEE BENEFITS	(10,783)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(146,452)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,033)	0	0	0	0	0	0	0	0	0	0	(3,033)	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	3,584	0	0	0	0	0	0	0	0	3,584	5
6	Maintenance	0	0	5,397	0	0	0	0	0	0	0	0	5,397	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,033)	0	8,981	0	0	0	0	0	0	0	0	5,948	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	(181,220)	0	0	0	0	0	0	0	0	(181,220)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(645)	11,662	0	0	0	0	0	0	0	0	11,017	19
20	Fees, Subscriptions & Promotions	(12,394)	0	876	0	0	0	0	0	0	0	0	(11,518)	20
21	Clerical & General Office Expenses	(39,068)	0	105,370	0	0	0	0	0	0	0	0	66,302	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	637	0	0	0	0	0	0	0	0	637	24
25	Other Admin. Staff Transportation	0	0	4,793	0	0	0	0	0	0	0	0	4,793	25
26	Insurance-Prop.Liab.Malpractice	0	0	928	0	0	0	0	0	0	0	0	928	26
27	Other (specify):*	0	0	25,364	0	0	0	0	0	0	0	0	25,364	27
28	TOTAL General Administration	(51,462)	(645)	(31,590)	0	0	0	0	0	0	0	0	(83,697)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,495)	(645)	(22,609)	0	0	0	0	0	0	0	0	(77,749)	29

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	(13,984)	139,688	4,752	0	0	0	0	0	0	0	0	130,456	30
31	Amortization of Pre-Op. & Org.	0	0	171	0	0	0	0	0	0	0	0	171	31
32	Interest	(40)	257,462	2,429	0	0	0	0	0	0	0	0	259,851	32
33	Real Estate Taxes	0	0	1,415	0	0	0	0	0	0	0	0	1,415	33
34	Rent-Facility & Grounds	0	(904,837)	439	0	0	0	0	0	0	0	0	(904,398)	34
35	Rent-Equipment & Vehicles	0	0	1,506	0	0	0	0	0	0	0	0	1,506	35
36	Other (specify):*	0	3,759	0	0	0	0	0	0	0	0	0	3,759	36
37	TOTAL Ownership	(14,024)	(503,928)	10,712	0	0	0	0	0	0	0	0	(507,240)	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):*	(93,503)	0	0	0	0	0	0	0	0	0	0	(93,503)	43
44	TOTAL Special Cost Centers	(93,503)	0	0	0	0	0	0	0	0	0	0	(93,503)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(162,022)	(504,573)	(11,897)	0	0	0	0	0	0	0	0	(678,492)	45

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 904,837	WOOD GLEN PAVILION REALTY, LLC		\$	(904,837)	1
2	V	30	DEPRECIATION				139,688	139,688	2
3	V	32	INTEREST				257,462	257,462	3
4	V	36	AMORTIZATION-LOAN COSTS				3,759	3,759	4
5	V								5
6	V								6
7	V								7
8	V	19	PROFESSIONAL FEES	26,400	PHC CONSULTANTS, LLC		25,755	(645)	8
9	V								9
10	V	19	PROFESSIONAL FEES	300	MTS CONSULTING		300		10
11	V								11
12	V								12
13	V								13
14	Total			\$ 931,537			\$ 426,964	\$ * (504,573)	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	\$ 204,039	PLATINUM HEALTH CARE, LLC	100.00%	\$	\$ (204,039)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		3,584	3,584	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		5,397	5,397	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		22,819	22,819	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		11,662	11,662	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		876	876	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		96,449	96,449	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		8,921	8,921	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		637	637	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		4,793	4,793	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		928	928	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		25,364	25,364	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		3,279	3,279	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		1,506	1,506	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		171	171	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,473	1,473	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		2,429	2,429	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		1,415	1,415	32
33	V	34	Office Rent		PLATINUM HEALTH CARE, LLC		439	439	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 204,039			\$ 192,142	\$ * (11,897)	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 LKEIN	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	2	3.85	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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PLATINUM HEALTH CARE, LLC
Street Address 7444 LONG AVENUE
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 329-4100
Fax Number (847) 329-7652

	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	923,219	30	\$ 44,791	\$	73,872	\$ 3,584	1
2	6	Repairs & Maintenance	Patient Days	923,219	30	67,446		73,872	5,397	2
3	17	Administrative Salary	Patient Days	923,219	30	285,177	285,177	73,872	22,819	3
4	19	Professional Fees	Patient Days	923,219	30	145,744		73,872	11,662	4
5	20	Fees, Subscriptions	Patient Days	923,219	30	10,954		73,872	876	5
6	21	Clerical Salaries	Patient Days	923,219	30	1,205,375	1,205,375	73,872	96,449	6
7	21	Office Expenses	Patient Days	923,219	30	111,487		73,872	8,921	7
8	24	Education & Seminars	Patient Days	923,219	30	7,956		73,872	637	8
9	25	Travel	Patient Days	923,219	30	59,896		73,872	4,793	9
10	26	Insurance	Patient Days	923,219	30	11,602		73,872	928	10
11	27	Employee Benefits	Patient Days	923,219	30	316,988		73,872	25,364	11
12	30	Depreciation	Patient Days	923,219	30	40,988		73,872	3,279	12
13	35	Equipment Rental	Patient Days	923,219	30	18,824		73,872	1,506	13
14	31	Amortization	Patient Days	923,219	30	2,134		73,872	171	14
15	30	Depreciation	Patient Days	923,219	30	18,405		73,872	1,473	15
16	32	Interest	Patient Days	923,219	30	30,356		73,872	2,429	16
17	33	Real Estate Taxes	Patient Days	923,219	30	17,678		73,872	1,415	17
18	34	Office Rent	Patient Days	923,219	30	5,488		73,872	439	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,401,289	\$ 1,490,552		\$ 192,142	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			\$					\$	257,462	1
2														2
3														3
4														4
5														5
	Working Capital													
6	HFG		X	LINE OF CREDIT									47,120	6
7														7
8														8
9	TOTAL Facility Related						\$					\$	304,582	9
	B. Non-Facility Related*													
10	INTEREST INCOME OFFSET												(40)	10
11														11
12														12
13	ALLOCATION FROM PLATINUM												2,429	13
14	TOTAL Non-Facility Related						\$					\$	2,389	14
15	TOTALS (line 9+line14)						\$					\$	306,971	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,433 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 2011 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.)		\$	307,219	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	19,219	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	308,000	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.		\$	327,219	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	252,405	8	
		2008	263,079	9	
		2009	286,692	10	
		2010	290,020	11	
		2011	307,219	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

WOOD GLEN NSG & REHAB CTR

COUNTY

DUPAGE

FACILITY IDPH LICENSE NUMBER

0043935

CONTACT PERSON REGARDING THIS REPORT

PAMELA PHILLIPS

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 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	01-28-401-085	Long Term Care	\$ 307,218.78	\$ 307,218.78
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 307,218.78	\$ 307,218.78

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 and 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

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	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4			1995	1995	\$ 3,067,125	\$ 78,645	35	\$ 87,632	\$ 8,987	\$ 1,488,547
5										
6										
7										
8										
	Improvement Type**									
9	FENCE		1998		5,042	337	15	337		5,264
10	FIRE ALARM		2002		44,058		20	2,203	2,203	41,416
11										
12	Various		1995		25,326		20	1,266	1,266	22,268
13	Various		1996		16,672		20	834	834	13,551
14	Various		1997		20,310		20	1,016	1,016	15,784
15	Various		1998		22,766		20	1,138	1,138	18,600
16						1,423			(1,423)	
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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 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	\$ 2,472	37
38	WATER HEATER	1999	4,100		20	205	205	2,696	38
39	CONTRACTOR	1999	919		20	46	46	621	39
40	PUMP	1999	1,887		20	94	94	1,228	40
41	MATV SYSTEM	1999	752		20	38	38	494	41
42	PRESSURE SWITCH	1999	1,341		20	67	67	871	42
43	BOILER	1999	1,964		20	98	98	1,274	43
44	AIR CONDITIONER	1999	612		20	31	31	403	44
45	SMOKE DETECTOR	1999	3,118		20	156	156	2,028	45
46	FIRE ALARM SYSTEM	1999	693		20	35	35	554	46
47	2 WATER HEATERS	2000	8,400		20	420	420	5,390	47
48	FLOORING	2000	1,284		20	64	64	789	48
49	CARPET	2000	1,284		20	64	64	784	49
50	FLOORING	2000	3,740		20	187	187	2,291	50
51	CARPET	2000	5,225		20	261	261	3,154	51
52	FIXTURES (\$31,000 REMOVED 2008 CAP COST AUDIT)	2000							52
53	FLUID PUMP	2000	2,429		20	121	121	1,533	53
54	FLUID PUMP	2000	905		20	45	45	570	54
55	FLUID PUMP SVC	2000	2,412		20	121	121	1,512	55
56	WATER LINES & DRAIN	2001	3,870		39	99	99	1,184	56
57	BURNER PILOT & PARTS	2001	1,593		39	41	41	490	57
58	4 DUPLEX OUTLETS	2001	2,275		39	58	58	694	58
59	WATER HEATER PIPING	2001	8,997		39	231	231	2,724	59
60	FLUES - WATER BOILER	2001	3,580		39	92	92	1,047	60
61	BRICK WALL	2001	4,515		39	116	116	1,300	61
62	EXPANSION MODULE	2001	947		20	47	47	544	62
63	CABLES	2001	1,031		20	52	52	576	63
64	CABLE WORK	2001	767		20	38	38	421	64
65	PHONES/CABLES	2001	544		20	27	27	324	65
66	LIGHTING	2001	1,022		20	51	51	565	66
67	LAMPS (\$742 TO MME PER '08 CAP COST AUDIT)	2001			20				67
68	FIRE PUMP WORK	2001	750		20	38	38	421	68
69	HEATING/COOLING WORK	2001	649		20	32	32	355	69
70	TOTAL (lines 4 thru 69)		\$ 3,276,654	\$ 80,405		\$ 97,589	\$ 17,184	\$ 1,644,739	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 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 12A, Carried Forward		\$ 3,276,654	\$ 80,405		\$ 97,589	\$ 17,184	\$ 1,644,739	1
2	LIGHTING	2001	903		20	45	45	506	2
3	MOTOR	2001	547		20	27	27	320	3
4	LIGHTING ENHANCEMENT	2001	903		20	45	45	521	4
5	REFRIGERATOR WORK	2001	1,044		20	52	52	585	5
6	PIPE WORK	2001	500		20	25	25	281	6
7	CONCERTE ANCHOR	2001	5,332		20	267	267	3,093	7
8	REFRIGERATOR WORK	2001	532		20	27	27	311	8
9	REFRIGERATOR WORK	2001	585		20	29	29	329	9
10	LIGHTING	2001	903		20	45	45	540	10
11	LIGHTING	2001	903		20	45	45	536	11
12	LIGHTING	2001	903		20	45	45	533	12
13	LIGHTING	2001	903		20	45	45	529	13
14	LIGHTING	2001	903		20	45	45	525	14
15	PUMP	2001	571		20	29	29	321	15
16	HEAT PUMP MOTOR	2001	1,409		20	70	70	782	16
17	PLUMBING	2001	1,038		20	52	52	624	17
18	PATIO	2002	2,250		10	94	94	2,250	18
19	A/C REPAIR	2002	3,529		10	146	146	3,529	19
20	A/C REPAIR	2002	1,305		10	61	61	1,306	20
21	A/C REPAIR	2002	1,240		10	72	72	1,240	21
22	A/C REPAIR	2002	888		10	72	72	888	22
23	A/C REPAIR	2002	846		10	74	74	846	23
24	A/C REPAIR	2002	664		10	37	37	664	24
25	WATER HEATERS	2002	1,700		10	71	71	1,700	25
26	WATER HEATERS	2002	2,460		10	102	102	2,460	26
27	FREEZER REPAIR	2002	587		20	29	29	319	27
28	FIRE PUMP WORK	2002	750		20	38	38	418	28
29	SERVICE PUMP	2002	540		20	27	27	297	29
30	ELECTRICAL SYSTEM	2002	528		20	26	26	286	30
31	PIPE WORK	2002	1,213		20	61	61	671	31
32	LIGHTING ENHANCEMENT	2002	12,442		20	622	622	6,842	32
33	MAIN ENTRANCE CAMERA	2003	13,445		5			13,445	33
34	TOTAL (lines 1 thru 33)		\$ 3,338,920	\$ 80,405		\$ 100,014	\$ 19,609	\$ 1,692,236	34

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

Facility Name & ID Number WOOD GLEN NSG & REHAB CTR

0043935

Report Period Beginning:

1/1/12

Ending:

12/31/12

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 12B, Carried Forward		\$ 3,338,920	\$ 80,405		\$ 100,014	\$ 19,609	\$ 1,692,236	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	1,426	5
6	CI RANG STEAM	2003	869		10	87	87	805	6
7	CI RANG STEAM	2003	2,289		10	229	229	2,118	7
8	DRAPES	2003	2,525		5			2,525	8
9	FROZEN COIL IN AIR HANDLER	2004	3,819		10	382	382	3,438	9
10	WATER HEATER	2004	8,714		10	871	871	7,694	10
11	INSTALL NEW COIL	2004	3,800		10	380	380	3,293	11
12	CONDENSING UNIT	2004	4,200		15	280	280	2,380	12
13	PLUMBING-DIALYSIS ROOM	2004	5,390		20	270	270	2,295	13
14	WATER HEATER	2004	6,748		10	675	675	5,737	14
15	SERVICE PUMP	2004	7,565		20	378	378	3,182	15
16	BOILER & STORAGE TANKS	2004	6,200		20	310	310	2,687	16
17	CHASE WALLS	2004	4,570		15	305	305	2,516	17
18	CARPETING	2004	12,311		5			12,311	18
19	HOT WATER TANK	2004	11,242		10	1,124	1,124	9,273	19
20	WATER TANK	2004	34,751		20	1,738	1,738	14,194	20
21	HOT WATER VALVE	2004	3,609		20	180	180	1,485	21
22	CARPETING	2004	28,726		5			28,726	22
23	HOT WATER BOILER	2004	7,344		20	367	367	2,936	23
24	ALUMINUM STREET SIGN DISP	2005	3,700		10	370	370	2,960	24
25	FIRE ALARMS/SMOKE DETECTORS	2005	2,134		10	213	213	1,687	25
26	TURNBURY INSULATED DOME	2005	1,545		10	155	155	1,227	26
27	STEEL PEDESTRIAN DOORS	2005	4,630		20	232	232	1,836	27
28	RED OAK UNFINISHED DOO	2005	1,580		15	105	105	823	28
29	FIRE DAMPERS	2005	5,294		10	529	529	4,100	29
30	SECURITY SYSTEM	2005	16,519		10	1,652	1,652	12,665	30
31	SMOKE DAMPER MOTORS	2005	7,524		10	752	752	5,766	31
32	ASPHALT REPLACEMENT	2005	10,862		8	1,358	1,358	10,298	32
33	SMOKE DAMPER MOTORS	2005	2,585		10	259	259	1,964	33
34	TOTAL (lines 1 thru 33)		\$ 3,558,361	\$ 80,405		\$ 113,360	\$ 32,955	\$ 1,851,525	34

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

Facility Name & ID Number WOOD GLEN NSG & REHAB CTR

0043935

Report Period Beginning:

1/1/12

Ending:

12/31/12

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 12C, Carried Forward		\$ 3,558,361	\$ 80,405		\$ 113,360	\$ 32,955	\$ 1,851,525	1
2	BOILER REPLACEMENT	2005	18,998		20	950	950	6,967	2
3	SECURITY SYSTEM	2005	2,400		10	240	240	1,740	3
4	FIRE ALARM DEVICES INSTALL	2005	4,687		10	469	469	3,400	4
5	HOT WATER HEATER EXCHAN	2005	27,374		10	2,737	2,737	19,615	5
6	VINYL FENCE & WALK GATE	2005	3,844		10	384	384	2,752	6
7	SATELLITE TV & INTERNET (\$12,699 TO MME '08 CC AUDI	2005							7
8	DOOR HOLDERS	2006	3,324		10	332	332	2,297	8
9	HOT WATER COILS-OFFICE	2006	4,472		10	447	447	3,055	9
10	ADD CONCRETE TO PATIO	2006	8,476		15	565	565	3,767	10
11	ROOF WORK	2006	4,560		20	228	228	1,501	11
12	EGRESS DOORS	2006	1,651		10	165	165	1,073	12
13	DOORS	2006	1,631		10	163	163	1,794	13
14	CABLE,SPLITTERS, WALL PLA	2006	16,577		20	829	829	4,974	14
15	ALARM & SPRINKLER INSPECTION (\$3,640 REMOVED '08 C	2007							15
16	FAN COIL UNIT	2007	5,215		10	522	522	2,914	16
17	PEERLESS FENCE	2007	2,576		15	172	172	960	17
18	SEALCOATING & CRACK SEALING	2007	4,525		8	566	566	2,971	18
19	PS-35 PYROTRONICS POWER SUPPLY (41,992 REM '08 CC A	2007							19
20	DOORS	2007	2,585		10	259	259	1,317	20
21	CHILLER	2008	106,846		10	10,685	10,685	47,192	21
22	AIR HANDLER/PNEUMATIC CONTROL	2008	3,300		10	330	330	1,622	22
23	INSTALL DOORS (1ST-3RD FLOOR)	2008	2,597		10	260	260	1,278	23
24	COMDIAL MP5000	2008	14,730		10	1,473	1,473	7,242	24
25	CHILLER REPLACEMENT PROJ	2008	9,740		10	974	974	4,708	25
26	INSTALL DOORS (LINEN/GARBAGE))	2008	2,212		10	221	221	1,050	26
27	FIRE SPRINKLER SUBCONTRACTOR	2008	6,965		10	697	697	3,252	27
28	INSTALL NEW CONDENSER & EVAPORATOR	2008	6,191		10	619	619	2,889	28
29	SECURTY UNIT	2008	6,740		10	674	674	3,089	29
30	REPAIR FIRE PUMP RUN TIMER	2008	6,318		10	632	632	2,791	30
31	POWER SUPPLY & DOME CAMERA	2008	1,099		10	110	110	440	31
32	REPAIR/REPLACE THERMOSTATIC VALVE-HOT WATER S	2008	3,086		10	309	309	1,236	32
33	BOILER REPAIR	2009	33,860		10	3,386	3,386	11,428	33
34	TOTAL (lines 1 thru 33)		\$ 3,874,940	\$ 80,405		\$ 142,758	\$ 62,353	\$ 2,000,837	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 12D, Carried Forward		\$ 3,874,940	\$ 80,405		\$ 142,758	\$ 62,353	\$ 2,000,837	1
2	CHILLER REPLACEMENT	2009	136,577		10	13,658	13,658	49,305	2
3	REMOVE/REPLACE RUBBER WALL DETAIL	2009	2,900		10	290	290	870	3
4	INSTALL NEW DOORS & MAGNETIC CLOSERS	2009	6,987		10	699	699	2,097	4
5	BACKUP GENSET-REPLACE COOLANT, HTR HOSES, FILTE	2009	1,205		10	121	121	363	5
6	PLUMBING-TWIST N CLOSE BATH WASTE	2009	1,086		10	109	109	327	6
7	ENTRY HEAT REMOVED/CLEANED BLOWERS	2009	2,547		10	255	255	765	7
8	BOILER #1 REPAIR	2009	4,138		10	414	414	1,242	8
9	FIRE ALARM REPAIR	2009	8,413		10	841	841	2,523	9
10	SPRINKLER REPAIR/REPLACE HEADS	2009	5,593		10	559	559	1,677	10
11	SPRINKLER INSPECTION	2009	2,282		10	228	228	684	11
12	REPAIR PLUMBING LEAKS	2009	776		10	78	78	234	12
13	PAINTING-DINING ROOM & PANTRY-CONTRACT-E&L PAI	2011	5,730		5	1,146	1,146	2,292	13
14	VINYL FLOORING & BASEBOARD-HALLWAYS/COMMON A	2011	117,197		10	11,720	11,720	21,486	14
15	CCTV INSTALLATION	2011	14,936		5	2,987	2,987	4,481	15
16	WATER PUMP REPAIR, THERMOSTAT, HOSES & BELTS	2011	4,044		10	404	404	572	16
17	FIRE DAMPERS & FIRE/SMOKE DAMPERS	2012	73,946		10	4,930	4,930	4,930	17
18	DRYWALL REPAIR DINING ROOM 1ST FLOOR-CONTRACT	2012	2,800		10	210	210	210	18
19	WATER PUMP REPLACEMENT	2012	3,892		15	173	173	173	19
20	FIRE DAMPER CONSTRUCTION	2012	75,000		10	2,500	2,500	2,500	20
21	FIRE DAMPER UPDATES	2012	50,000		10	833	833	833	21
22	REPLACE CPU	2012	6,016		10	50	50	50	22
23				69,342			(69,342)		23
24				55,984			(55,984)		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)		\$ 4,401,005	\$ 205,731		\$ 184,963	\$ (20,768)	\$ 2,098,451	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		\$ 4,401,005	\$ 205,731		\$ 184,963	\$ (20,768)	\$ 2,098,451	1
2	ALLOCATIONS FROM PLATINUM (HO):								2
3	BUILDING (CONSTRUCTED 1955; PURCH 2004)	2004	22,672						3
4	FIRE ALARM & SECURITY SYSTEM	2004	141						4
5	PAINTING	2004	152						5
6	CARPETING	2004	317						6
7	BLINDS	2004	74						7
8	BLINDS	2005	109						8
9	REMODELING-FLOORS, LIGHTS, PLUMBING & WALLS	2005	1,088						9
10	REMODELING-WALLS	2005	44						10
11	BATHROOM REMODELING	2005	109						11
12	BATHROOM REMODELING	2005	159						12
13	BATHROOM REMODELING	2006	620						13
14	WINDOWS	2006	272						14
15	TUCK POINTING	2008	91						15
16	REMODEL PARESH'S OFFICE	2008	336						16
17	HEAT EXCHANGER	2009	311						17
18	RENZOR UNIT HEATER	2009	312						18
19	RELOCATION OF STAT FOR NW UNIT HEATER	2009	61						19
20	REMODEL BOOKKEEPING OFFICE	2009	336						20
21	AWNING	2009	661						21
22	PARKING LOT REPAIR	2009	256						22
23	ROOF TOP UNIT	2010	1,319						23
24	COMPRESSOR AC UNIT	2010	177						24
25				1,051		1,051			25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,430,622	\$ 206,782		\$ 186,014	\$ (20,768)	\$ 2,098,451	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	\$442,774	\$8,078	\$19,659	\$11,581		\$354,952	71
72	Current Year Purchases	6,214	3,400	278	(3,122)		278	72
73	Fully Depreciated Assets							73
74	ALLOCATION FROM PLATINUM		3,700	3,700				74
75	TOTALS	\$448,988	\$15,178	\$23,637	\$8,459		\$355,230	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	2	
	Reference	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)	\$5,410,19681
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$223,63582
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$209,65183**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(13,984)84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,519,26785

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: \$ 26,411
- Description: Beds 3,905; Maint equip 618; Printer/copier 11,881; Dish mach 3,486; CPAP 2,400; Postage mtr 4,122
- (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	2011 Escalade	\$ #####	\$ 14,700	17
18	Facility	2012 Honda Civic	599.36	6,593	18
19	Facility	2007 Ford E350 Van	#####	2,400	19
20				(6,255)	20
21	TOTAL		\$ #####	\$ 17,438	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

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.)

		1	2	3	4	5	6	7	8	
	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				83,081		83,081	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Cons	10a-03				598			598	12
13	Other (specify): Lab & X-ray	39-02					1,747		1,747	13
14	TOTAL			\$		\$ 598	\$ 84,828		\$ 85,426	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 65,279	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,206,901		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,782		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,342,962	\$	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	576,279		15
16	Equipment, at Historical Cost	369,406		16
17	Accumulated Depreciation (book methods)	(628,930)		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):	228,361		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 545,116	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,888,078	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 528,699	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	375,957		29
30	Accrued Salaries Payable	55,167		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	308,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	165,938		36
37	Due Others, Adv Billing	289,023		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,722,784	\$	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)	\$ 1,722,784	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,165,294	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,888,078	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,327,201	1
2	Restatements (describe):		2
3			3
4	ROUNDING	3	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,327,204	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,319,814	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	(481,724)	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)	\$ 838,090	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)	\$ 2,165,294	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		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,600,362	1
2	Discounts and Allowances for all Levels	465,772	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,066,134	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	329,117	6
7	Oxygen	250	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 329,367	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	2,989	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	80,332	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,073	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 86,394	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	40	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 40	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	(571)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (571)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,481,364	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,611,769	31
32	Health Care	2,985,893	32
33	General Administration	2,194,553	33
B. Capital Expense			
34	Ownership	1,402,221	34
C. Ancillary Expense			
35	Special Cost Centers	84,828	35
36	Provider Participation Fee	882,286	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,161,550	40
41	Income before Income Taxes (line 30 minus line 40)**	1,319,814	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,319,814	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,885,512	44
45	Private Pay - Net Inpatient Revenue	554,135	45
46	Medicare - Net Inpatient Revenue	326,987	46
47	Other-(specify) <u>Managed Care</u>	22,711	47
48	Other-(specify) <u>Part B, Bad Debts, Prior Period Adjustments</u>	276,789	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,066,134	49

* 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	1,880	2,081	\$ 128,874	\$ 61.93	1
2	Assistant Director of Nursing	4,736	5,316	204,892	38.54	2
3	Registered Nurses	20,671	21,396	702,503	32.83	3
4	Licensed Practical Nurses	13,003	13,677	371,684	27.18	4
5	CNAs & Orderlies	61,388	64,125	910,007	14.19	5
6	CNA Trainees					6
7	Licensed Therapist	739	739	38,160	51.64	7
8	Rehab/Therapy Aides	2,578	2,922	101,386	34.70	8
9	Activity Director					9
10	Activity Assistants	6,225	6,710	66,110	9.85	10
11	Social Service Workers	10,935	12,033	268,192	22.29	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	78,530	37.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,673	22,702	227,748	10.03	15
16	Dishwashers					16
17	Maintenance Workers	12,159	12,814	169,737	13.25	17
18	Housekeepers	25,693	27,735	250,769	9.04	18
19	Laundry					19
20	Administrator	1,864	2,085	247,466	118.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,290	6,678	212,117	31.76	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	3,687	4,098	69,385	16.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	195,497	207,191	\$ 4,047,560 *	\$ 19.54	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	157	\$ 8,652	1.3	35
36	Medical Director	Monthly	36,000	9.3	36
37	Medical Records Consultant	Quarterly	1,176	10.3	37
38	Nurse Consultant		304	10.3	38
39	Pharmacist Consultant		13,392	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	812	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	169	\$ 60,336		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.

STATE OF ILLINOIS

0043935

Report Period Beginning:

1/1/12

Page 21

Ending: 12/31/12

Facility Name & ID Number

WOOD GLEN NSG & REHAB CTR

XIX. SUPPORT SCHEDULES

A. Administrative Salaries <table> <tr> <th>Name</th> <th>Function</th> <th>Ownership %</th> <th>Amount</th> </tr> <tr> <td>JEFFREY WHITE</td> <td>ADMINISTRATOR</td> <td></td> <td>\$ 247,466</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 247,466</td> </tr> </table>				Name	Function	Ownership %	Amount	JEFFREY WHITE	ADMINISTRATOR		\$ 247,466																					TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 247,466	D. Employee Benefits and Payroll Taxes <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>Workers' Compensation Insurance</td> <td>\$ 67,424</td> </tr> <tr> <td>Unemployment Compensation Insurance</td> <td>38,892</td> </tr> <tr> <td>FICA Taxes</td> <td>306,606</td> </tr> <tr> <td>Employee Health Insurance</td> <td>41,247</td> </tr> <tr> <td>Employee Meals</td> <td></td> </tr> <tr> <td>Illinois Municipal Retirement Fund (IMRF)*</td> <td></td> </tr> <tr> <td>401K</td> <td>1,093</td> </tr> <tr> <td>EMPLOYEE BENEFITS - OTHER</td> <td>73,625</td> </tr> <tr> <td>EMPLOYEE PHYSICAL EXAM</td> <td>55</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 22, col.8)</td> </tr> </table>				Description	Amount	Workers' Compensation Insurance	\$ 67,424	Unemployment Compensation Insurance	38,892	FICA Taxes	306,606	Employee Health Insurance	41,247	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		401K	1,093	EMPLOYEE BENEFITS - OTHER	73,625	EMPLOYEE PHYSICAL EXAM	55							TOTAL (agree to Schedule V, line 22, col.8)		F. Dues, Fees, Subscriptions and Promotions <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>IDPH License Fee</td> <td>\$</td> </tr> <tr> <td>Advertising: Employee Recruitment</td> <td>339</td> </tr> <tr> <td>Health Care Worker Background Check (Indicate # of checks performed 86)</td> <td>982</td> </tr> <tr> <td>Patient Background Checks</td> <td>6</td> </tr> <tr> <td>ADVERTISING & MARKETING</td> <td>4,740</td> </tr> <tr> <td>DUES & SUBSCRIPTIONS</td> <td>11,553</td> </tr> <tr> <td>LICENSES</td> <td>1,723</td> </tr> <tr><td> </td><td> </td></tr> <tr> <td>ALLOCATION FROM PLATINUM</td> <td>876</td> </tr> <tr> <td>Less: Public Relations Expense</td> <td>()</td> </tr> <tr> <td>Non-allowable advertising</td> <td>(4,740)</td> </tr> <tr> <td>Yellow page advertising</td> <td>()</td> </tr> <tr> <td colspan="2">TOTAL (agree to Sch. V, line 20, col. 8)</td> </tr> </table>				Description	Amount	IDPH License Fee	\$	Advertising: Employee Recruitment	339	Health Care Worker Background Check (Indicate # of checks performed 86)	982	Patient Background Checks	6	ADVERTISING & MARKETING	4,740	DUES & SUBSCRIPTIONS	11,553	LICENSES	1,723			ALLOCATION FROM PLATINUM	876	Less: Public Relations Expense	()	Non-allowable advertising	(4,740)	Yellow page advertising	()	TOTAL (agree to Sch. V, line 20, col. 8)	
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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 ON LTC \$18,996

(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?

(5) Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 17,949

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.

\$ 882,286

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.

\$ N/A

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$ N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

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 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.