FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0043935

Facility Name: WOOD GLEN NURSING & REHAB CTR

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

County: DUPAGE

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 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.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) DARRYL BUEKER, CPA / PARTNER
(Firm Name & Address) BKD, LLP / P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	207	Skilled (SNF)	207	75,555	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	207	TOTALS	207	75,555	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	69,193		700	69,893	8
9	SNF/PED					9
10	ICF		2,903		2,903	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,193	2,903	700	72,796	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.35%

D. How many bed-hold days during this year were paid by the Department?
524 (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 207 and days of care provided 689

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	288,745	25,145	8,196	322,086		322,086		322,086			1
2	Food Purchase		367,605		367,605		367,605	(4,648)	362,957			2
3	Housekeeping	269,782	45,969		315,751		315,751		315,751			3
4	Laundry			45,307	45,307		45,307		45,307			4
5	Heat and Other Utilities			277,611	277,611		277,611	6,521	284,132			5
6	Maintenance	137,650		106,852	244,502		244,502	6,118	250,620			6
7	Other (specify):*											7
8	**TOTAL General Services**	696,177	438,719	437,966	1,572,862		1,572,862	7,991	1,580,853			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,296,666	83,067	14,375	2,394,108		2,394,108		2,394,108			10
10a	Therapy	132,716		275	132,991		132,991		132,991			10a
11	Activities	80,062	5,737	1,318	87,117		87,117		87,117			11
12	Social Services	213,119		105	213,224		213,224		213,224			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,722,563	88,804	52,073	2,863,440		2,863,440		2,863,440			16
	C. General Administration											
17	Administrative	174,621		628,320	802,941		802,941	(123,415)	679,526			17
18	Directors Fees											18
19	Professional Services			138,257	138,257		138,257	8,632	146,889			19
20	Dues, Fees, Subscriptions & Promotions			26,233	26,233		26,233	(8,805)	17,428			20
21	Clerical & General Office Expenses	203,187	18,142	95,088	316,417		316,417	94,354	410,771			21
22	Employee Benefits & Payroll Taxes			503,166	503,166		503,166		503,166			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,771	7,771		7,771	576	8,347			24
25	Other Admin. Staff Transportation			18,049	18,049		18,049	(285)	17,764			25
26	Insurance-Prop.Liab.Malpractice			183,153	183,153		183,153	841	183,994			26
27	Other (specify):*							18,478	18,478			27
28	**TOTAL General Administration**	377,808	18,142	1,600,037	1,995,987		1,995,987	(9,624)	1,986,363			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,796,548	545,665	2,090,076	6,432,289		6,432,289	(1,633)	6,430,656			29

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

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR #0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			42,229	42,229		42,229	156,472	198,701			30
31	Amortization of Pre-Op. & Org.							458	458			31
32	Interest			14,257	14,257		14,257	245,947	260,204			32
33	Real Estate Taxes			310,692	310,692		310,692	2,191	312,883			33
34	Rent-Facility & Grounds			784,891	784,891		784,891	(784,891)				34
35	Rent-Equipment & Vehicles			31,885	31,885		31,885	342	32,227			35
36	Other (specify):*							3,759	3,759			36
37	**TOTAL Ownership**			1,183,954	1,183,954		1,183,954	(375,722)	808,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			52,246	52,246		52,246		52,246			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):*							(43,734)	(43,734)			43
44	**TOTAL Special Cost Centers**			165,579	165,579		165,579	(43,734)	121,845			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,796,548	545,665	3,439,609	7,781,822		7,781,822	(421,089)	7,360,733			45

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	(4,645)	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	(25)	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				17
18	Fines and Penalties	(8,645)	21		18
19	Entertainment				19
20	Contributions	(4,550)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,485)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,171)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(48,237)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (79,761)		$	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)	(341,328)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (341,328)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (421,089)		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

STATE OF ILLINOIS

WOOD GLEN NURSING & REHAB CTR

ID# 0043935

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (7,199)	20	1
2	BANK FEES	(25,985)	21	2
3	TAXES - GENERAL	(458)	21	3
4	DAMAGE/THEFT/LOSS	(1,763)	21	4
5	TRAVEL EXPENSE	(8,528)	25	5
6	MARKETING SALARIES	(38,616)	43	6
7	MARKETING EMPLOYEE BENEFITS	(5,118)	43	7
8	ADJ TO S/L	39,430	30	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**	(48,237)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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	(4,648)	0	0	0	0	0	0	0	0	0	0	(4,648)	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	6,521	0	0	0	0	0	0	0	0	6,521	5
6	Maintenance	0	0	6,118	0	0	0	0	0	0	0	0	6,118	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,648)	0	12,639	0	0	0	0	0	0	0	0	7,991	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	(123,415)	0	0	0	0	0	0	0	0	(123,415)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(1,485)	10,117	0	0	0	0	0	0	0	0	8,632	19
20	Fees, Subscriptions & Promotions	(10,684)	0	1,879	0	0	0	0	0	0	0	0	(8,805)	20
21	Clerical & General Office Expenses	(51,572)	0	145,926	0	0	0	0	0	0	0	0	94,354	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	576	0	0	0	0	0	0	0	0	576	24
25	Other Admin. Staff Transportation	(8,528)	0	8,243	0	0	0	0	0	0	0	0	(285)	25
26	Insurance-Prop.Liab.Malpractice	0	0	841	0	0	0	0	0	0	0	0	841	26
27	Other (specify):*	0	0	18,478	0	0	0	0	0	0	0	0	18,478	27
28	**TOTAL General Administration**	(70,784)	(1,485)	62,645	0	0	0	0	0	0	0	0	(9,624)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(75,432)	(1,485)	75,284	0	0	0	0	0	0	0	0	(1,633)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	39,430	112,983	4,059	0	0	0	0	0	0	0	0	156,472	30
31	Amortization of Pre-Op. & Org.	0	0	458	0	0	0	0	0	0	0	0	458	31
32	Interest	(25)	242,074	3,898	0	0	0	0	0	0	0	0	245,947	32
33	Real Estate Taxes	0	0	2,191	0	0	0	0	0	0	0	0	2,191	33
34	Rent-Facility & Grounds	0	(784,891)	0	0	0	0	0	0	0	0	0	(784,891)	34
35	Rent-Equipment & Vehicles	0	0	342	0	0	0	0	0	0	0	0	342	35
36	Other (specify):*	0	3,759	0	0	0	0	0	0	0	0	0	3,759	36
37	**TOTAL Ownership**	39,405	(426,075)	10,948	0	0	0	0	0	0	0	0	(375,722)	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):*	(43,734)	0	0	0	0	0	0	0	0	0	0	(43,734)	43
44	**TOTAL Special Cost Centers**	(43,734)	0	0	0	0	0	0	0	0	0	0	(43,734)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(79,761)	(427,560)	86,232	0	0	0	0	0	0	0	0	(421,089)	45

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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	$ 784,891	WOOD GLEN PAVILION REALTY, LLC		$	$ (784,891)	1
2	V	30	DEPRECIATION				112,983	112,983	2
3	V	32	INTEREST				242,074	242,074	3
4	V	36	AMORTIZATION-LOAN COSTS				3,759	3,759	4
5	V								5
6	V								6
7	V	19	PROFESSIONAL FEES	27,200	PHC CONSULTANTS, LLC		25,715	(1,485)	7
8	V								8
9	V	19	PROFESSIONAL FEES	2,664	MTS CONSULTING		2,664		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 814,755			$ 387,195	$ * (427,560)	14

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] 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)	
15	V	17	HOME OFFICE	$ 148,320	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (148,320)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		6,521	6,521	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		6,118	6,118	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		24,905	24,905	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		10,117	10,117	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		1,879	1,879	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		128,965	128,965	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		16,961	16,961	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		576	576	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		8,243	8,243	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		841	841	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		18,478	18,478	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,754	1,754	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		342	342	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		458	458	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		2,305	2,305	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		3,898	3,898	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		2,191	2,191	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 148,320			$ 234,552	$ * 86,232	39

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BEN KLEIN		Administrative	70.10	SEE ATTACHED	2	6.45	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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	581,243	18	$ 52,068	$	72,796	$ 6,521	1
2	6	Repairs & Maintenance	Patient Days	581,243	18	48,848		72,796	6,118	2
3	17	Administrative Salary	Patient Days	581,243	18	198,854	198,854	72,796	24,905	3
4	19	Professional Fees	Patient Days	581,243	18	80,779		72,796	10,117	4
5	20	Fees, Subscriptions	Patient Days	581,243	18	15,003		72,796	1,879	5
6	21	Clerical Salaries	Patient Days	581,243	18	1,029,725	1,029,725	72,796	128,965	6
7	21	Office Expenses	Patient Days	581,243	18	135,424		72,796	16,961	7
8	24	Education & Seminars	Patient Days	581,243	18	4,602		72,796	576	8
9	25	Travel	Patient Days	581,243	18	65,815		72,796	8,243	9
10	26	Insurance	Patient Days	581,243	18	6,717		72,796	841	10
11	27	Employee Benefits	Patient Days	581,243	18	147,536		72,796	18,478	11
12	30	Depreciation	Patient Days	581,243	18	14,004		72,796	1,754	12
13	35	Equipment Rental	Patient Days	581,243	18	2,729		72,796	342	13
14	31	Amortization	Patient Days	581,243	18	3,657		72,796	458	14
15	30	Depreciation	Patient Days	581,243	18	18,405		72,796	2,305	15
16	32	Interest	Patient Days	581,243	18	31,121		72,796	3,898	16
17	33	Real Estate Taxes	Patient Days	581,243	18	17,492		72,796	2,191	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,872,779	$ 1,228,579		$ 234,552	25

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1			X	MORTGAGE			$	$			$ 242,074	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Cole Taylor Bank		X	LINE OF CREDIT							14,257	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 256,331	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(25)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										3,898	13
14	TOTAL Non-Facility Related						$	$			$ 3,873	14
15	TOTALS (line 9+line14)						$	$			$ 260,204	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 21,985 **Line #** 32

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

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR **#** 0043935 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 264,000	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.)		$ 286,692	2
3. Under or (over) accrual (line 2 minus line 1).		$ 22,692	3
4. Real Estate Tax accrual used for 2010 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.		$ 310,692	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	190,000	8
2006	200,113	9
2007	252,405	10
2008	263,079	11
2009	286,692	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOOD GLEN NURSING & REHAB CTR COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0043935

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

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

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-28-401-085	Long Term Care	$ 286,691.68	$ 286,691.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 286,691.68	$ 286,691.68

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X] (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 [X] (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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 465,000	1
2					2
3	TOTALS			$ 465,000	3

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1995	1995	$ 3,067,125	$ 78,645	35	$ 87,632	$ 8,987	$ 1,313,283	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FENCE			1998	5,042	337	15	337		4,590	9
10	FIRE ALARM			2002	44,058		20	2,203	2,203	37,010	10
11											11
12	Various			1995	25,326		20	1,266	1,266	19,736	12
13	Various			1996	16,672		20	834	834	11,883	13
14	Various			1997	20,310		20	1,016	1,016	13,752	14
15	Various			1998	22,766		20	1,138	1,138	16,324	15
16						1,423			(1,423)		16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LOBBY IMPROVEMENTS	1999	$ 3,750	$	20	$ 188	$ 188	$ 2,096	37
38	WATER HEATER	1999	4,100		20	205	205	2,286	38
39	CONTRACTOR	1999	919		20	46	46	529	39
40	PUMP	1999	1,887		20	94	94	1,040	40
41	MATV SYSTEM	1999	752		20	38	38	418	41
42	PRESSURE SWITCH	1999	1,341		20	67	67	737	42
43	BOILER	1999	1,964		20	98	98	1,078	43
44	AIR CONDITIONER	1999	612		20	31	31	341	44
45	SMOKE DETECTOR	1999	3,118		20	156	156	1,716	45
46	FIRE ALARM SYSTEM	1999	693		20	35	35	484	46
47	2 WATER HEATERS	2000	8,400		20	420	420	4,550	47
48	FLOORING	2000	1,284		20	64	64	661	48
49	CARPET	2000	1,284		20	64	64	656	49
50	FLOORING	2000	3,740		20	187	187	1,917	50
51	CARPET	2000	5,225		20	261	261	2,632	51
52	FIXTURES ($31,000 REMOVED 2008 CAP COST AUDIT)	2000							52
53	FLUID PUMP	2000	2,429		20	121	121	1,291	53
54	FLUID PUMP	2000	905		20	45	45	480	54
55	FLUID PUMP SVC	2000	2,412		20	121	121	1,270	55
56	WATER LINES & DRAIN	2001	3,870		39	99	99	986	56
57	BURNER PILOT & PARTS	2001	1,593		39	41	41	408	57
58	4 DUPLEX OUTLETS	2001	2,275		39	58	58	578	58
59	WATER HEATER PIPING	2001	8,997		39	231	231	2,262	59
60	FLUES - WATER BOILER	2001	3,580		39	92	92	863	60
61	BRICK WALL	2001	4,515		39	116	116	1,068	61
62	EXPANSION MODULE	2001	947		20	47	47	450	62
63	CABLES	2001	1,031		20	52	52	472	63
64	CABLE WORK	2001	767		20	38	38	345	64
65	PHONES/CABLES	2001	544		20	27	27	270	65
66	LIGHTING	2001	1,022		20	51	51	463	66
67	LAMPS ($742 TO MME PER '08 CAP COST AUDIT)	2001			20				67
68	FIRE PUMP WORK	2001	750		20	38	38	345	68
69	HEATING/COOLING WORK	2001	649		20	32	32	291	69
70	TOTAL (lines 4 thru 69)		$ 3,276,654	$ 80,405		$ 97,589	$ 17,184	$ 1,449,561	70

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,276,654	$ 80,405		$ 97,589	$ 17,184	$ 1,449,561	1
2	LIGHTING	2001	903		20	45	45	416	2
3	MOTOR	2001	547		20	27	27	266	3
4	LIGHTING ENHANCEMENT	2001	903		20	45	45	431	4
5	REFRIGERATOR WORK	2001	1,044		20	52	52	481	5
6	PIPE WORK	2001	500		20	25	25	231	6
7	CONCERTE ANCHOR	2001	5,332		20	267	267	2,559	7
8	REFRIGERATOR WORK	2001	532		20	27	27	257	8
9	REFRIGERATOR WORK	2001	585		20	29	29	271	9
10	LIGHTING	2001	903		20	45	45	450	10
11	LIGHTING	2001	903		20	45	45	446	11
12	LIGHTING	2001	903		20	45	45	443	12
13	LIGHTING	2001	903		20	45	45	439	13
14	LIGHTING	2001	903		20	45	45	435	14
15	PUMP	2001	571		20	29	29	263	15
16	HEAT PUMP MOTOR	2001	1,409		20	70	70	642	16
17	PLUMBING	2001	1,038		20	52	52	520	17
18	PATIO	2002	2,250		10	225	225	1,931	18
19	A/C REPAIR	2002	3,529		10	353	353	3,030	19
20	A/C REPAIR	2002	1,305		10	131	131	1,113	20
21	A/C REPAIR	2002	1,240		10	124	124	1,044	21
22	A/C REPAIR	2002	888		10	89	89	727	22
23	A/C REPAIR	2002	846		10	85	85	687	23
24	A/C REPAIR	2002	664		10	66	66	561	24
25	WATER HEATERS	2002	1,700		10	170	170	1,459	25
26	WATER HEATERS	2002	2,460		10	246	246	2,112	26
27	FREEZER REPAIR	2002	587		20	29	29	261	27
28	FIRE PUMP WORK	2002	750		20	38	38	342	28
29	SERVICE PUMP	2002	540		20	27	27	243	29
30	ELECTRICAL SYSTEM	2002	528		20	26	26	234	30
31	PIPE WORK	2002	1,213		20	61	61	549	31
32	LIGHTING ENHANCEMENT	2002	12,442		20	622	622	5,598	32
33	MAIN ENTRANCE CAMERA	2003	13,445		5			13,445	33
34	TOTAL (lines 1 thru 33)		$ 3,338,920	$ 80,405		$ 100,774	$ 20,369	$ 1,491,447	34

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,338,920	$ 80,405		$ 100,774	$ 20,369	$ 1,491,447	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	1,136	5
6	CI RANG STEAM	2003	869		10	87	87	631	6
7	CI RANG STEAM	2003	2,289		10	229	229	1,660	7
8	DRAPES	2003	2,525		5			2,525	8
9	FROZEN COIL IN AIR HANDLER	2004	3,819		10	382	382	2,674	9
10	WATER HEATER	2004	8,714		10	871	871	5,952	10
11	INSTALL NEW COIL	2004	3,800		10	380	380	2,533	11
12	CONDENSING UNIT	2004	4,200		15	280	280	1,820	12
13	PLUMBING-DIALYSIS ROOM	2004	5,390		20	270	270	1,755	13
14	WATER HEATER	2004	6,748		10	675	675	4,387	14
15	SERVICE PUMP	2004	7,565		20	378	378	2,426	15
16	BOILER & STORAGE TANKS	2004	6,200		20	310	310	2,067	16
17	CHASE WALLS	2004	4,570		15	305	305	1,906	17
18	CARPETING	2004	12,311		5			12,311	18
19	HOT WATER TANK	2004	11,242		10	1,124	1,124	7,025	19
20	WATER TANK	2004	34,751		20	1,738	1,738	10,718	20
21	HOT WATER VALVE	2004	3,609		20	180	180	1,125	21
22	CARPETING	2004	28,726		5			28,726	22
23	HOT WATER BOILER	2004	7,344		20	367	367	2,202	23
24	ALUMINUM STREET SIGN DISP	2005	3,700		10	370	370	2,220	24
25	FIRE ALARMS/SMOKE DETECTORS	2005	2,134		10	213	213	1,261	25
26	TURNBURY INSULATED DOME	2005	1,545		10	155	155	917	26
27	STEEL PEDESTRIAN DOORS	2005	4,630		20	232	232	1,372	27
28	RED OAK UNFINISHED DOO	2005	1,580		15	105	105	613	28
29	FIRE DAMPERS	2005	5,294		10	529	529	3,042	29
30	SECURITY SYSTEM	2005	16,519		10	1,652	1,652	9,361	30
31	SMOKE DAMPER MOTORS	2005	7,524		10	752	752	4,262	31
32	ASPHALT REPLACEMENT	2005	10,862		8	1,358	1,358	7,582	32
33	SMOKE DAMPER MOTORS	2005	2,585		10	259	259	1,446	33
34	TOTAL (lines 1 thru 33)		$ 3,558,361	$ 80,405		$ 114,120	$ 33,715	$ 1,624,043	34

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,558,361	$ 80,405		$ 114,120	$ 33,715	$ 1,624,043	1
2	BOILER REPLACEMENT	2005	18,998		20	950	950	5,067	2
3	SECURITY SYSTEM	2005	2,400		10	240	240	1,260	3
4	FIRE ALARM DEVICES INSTALL	2005	4,687		10	469	469	2,462	4
5	HOT WATER HEATER EXCHAN	2005	27,374		10	2,737	2,737	14,141	5
6	VINYL FENCE & WALK GATE	2005	3,844		10	384	384	1,984	6
7	SATELLITE TV & INTERNET ($12,699 TO MME '08 CC AUDI	2005							7
8	DOOR HOLDERS	2006	3,324		10	332	332	1,633	8
9	HOT WATER COILS-OFFICE	2006	4,472		10	447	447	2,161	9
10	ADD CONCRETE TO PATIO	2006	8,476		15	565	565	2,637	10
11	ROOF WORK	2006	4,560		20	228	228	1,045	11
12	EGRESS DOORS	2006	1,651		10	165	165	743	12
13	DOORS	2006	1,631		10	163	163	1,471	13
14	CABLE,SPLITTERS, WALL PLA	2006	16,577		20	829	829	3,316	14
15	ALARM & SPRINKLER INSPECTION ($3,640 REMOVED '08 C	2007							15
16	FAN COIL UNIT	2007	5,215		10	522	522	1,870	16
17	PEERLESS FENCE	2007	2,576		15	172	172	616	17
18	SEALCOATING & CRACK SEALING	2007	4,525		8	566	566	1,839	18
19	PS-35 PYROTRONICS POWER SUPPLY (41,992 REM '08 CC A	2007							19
20	DOORS	2007	2,585		10	259	259	799	20
21	CHILLER	2008	106,846		10	10,685	10,685	25,822	21
22	AIR HANDLER/PNEUMATIC CONTROL	2008	3,300		10	330	330	962	22
23	INSTALL DOORS (1ST-3RD FLOOR)	2008	2,597		10	260	260	758	23
24	COMDIAL MP5000	2008	14,730		10	1,473	1,473	4,296	24
25	CHILLER REPLACEMENT PROJ	2008	9,740		10	974	974	2,760	25
26	INSTALL DOORS (LINEN/GARBAGE))	2008	2,212		10	221	221	608	26
27	FIRE SPRINKLER SUBCONTRACTOR	2008	6,965		10	697	697	1,858	27
28	INSTALL NEW CONDENSER & EVAPORATOR	2008	6,191		10	619	619	1,651	28
29	SECURTY UNIT	2008	6,740		10	674	674	1,741	29
30	REPAIR FIRE PUMP RUN TIMER	2008	6,318		10	632	632	1,527	30
31	POWER SUPPLY & DOME CAMERA	2008	1,099		10	110	110	220	31
32	REPAIR/REPLACE THERMOSTATIC VALVE-HOT WATER S	2008	3,086		10	309	309	618	32
33	BOILER REPAIR	2009	33,860		10	3,386	3,386	4,656	33
34	TOTAL (lines 1 thru 33)		$ 3,874,940	$ 80,405		$ 143,518	$ 63,113	$ 1,714,562	34

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,874,940	$ 80,405		$ 143,518	$ 63,113	$ 1,714,562	1
2	CHILLER REPLACEMENT	2009	136,577		10	13,658	13,658	21,989	2
3	REMOVE/REPLACE RUBBER WALL DETAIL	2009	2,900		10	290	290	290	3
4	INSTALL NEW DOORS & MAGNETIC CLOSERS	2009	6,987		10	699	699	699	4
5	BACKUP GENSET-REPLACE COOLANT, HTR HOSES, FILTI	2009	1,205		10	121	121	121	5
6	PLUMBING-TWIST N CLOSE BATH WASTE	2009	1,086		10	109	109	109	6
7	ENTRY HEAT REMOVED/CLEANED BLOWERS	2009	2,547		10	255	255	255	7
8	BOILER #1 REPAIR	2009	4,138		10	414	414	414	8
9	FIRE ALARM REPAIR	2009	8,413		10	841	841	841	9
10	SPRINKLER REPAIR/REPLACE HEADS	2009	5,593		10	559	559	559	10
11	SPRINKLER INSPECTION	2009	2,282		10	228	228	228	11
12	REPAIR PLUMBING LEAKS	2009	776		10	78	78	78	12
13				18,976			(18,976)		13
14				31,915			(31,915)		14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,047,444	$ 131,296		$ 160,770	$ 29,474	$ 1,740,145	34

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,047,444	$ 131,296		$ 160,770	$ 29,474	$ 1,740,145	1
2	ALLOCATIONS FROM PLATINUM (HO):								2
3	BUILDING (CONSTRUCTED 1955; PURCH 2004)	2004	35,487						3
4	FIRE ALARM & SECURITY SYSTEM	2004	221						4
5	PAINTING	2004	238						5
6	CARPETING	2004	497						6
7	BLINDS	2004	117						7
8	BLINDS	2005	170						8
9	REMODELING-FLOORS, LIGHTS, PLUMBING & WALLS	2005	1,703						9
10	REMODELING-WALLS	2005	68						10
11	BATHROOM REMODELING	2005	170						11
12	BATHROOM REMODELING	2005	249						12
13	BATHROOM REMODELING	2006	971						13
14	WINDOWS	2006	426						14
15	TUCK POINTING	2008	143						15
16	REMODEL PARESH'S OFFICE	2008	525						16
17	HEAT EXCHANGER	2009	487						17
18	RENZOR UNIT HEATER	2009	489						18
19	RELOCATION OF STAT FOR NW UNIT HEATER	2009	96						19
20	REMODEL BOOKKEEPING OFFICE	2009	525						20
21	AWNING	2009	1,035						21
22	PARKING LOT REPAIR	2009	401						22
23	ROOF TOP UNIT	2010	2,065						23
24	COMPRESSOR AC UNIT	2010	277						24
25				1,752		1,752			25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,093,804	$ 133,048		$ 162,522	$ 29,474	$ 1,740,145	34

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 422,175	$ 16,136	$ 33,719	$ 17,583		$ 320,863	71
72	Current Year Purchases	6,105	6,105	153	(5,952)		153	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		2,308	2,308				74
75	TOTALS	$ 428,280	$ 24,549	$ 36,180	$ 11,631		$ 321,016	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		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)	$ 5,052,670	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 159,272	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 198,702	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 39,430	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,126,747	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.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ $18,337 Description: See attached schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		See attached schedule	$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	10a-03	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs		13	275		13	275	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	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				49,518		49,518	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab and X-ray	39-02					2,728		2,728	13
14	TOTAL			$	13	$ 275	$ 52,246	13	$ 52,521	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,144	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,777)	373,278		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,365		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)**	$ 454,787	$	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)	(523,292)		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	680,308		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,043,399	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,498,186	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 137,086	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	250,000		29
30	Accrued Salaries Payable	175,369		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	37,448		36
37	Due Others, Adv Billing	267,891		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,155,794	$	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)**	$ 1,155,794	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 342,392	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,498,186	$	48

***(See instructions.)**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,491,150	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	20,181	3
4	**Rounding**	3	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,511,334	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,927,228	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	(3,096,170)	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)**	$ (1,168,942)	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)**	$ 342,392	24 *

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,793,413	1
2	Discounts and Allowances for all Levels	602,989	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,396,402	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	263,150	6
7	Oxygen	150	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 263,300	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	4,645	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	43,119	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,580	19
20	Radiology and X-Ray	140	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 49,484	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INC	(161)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (161)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,709,050	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,572,862	31
32	Health Care	2,863,440	32
33	General Administration	1,995,987	33
	B. Capital Expense		
34	Ownership	1,183,954	34
	C. Ancillary Expense		
35	Special Cost Centers	52,246	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)***	$ 7,781,822	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,927,228	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,927,228	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.**

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,121	$ 125,524	$ 59.18	1
2	Assistant Director of Nursing	5,824	6,241	223,457	35.80	2
3	Registered Nurses	21,982	23,103	729,588	31.58	3
4	Licensed Practical Nurses	11,262	11,839	320,765	27.09	4
5	CNAs & Orderlies	58,982	61,534	845,532	13.74	5
6	CNA Trainees					6
7	Licensed Therapist	696	696	36,538	52.50	7
8	Rehab/Therapy Aides	2,712	2,856	96,178	33.68	8
9	Activity Director					9
10	Activity Assistants	8,600	8,970	80,062	8.93	10
11	Social Service Workers	10,244	10,781	213,119	19.77	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,120	75,695	35.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,581	22,674	213,050	9.40	15
16	Dishwashers					16
17	Maintenance Workers	10,733	11,284	137,650	12.20	17
18	Housekeepers	29,857	31,728	269,782	8.50	18
19	Laundry					19
20	Administrator	1,864	2,120	174,621	82.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,963	6,604	203,187	30.77	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	3,600	3,890	51,800	13.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	197,796	208,561	$ 3,796,548 *	$ 18.20	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	168	$ 8,196	01-03	35
36	Medical Director	Monthly	36,000	09-03	36
37	Medical Records Consultant	Quarterly	1,568	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		12,807	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	16	1,028	11-03	44
45	Social Service Consultant	2	105	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	186	$ 59,704		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JEFFREY WHITE	ADMINISTRATOR		$ 174,621
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 174,621

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 138,257
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 138,257

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,757
Unemployment Compensation Insurance	52,431
FICA Taxes	275,446
Employee Health Insurance	29,150
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	300
EMPLOYEE BENEFITS-OTHER	77,082
EMPLOYEE PHYSICAL EXAM	
TOTAL (agree to Schedule V, line 22, col.8)	$ 503,166

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	825
Health Care Worker Background Check	1,784
(Indicate # of checks performed 4)	
Patient Background Checks 86	
ADVERTISING & MARKETING	3,485
DUES & SUBSCRIPTIONS	10,197
LICENSES	2,743
ALLOCATION FROM PLATINUM	1,879
Less: Public Relations Expense	( )
Non-allowable advertising	(3,485)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,428

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,771
ALLOCATION FROM PLATINUM	576
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,347

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/10 Ending: 12/31/10

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR # 0043935 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 $17,109**

(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. $ **14,534** 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? **NO**
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?
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.