FOR BHF USE

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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: 0012252

Facility Name: Oak Glen Home

Address: 11210 95th Street, P O Box 430 (Number) Coal Valley (City) 61240 (Zip Code)

County: Rock Island County

Telephone Number: 309-799-3161 **Fax #** 309-799-5904

HFS ID Number: 36-600-6649-001

Date of Initial License for Current Owners: 9/01/1972

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 789-7700
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 12/01/07 to 11/30/08 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) Trudy Whittington
(Title) Administrator

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 15 S. Old State Capitol Plz, Ste. 200, Springfield, IL 62701
(Telephone) (217) 789-7700 Fax # (217) 753-1654

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

III. STATISTICAL DATA

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

	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	245	Skilled (SNF)	245	89,670	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	245	TOTALS	245	89,670	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	10,238	1,561	4,223	16,022	8
9	SNF/PED					9
10	ICF	34,176	11,735	422	46,333	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,414	13,296	4,645	62,355	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.54%

D. How many bed-hold days during this year were paid by the Department?
0 (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)
None

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 [X] NO [ ] Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 09/01/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 4,210

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 11/30/2008 Fiscal Year: 11/30/2008

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

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	563,321	55,318	19,590	638,229		638,229		638,229			1
2	Food Purchase		448,526		448,526		448,526		448,526			2
3	Housekeeping	272,217	41,253	3,840	317,310		317,310		317,310			3
4	Laundry	215,922	47,655	488	264,065		264,065		264,065			4
5	Heat and Other Utilities			265,593	265,593		265,593		265,593			5
6	Maintenance	275,483	46,039	40,882	362,404		362,404		362,404			6
7	Other (specify):*											7
8	TOTAL General Services	1,326,943	638,791	330,393	2,296,127		2,296,127		2,296,127			8
	B. Health Care and Programs											
9	Medical Director			16,537	16,537		16,537		16,537			9
10	Nursing and Medical Records	3,495,008	215,355	29,012	3,739,375		3,739,375		3,739,375			10
10a	Therapy	141,430	2,949	413,790	558,169		558,169		558,169			10a
11	Activities	143,499		465	143,964		143,964		143,964			11
12	Social Services	119,582	5,658		125,240		125,240		125,240			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,899,519	223,962	459,804	4,583,285		4,583,285		4,583,285			16
	C. General Administration											
17	Administrative	123,242			123,242		123,242		123,242			17
18	Directors Fees							9,867	9,867			18
19	Professional Services			195	195		195	416,711	416,906			19
20	Dues, Fees, Subscriptions & Promotions			6,712	6,712		6,712		6,712			20
21	Clerical & General Office Expenses	144,128	10,053	51,928	206,109		206,109		206,109			21
22	Employee Benefits & Payroll Taxes			2,006,939	2,006,939		2,006,939	82,320	2,089,259			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,849	3,849		3,849	(104)	3,745			24
25	Other Admin. Staff Transportation			1,936	1,936		1,936		1,936			25
26	Insurance-Prop.Liab.Malpractice			26,014	26,014		26,014		26,014			26
27	Other (specify):*											27
28	TOTAL General Administration	267,370	10,053	2,097,573	2,374,996		2,374,996	508,794	2,883,790			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,493,832	872,806	2,887,770	9,254,408		9,254,408	508,794	9,763,202			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Oak Glen Home #0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

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							56,058	56,058			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							616	616			34
35	Rent-Equipment & Vehicles			58,754	58,754		58,754		58,754			35
36	Other (specify):* **Donated Goods**							2,500	2,500			36
37	**TOTAL Ownership**			58,754	58,754		58,754	59,174	117,928			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,523	2,762	160,285		160,285		160,285			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,602,184	1,602,184		1,602,184		1,602,184			42
43	Other (specify):* **Non-allowable cost**		5,758	296,403	302,161		302,161	(302,161)				43
44	**TOTAL Special Cost Centers**		163,281	1,901,349	2,064,630		2,064,630	(302,161)	1,762,469			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,493,832	1,036,087	4,847,873	11,377,792		11,377,792	265,807	11,643,599			45

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

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

VI. ADJUSTMENT DETAIL

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

	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
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	56,058	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions				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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(302,265)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (246,207)		$	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*	2,500	36	32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	509,514	Vari.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 512,014		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 265,807		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.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Oak Glen Home

ID# 0012252

Report Period Beginning: 12/01/07

Ending: 11/30/08

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (8,060)	43	1
2	X-Rays - Part A	(1,040)	43	2
3	Offset Transfers to Other Funds	(268,893)	43	3
4	Marketing Expenses	(18,410)	43	4
5	Marketing Supplies Expenses	(5,758)	43	5
6	Un-supported Travel & Seminar Exp	(104)	24	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**	(302,265)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oak Glen Home # 0012252 **Report Period Beginning:** 12/01/07 **Ending:** 11/30/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	9,867	0	0	0	0	0	0	0	0	0	9,867	18
19	Professional Services	0	416,711	0	0	0	0	0	0	0	0	0	416,711	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	82,320	0	0	0	0	0	0	0	0	0	82,320	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(104)	0	0	0	0	0	0	0	0	0	0	(104)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(104)	508,898	0	0	0	0	0	0	0	0	0	508,794	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(104)	508,898	0	0	0	0	0	0	0	0	0	508,794	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Oak Glen Home** **#** **0012252** **Report Period Beginning:** **12/01/07** **Ending:** **11/30/08**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	616	0	0	0	0	0	0	0	0	0	616	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	2,500	0	0	0	0	0	0	0	0	0	0	2,500	36
37	**TOTAL Ownership**	2,500	616	0	0	0	0	0	0	0	0	0	3,116	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):*	(302,161)	0	0	0	0	0	0	0	0	0	0	(302,161)	43
44	**TOTAL Special Cost Centers**	(302,161)	0	0	0	0	0	0	0	0	0	0	(302,161)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(299,765)	509,514	0	0	0	0	0	0	0	0	0	209,749	45

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rock Island County	100	Oak Glen Home	Coal Valley	N/A		

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	18	Welfare Committee	$	Rock Island County	100.00%	$ 9,867	$ 9,867	1
2	V	19	Risk Management		Rock Island County	100.00%	201,838	201,838	2
3	V	19	General Management		Rock Island County	100.00%	33,061	33,061	3
4	V	19	Auditor		Rock Island County	100.00%	22,218	22,218	4
5	V	19	Purchasing		Rock Island County	100.00%	5,848	5,848	5
6	V	19	Information Systems		Rock Island County	100.00%	50,630	50,630	6
7	V	19	Treasurer		Rock Island County	100.00%	316	316	7
8	V	19	County Board		Rock Island County	100.00%	102,800	102,800	8
9	V	22	Worker's Comp		Rock Island County	100.00%	63,021	63,021	9
10	V	22	Unemployment Comp		Rock Island County	100.00%	19,299	19,299	10
11	V	34	County Buildings		Rock Island County	100.00%	616	616	11
12	V								12
13	V								13
14	Total			$			$ 509,514	$ * 509,514	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

VII. RELATED PARTIES (continued)

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

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

	1	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	KAREN CALVILLO	CHAIR, NUR HM C(	DIRECTOR	0.00	0	1	2.00	SALARY	$ 1,619	18(7)	1
2	STEVE BALLARD	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	810	18(7)	2
3	JOHN BRANDMEYER	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	759	18(7)	3
4	DON JACOBS	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,214	18(7)	4
5	KEN MARANDA	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	2,429	18(7)	5
6	STEVE MEERSMAN	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,518	18(7)	6
7	HARRY PEREZ	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,518	18(7)	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,867		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 Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ROCK ISLAND COUNTY
Street Address: 11210 95TH STREET
City / State / Zip Code: COAL VALLEY, IL 61240
Phone Number: (309) 558-3585
Fax Number: (309) 558-3516

	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	18	Welfare Committee	Cost Allocation Study	100		$ 9,867	$	100	$ 9,867	1
2	19	Risk Management	Cost Allocation Study	100		201,838		100	201,838	2
3	19	General Management	Cost Allocation Study	100		33,061		100	33,061	3
4	19	Auditor	Cost Allocation Study	100		22,218		100	22,218	4
5	19	Purchasing	Cost Allocation Study	100		5,848		100	5,848	5
6	19	Information Systems	Cost Allocation Study	100		50,630		100	50,630	6
7	19	Treasurer	Cost Allocation Study	100		316		100	316	7
8	19	County Board	Cost Allocation Study	100		102,800		100	102,800	8
9	22	Worker's Comp	Actual Cost	100		63,021		100	63,021	9
10	22	Unemployment Comp	Actual Cost	100		19,299		100	19,299	10
11	34	County Buildings	Cost Allocation Study	100		616		100	616	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	TOTALS					$ 509,514	$		$ 509,514	25

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

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							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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 Oak Glen Home **#** 0012252 **Report Period Beginning:** 12/01/07 **Ending:** 11/30/08

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 2007 report.	N/A	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.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	$	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.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2003		8
	2004		9
	2005		10
	2006		11
	2007		12

County Facility

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	$	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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oak Glen Home COUNTY Rock Island County

FACILITY IDPH LICENSE NUMBER 0012252

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,498 B. General Construction Type: Exterior Brick Frame Block & Brick Number of Stories 2

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

N/A

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

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

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	Acres 280	1917	$ 18,526	1
2					2
3	TOTALS	280		$ 18,526	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1954	1954	$ 436,798	$		$	$	$ 436,798	4
5			1966	1966	3,438					3,438	5
6			1967	1967	601,561					601,561	6
7			1969	1969	176,656					176,656	7
8			1972	1972	20,431					20,431	8
	Improvement Type**										
9	Water System			1969	174,960					174,960	9
10	Mutiple Improvements			1984	84,571		25	3,382	3,382	82,795	10
11	Reroof work project			1986	6,350		VARI			6,350	11
12	Caninet work & blacktop			1987	36,101		VARI			36,101	12
13	Remodeled front entrance			1989	22,670		25	907	907	17,306	13
14	Reroofing Job			1990	16,161		20	808	808	14,680	14
15	Handicap feat. added to elevator			1992	6,989		20	349	349	5,619	15
16	Install of firestorm roof system			1993	16,131		VARI	806	806	12,634	16
17	Chimney Repair & roof work			1995	59,404		VARI	2,970	2,970	39,824	17
18	Asbestos & Replacement Windows			1997	14,800		VARI	740	740	8,397	18
19	Roofing & painting water tower			1998	106,570		VARI	1,829	1,829	88,893	19
20	Driveway & Sidewalks			1999	22,375		8			22,375	20
21	Gutters and Boiler Stack			2003	58,868		VARI	5,342	5,342	29,246	21
22	New Roof on Boiler Room			2004	25,970		10	2,597	2,597	11,764	22
23	STAIR RAILING RENOVATION			2005	34,069		15	2,263	2,263	8,311	23
24	PELLA WINDOWS			2005	36,425		15	2,420	2,420	8,280	24
25	RENOVATION WORK FOR ALZHEIMERS WING			2005	186,657		15	12,504	12,504	40,563	25
26	Life Safety Work			2006	34,863		10	3,486	3,486	7,251	26
27	Smoke & Fire Dampers			2007	109,000		20	5,495	5,495	10,990	27
28											28
29											29
30											30
31	Cash Basis Expense for current year are zero										31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,291,818	$		$ 45,898	$ 45,898	$ 1,865,223	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 101,604	$	$ 10,160	$ 10,160	VARIOUS	$ 95,681	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	314,882				VARIOUS	314,882	73
74								74
75	TOTALS	$ 416,486	$	$ 10,160	$ 10,160		$ 410,563	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	Patient Care	Ford, Diesel Bus, 1994	1994	$ 26,111	$	$	$	5	$ 26,111	76
77	Patient Care	Ford, Taurus, 2002	2002	15,400				5	15,400	77
78	Patient Care	Chevy, Lumina, 1996	1996	14,536				5	14,536	78
79	Patient Care	Carprice, Wagon 1993	1993	14,797				10	14,797	79
80	TOTALS			$ 70,844	$	$	$		$ 70,844	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)	$ 2,797,674	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 56,058	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 56,058	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,346,631	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	Non-Patient Care Vehicles	$ 69,752	$	$ 69,752	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 69,752	$	$ 69,752	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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 [X] 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	County Buildings				616			6
7	TOTAL				$ 616 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2009	$
13.	/2010	$
14.	/2011	$

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

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

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: $ 58,754 Description: Nursing Equip 54774 (Oxygen & Concentrator); Maintenance 3802; Misc 178
(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	N/A		$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home | STATE OF ILLINOIS # 0012252 | Report Period Beginning: 12/01/07 Ending: 11/30/08

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C2,C3	hrs	$	2,326	$ 194,820	$ 1,474	2,326	$ 196,295	1
2	Licensed Speech and Language Development Therapist	L10A, C2,C3	hrs		772	54,147	271	772	54,418	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C2,C3	hrs		1,948	164,822	1,204	1,948	166,026	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				157,523		157,523	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Ambulance	L39, C3				2,762			2,762	13
14	TOTAL			$	5,046	$ 416,552	$ 160,472	5,046	$ 577,024	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Oak Glen Home **#** 0012252 **Report Period Beginning:** 12/01/07 **Ending:** 11/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/08 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 411,156	$ 411,156	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	1,164,310	1,164,310	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	4,415	4,415	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	376	376	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Other Gov. Unit	282,167	282,167	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,862,424	$ 1,862,424	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		18,526	13
14	Buildings, at Historical Cost		2,291,818	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		487,330	16
17	Accumulated Depreciation (book methods)		(2,346,631)	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 (spe L/T Investments	2,901,000	2,901,000	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,901,000	$ 3,352,043	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,763,424	$ 5,214,467	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 282,557	$ 282,557	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	400	400	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	235,824	235,824	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	3,034	3,034	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 521,815	$ 521,815	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)**	$ 521,815	$ 521,815	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,241,609	$ 4,692,652	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,763,424	$ 5,214,467	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Oak Glen Home
Provider #: 0012252
12/1/2007 to 11/30/2008 **Schedule 17A**

XV. Balance Sheet

	Operating	After Consolidation
Other Current Liabilities - Line 36		
Unclaimed Voucher Checks	2,911	2,911
Unclaimed Payroll Checks	123	123
	3,034	3,034

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 **Report Period Beginning:** 12/01/07 **Ending:** 11/30/08

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,341,431	1
2	Restatements (describe):		2
3			3
4	**Prior Year Adjustment**	(260,639)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,080,792	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,160,817	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	( )	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)**	$ 2,160,817	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)**	$ 4,241,609	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,234,935	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,234,935	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	169,356	6
7	Oxygen	2,167	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 171,523	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	1,995	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	50,035	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	6,965	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	76,794	21
22	Laundry	12,931	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 148,720	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	66,011	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 66,011	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Sch 19A	1,917,420	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,917,420	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,538,609	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,296,127	31
32	Health Care	4,583,285	32
33	General Administration	2,374,996	33
	B. Capital Expense		
34	Ownership	58,754	34
	C. Ancillary Expense		
35	Special Cost Centers	462,446	35
36	Provider Participation Fee	1,602,184	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,377,792	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,160,817	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,160,817	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.**
Govermental Entity

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

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

Champaign County Nursing Home
Provider #: 0012252
12/1/2007 to 11/30/2008 **Schedule 19A**

XVII. Income Statement
Line 28 Other Income(specify):

Description	Amount
Transfer from Nursing Home Tax Levy	1,916,000
Sales of Junk or Salvage	184
Transportation Rev	692
Nurses Aid Reimbursement	44
Sale of Capital Asset	500
Total - Line 28	1,917,420

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

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	1,647	1,712	$ 44,421	$ 25.95	1
2	Assistant Director of Nursing	1,724	2,155	54,021	25.07	2
3	Registered Nurses	13,722	16,398	384,749	23.46	3
4	Licensed Practical Nurses	52,699	63,340	1,131,574	17.87	4
5	CNAs & Orderlies	129,572	151,162	1,856,131	12.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,523	8,258	141,430	17.13	8
9	Activity Director	1,739	2,165	47,262	21.83	9
10	Activity Assistants	6,863	7,670	96,237	12.55	10
11	Social Service Workers	5,405	6,268	119,582	19.08	11
12	Dietician					12
13	Food Service Supervisor	3,593	4,430	79,915	18.04	13
14	Head Cook	7,584	8,630	124,306	14.40	14
15	Cook Helpers/Assistants	27,889	31,679	359,100	11.34	15
16	Dishwashers					16
17	Maintenance Workers	11,444	14,055	275,483	19.60	17
18	Housekeepers	16,540	19,574	272,217	13.91	18
19	Laundry	14,365	17,049	215,922	12.66	19
20	Administrator	1,694	2,032	65,938	32.45	20
21	Assistant Administrator	1,713	2,098	57,304	27.31	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,215	10,342	144,128	13.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,893	2,123	24,112	11.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	315,824	371,140	$ 5,493,832 *	$ 14.80	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	541	$ 18,926	L1 C3	35
36	Medical Director	12 Months	16,537	L9 C5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12 Months	1,140	L10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	7	465	L12 C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	548	$ 37,068		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trudy Whittingron	Administrator		$ 65,938
Sheryl Thomas	Asst. Administrator		57,304
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 123,242

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Ramirez Consulting	Consulting	$ 195
See Sch 21A		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 195

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,021
Unemployment Compensation Insurance	19,299
FICA Taxes	404,513
Employee Health Insurance	1,122,183
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	478,583
Work Fitness	1,660
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,089,259

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,072
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 58)	690
Patient Background Checks 193	2,310
CHNA Dues	1,640
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,712

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	3,745
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,745

* Attach copy of IMRF notifications

**See instructions.

Oak Glen Home
Provider #: 0012252
12/1/2007 to 11/30/2008 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Brought forward from page 21		195
Vendor	Type	
Total agreeing to Schedule V, Line 19, Col 3		195
County Allocated Expenses (See Page 8)		
Risk Management		201,838
General Management		33,061
Auditor		22,218
Purchasing		5,848
Information Systems		50,630
Treasurer		316
County Board		102,800
Total (agree to Schedule V, line 19, column 8)		416,906

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

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								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/01/07 Ending: 11/30/08

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **COUNTY NURSING HOME ASSOC - 1640**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,081** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **134,138**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey & Pullen, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audited Statements not issued yet**

(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 $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees