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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0032839

Facility Name: Glenwood Healthcare & Rehab

Address: 19330 S Cottage Grv (Number) | Glenwood (City) | 60425 (Zip Code)

County: Cook

Telephone Number: (708) 758-6200 **Fax #** (708) 758-9563

HFS ID Number:

Date of Initial License for Current Owners: 9/1/1987

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/14 to 12/31/14 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) Steven N. Lavenda, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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 Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	184	Skilled (SNF)	184	67,160	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	184	TOTALS	184	67,160	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	1,358		6,697	8,055	8
9	SNF/PED					9
10	ICF	39,825	459	1,687	41,971	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,183	459	8,384	50,026	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.49%

D. How many bed-hold days during this year were paid by the Department?
None (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 [ ] 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 09/01/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 184 and days of care provided 4,354

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	263,369	26,218	9,280	298,867		298,867		298,867			1
2	Food Purchase		262,698		262,698		262,698	80	262,778			2
3	Housekeeping	208,227	22,644		230,871		230,871	168	231,039			3
4	Laundry	108,932	31,402		140,334		140,334		140,334			4
5	Heat and Other Utilities			183,975	183,975		183,975	1,195	185,170			5
6	Maintenance	105,685	109,290	71,512	286,487		286,487	15,953	302,440			6
7	Other (specify):*											7
8	TOTAL General Services	686,213	452,252	264,767	1,403,232		1,403,232	17,396	1,420,628			8
	B. Health Care and Programs											
9	Medical Director			35,200	35,200		35,200		35,200			9
10	Nursing and Medical Records	2,558,236	67,609	16,531	2,642,376		2,642,376	(270)	2,642,106			10
10a	Therapy	61,088	3,510	6,411	71,009		71,009		71,009			10a
11	Activities	152,910	20,355		173,265		173,265		173,265			11
12	Social Services	143,007		4,943	147,950		147,950		147,950			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,792	6,792			15
16	TOTAL Health Care and Programs	2,915,241	91,474	63,085	3,069,800		3,069,800	6,522	3,076,322			16
	C. General Administration											
17	Administrative	112,758			112,758		112,758	99,902	212,660			17
18	Directors Fees											18
19	Professional Services			721,806	721,806	(44,855)	676,951	(480,561)	196,390			19
20	Dues, Fees, Subscriptions & Promotions			86,020	86,020		86,020	(19,714)	66,306			20
21	Clerical & General Office Expenses	281,625	7,422	326,099	615,146		615,146	(65,628)	549,518			21
22	Employee Benefits & Payroll Taxes			777,373	777,373		777,373		777,373			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,278	4,278		4,278	548	4,826			24
25	Other Admin. Staff Transportation			14,210	14,210		14,210	10,662	24,872			25
26	Insurance-Prop.Liab.Malpractice			521,370	521,370		521,370	4,196	525,566			26
27	Other (specify):*							49,231	49,231			27
28	TOTAL General Administration	394,383	7,422	2,451,156	2,852,961	(44,855)	2,808,106	(401,364)	2,406,742			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,995,837	551,148	2,779,008	7,325,993	(44,855)	7,281,138	(377,446)	6,903,692			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 Glenwood Healthcare & Rehab #0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			215,578	215,578		215,578	82,709	298,287			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,202	61,202		61,202	729,105	790,307			32
33	Real Estate Taxes			369,015	369,015	44,855	413,870		413,870			33
34	Rent-Facility & Grounds			1,252,975	1,252,975		1,252,975	(1,242,280)	10,695			34
35	Rent-Equipment & Vehicles			27,628	27,628		27,628	7,775	35,403			35
36	Other (specify):*											36
37	TOTAL Ownership			1,926,398	1,926,398	44,855	1,971,253	(422,691)	1,548,562			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		339,904	455,822	795,726		795,726		795,726			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			376,829	376,829		376,829		376,829			42
43	Other (specify):*	135,658			135,658		135,658	(135,658)				43
44	TOTAL Special Cost Centers	135,658	339,904	832,651	1,308,213		1,308,213	(135,658)	1,172,555			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,131,495	891,052	5,538,057	10,560,604		10,560,604	(935,795)	9,624,809			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 Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(11,745)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(66,536)	30		9
10	Interest and Other Investment Income	(5,852)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(24)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,741)	21		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	(214,484)	21		24
25	Fund Raising, Advertising and Promotional	(20,533)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,481)	20		28
29	Other-Attach Schedule	(263,553)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (591,949)		$	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)	(343,846)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (343,846)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (935,795)		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

Glenwood Healthcare & Rehab

ID# 0032839

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Purchased Services - Veterans	$ (41,901)	10	1
2	Marketing	(135,658)	43	2
3	Bank Charges	(12,880)	21	3
4	Theft and Damages	(1,522)	21	4
5	Additional R&M	28,486	06	5
6	Capitalize R&M	(2,655)	06	6
7	Non Allowable Legal Fees	(5,256)	19	7
8	Misc Income	(9,396)	21	8
9	Lab - Veterans	(1,573)	10	9
10	State Replacement tax	(9,902)	21	10
11	Building Co:			11
12	Amortization of Goodwill	(55,910)	36	12
13	Accounting Fees	(1,480)	19	13
14	Legal Fees	(11,126)	19	14
15	Bank Charges	(948)	21	15
16	Taxes	(1,831)	21	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**	(263,553)		49

Glenwood Healthcare & Rehab

ID# 0032839

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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													1
2	Food Purchase	(24)		104									80	2
3	Housekeeping			168									168	3
4	Laundry													4
5	Heat and Other Utilities			1,195									1,195	5
6	Maintenance	14,086		1,867									15,953	6
7	Other (specify):*													7
8	**TOTAL General Services**	14,062		3,334									17,396	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(43,474)		43,204									(270)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			6,792									6,792	15
16	**TOTAL Health Care and Programs**	(43,474)		49,996									6,522	16
	C. General Administration													
17	Administrative			99,902									99,902	17
18	Directors Fees													18
19	Professional Services	(17,862)	27,306	(490,005)									(480,561)	19
20	Fees, Subscriptions & Promotions	(26,014)		6,300									(19,714)	20
21	Clerical & General Office Expenses	(254,705)	2,779	186,298									(65,628)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			548									548	24
25	Other Admin. Staff Transportation			10,662									10,662	25
26	Insurance-Prop.Liab.Malpractice			4,196									4,196	26
27	Other (specify):*			49,231									49,231	27
28	**TOTAL General Administration**	(298,581)	30,085	(132,868)									(401,364)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(327,993)	30,085	(79,538)									(377,446)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	(66,536)	136,850	12,395									82,709	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,852)	734,943	14									729,105	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,252,975)	10,695									(1,242,280)	34
35	Rent-Equipment & Vehicles			7,775									7,775	35
36	Other (specify):*	(55,910)	55,910											36
37	**TOTAL Ownership**	(128,298)	(325,272)	30,879									(422,691)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(135,658)											(135,658)	43
44	**TOTAL Special Cost Centers**	(135,658)											(135,658)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(591,949)	(295,187)	(48,659)									(935,795)	45

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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	$ 1,252,975	Glenwood Terrace, LLC	100.00%	$	$ (1,252,975)	1
2	V	33	Real Estate Taxes	241,995	Glenwood Terrace, LLC	100.00%		(241,995)	2
3	V	32	Interest Income	1,907	Glenwood Terrace, LLC	100.00%		(1,907)	3
4	V	19	Accounting Fees		Glenwood Terrace, LLC	100.00%	1,480	1,480	4
5	V	36	Amortization of Goodwill		Glenwood Terrace, LLC	100.00%	55,910	55,910	5
6	V	30	Deprecation		Glenwood Terrace, LLC	100.00%	136,850	136,850	6
7	V	19	Legal Fees		Glenwood Terrace, LLC	100.00%	11,126	11,126	7
8	V	32	Mortage Interest		Glenwood Terrace, LLC	100.00%	559,637	559,637	8
9	V	33	Real Estate Taxes		Glenwood Terrace, LLC	100.00%	241,995	241,995	9
10	V	32	Swap Interest		Glenwood Terrace, LLC	100.00%	177,213	177,213	10
11	V	21	Bank Charges		Glenwood Terrace, LLC	100.00%	948	948	11
12	V	19	Appraisal Fees		Glenwood Terrace, LLC	100.00%	14,700	14,700	12
13	V	21	Taxes		Glenwood Terrace, LLC	100.00%	1,831	1,831	13
14	Total			$ 1,496,877			$ 1,201,690	$ * (295,187)	14

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2	FOOD	$	CERTIFIED HEALTH MANAGEMENT	100.00%	$ 104	$ 104	15
16	V	3	HOUSEKEEPING		CERTIFIED HEALTH MANAGEMENT	100.00%	168	168	16
17	V	5	UTILITIES		CERTIFIED HEALTH MANAGEMENT	100.00%	1,195	1,195	17
18	V	6	REPAIRS AND MAINTENANCE		CERTIFIED HEALTH MANAGEMENT	100.00%	1,867	1,867	18
19	V	10	NURSING		CERTIFIED HEALTH MANAGEMENT	100.00%	43,204	43,204	19
20	V	15	EMP. BEN. HEALTHCARE		CERTIFIED HEALTH MANAGEMENT	100.00%	6,792	6,792	20
21	V	17	ADMINISTRATIVE SALARIES		CERTIFIED HEALTH MANAGEMENT	100.00%	40,484	40,484	21
22	V	19	PROFESSIONAL FEES		CERTIFIED HEALTH MANAGEMENT	100.00%	47,155	47,155	22
23	V	20	DUES, FEES, SUBSCRIPTIONS		CERTIFIED HEALTH MANAGEMENT	100.00%	6,300	6,300	23
24	V	21	SALARIES - CLERICAL		CERTIFIED HEALTH MANAGEMENT	100.00%	153,598	153,598	24
25	V	21	OFFICE EXPENSES		CERTIFIED HEALTH MANAGEMENT	100.00%	32,700	32,700	25
26	V	24	SEMINAR EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	548	548	26
27	V	25	AUTO & TRAVEL EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	10,662	10,662	27
28	V	26	INSURANCE		CERTIFIED HEALTH MANAGEMENT	100.00%	4,196	4,196	28
29	V	27	EMP. BEN. GEN. ADMIN.		CERTIFIED HEALTH MANAGEMENT	100.00%	36,946	36,946	29
30	V	30	DEPRECIATION		CERTIFIED HEALTH MANAGEMENT	100.00%	12,395	12,395	30
31	V	32	INTEREST		CERTIFIED HEALTH MANAGEMENT	100.00%	14	14	31
32	V	34	RENT		CERTIFIED HEALTH MANAGEMENT	100.00%	10,695	10,695	32
33	V	35	EQUIPMENT RENTAL		CERTIFIED HEALTH MANAGEMENT	100.00%	880	880	33
34	V	35	AUTO LEASE		CERTIFIED HEALTH MANAGEMENT	100.00%	6,895	6,895	34
35	V								35
36	V	17	ADMIN COMP - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	59,418	59,418	36
37	V	27	EMP. BEN. - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	12,285	12,285	37
38	V	19	HOME OFFICE EXPENSE	537,160	CERTIFIED HEALTH MANAGEMENT	100.00%		(537,160)	38
39	Total			$ 537,160			$ 488,501	$ * (48,659)	39

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	RITA L. GELLER	38.044%	DANVILLE CARE CENTER, LTD.	DANVILLE	GLENWOOD TERRACE, LLC	SKOKIE	BUILDING CO.	1
2	BRADLEY M. ALTER	22.826%	PRAIRIE VIEW CARE CENTER OF LEWISTOWN,INC.	LEWISTOWN	CERTIFIED HEALTH MGMT.	SKOKIE, ILLINOIS	MANAGEMENT	2
3	ESBT FOR JULIE T.Y. BRUM 12/17/02	19.565%	RENAISSANCE CARE CENTER, INC.	CANTON				3
4	ESBT FOR JENNIFER T.W. CHOW 12/17/02	19.565%	PAXTON HEALTHCARE AND REHAB	PAXTON				4
5			PONTIAC HEALTHCARE AND REHAB	PONTIAC				5
6								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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Bradley M. Alter	Owner	Administration	22.83%	See Attached	14.85	29.70%	Alloc. Salary	$ 59,418	17-7	1
2	Daniel Alter	Relative	Clerical		See Attached	10.4	29.71%	Alloc. Salary	7,048	21-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 66,466		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 Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										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	TOTALS					$	$		$	25

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 W. OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	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	2	FOOD	PATIENT DAYS	168,387	6	$ 349	$	50,026	$ 104	1
2	3	HOUSEKEEPING	PATIENT DAYS	168,387	6	566		50,026	168	2
3	5	UTILITIES	PATIENT DAYS	168,387	6	4,022		50,026	1,195	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	168,387	6	6,283		50,026	1,867	4
5	10	NURSING	PATIENT DAYS	168,387	6	145,423	145,423	50,026	43,204	5
6	15	EMP. BEN. HEALTHCARE	PATIENT DAYS	168,387	6	22,862		50,026	6,792	6
7	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	168,387	6	136,269	136,269	50,026	40,484	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	168,387	6	158,722		50,026	47,155	8
9	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	168,387	6	21,206		50,026	6,300	9
10	21	SALARIES - CLERICAL	PATIENT DAYS	168,387	6	517,009	517,009	50,026	153,598	10
11	21	OFFICE EXPENSES	PATIENT DAYS	168,387	6	110,068		50,026	32,700	11
12	24	SEMINAR EXPENSE	PATIENT DAYS	168,387	6	1,845		50,026	548	12
13	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	168,387	6	35,887		50,026	10,662	13
14	26	INSURANCE	PATIENT DAYS	168,387	6	14,124		50,026	4,196	14
15	27	EMP. BEN. GEN. ADMIN.	PATIENT DAYS	168,387	6	124,361		50,026	36,946	15
16	30	DEPRECIATION	PATIENT DAYS	168,387	6	41,720		50,026	12,395	16
17	32	INTEREST	PATIENT DAYS	168,387	6	49		50,026	14	17
18	34	RENT	PATIENT DAYS	168,387	6	36,000		50,026	10,695	18
19	35	EQUIPMENT RENTAL	PATIENT DAYS	168,387	6	2,961		50,026	880	19
20	35	AUTO LEASE	PATIENT DAYS	168,387	6	23,207		50,026	6,895	20
21										21
22	17	ADMIN COMP - B. ALTER	AVERAGE HOURS WORKI	50	6	200,000	200,000	14.85	59,418	22
23	27	EMP. BEN. - B. ALTER	AVERAGE HOURS WORKI	50	6	41,351		14.85	12,285	23
24										24
25	TOTALS					$ 1,644,284	$ 998,701		$ 488,501	25

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										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	TOTALS					$	$		$	25

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										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	TOTALS					$	$		$	25

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										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	TOTALS					$	$		$	25

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										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	TOTALS					$	$		$	25

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										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	TOTALS					$	$		$	25

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										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	TOTALS					$	$		$	25

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										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	TOTALS					$	$		$	25

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										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	TOTALS					$	$		$	25

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Enloe-St		X	Note Payable	$3,350.71	04/07/2011	$	$ 38,649		5.7500	$ 4,184	1
2	Cole Taylor Bank		X	Mortgage Payable				11,000,000			434,512	2
3	Cole Taylor Bank		X	Mortgage Payable				5,500,000			125,125	3
4												4
5												5
	Working Capital											
6	Bank Financial		X	Line of Credit				1,231,034		5.5000	48,928	6
7	Insurance Financing		X								8,090	7
8	See Supplemental Schedule										177,227	8
9	TOTAL Facility Related				$3,350.71		$	$ 17,769,683			$ 798,065	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,852)	10
11	Interest Income- Buildin Co		X								(1,908)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,760)	14
15	TOTALS (line 9+line14)						$	$ 17,769,683			$ 790,305	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ **None** Line # **N/A**

*** 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 Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9	Swap Interest		X								177,213	9
10	Allocated from Certified										14	10
11												11
12												12
13												13
14	TOTAL Working Capital										177,227	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* 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 Glenwood Healthcare & Rehab # 0032839 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 374,076	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.)		$ 366,092	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,984)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 377,000	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.)**		$ 44,855	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** $ 127,020 **For** 11,'12 **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.		$ 413,871	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	342,229	8
	2010	347,366	9
	2011	405,014	10
	2012	356,263	11
	2013	366,092	12

2013 Accrual - $366092 x 1.03 =$377,000 (rounded)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glenwood Healthcare & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032839

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-10-201-009-0000	Long-Term Care Property	$ 366,091.79	$ 366,091.79
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 366,091.79	$ 366,091.79

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glenwood Healthcare & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032839

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 98,010 B. General Construction Type: Exterior Brick 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? [X] (a) Own the Equipment [X] (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).

None

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: _____ 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		1999	$ 322,000	1
2					2
3	TOTALS			$ 322,000	3

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	184		1999	1975	$ 5,474,000	$ 136,850	39	$ 140,359	$ 3,509	$ 2,245,744	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	20,662		20			20,662	9
10	Various			1989	4,071		20			4,071	10
11	Various			1990	28,171		20			28,171	11
12	Various			1991	31,712		20			31,712	12
13	Various			1992	10,071		20			10,071	13
14	Various			1993	4,809		20			4,809	14
15	Various			1994	17,594		20	437	437	17,594	15
16	Various			1995	31,602		20	1,580	1,580	30,812	16
17	Various			1996	39,136		20	1,957	1,957	36,105	17
18	Various			1997	43,166		20	2,158	2,158	37,935	18
19	Various			1998	163,365		20	8,168	8,168	134,776	19
20	Various			1999	136,071		20	6,804	6,804	106,022	20
21	Various			2000	36,744		20	1,837	1,837	26,975	21
22	Various			2001	7,300		20	365	365	5,080	22
23	Various			2002	13,080		20	654	654	8,121	23
24	Various			2003	62,327		20	3,116	3,116	35,600	24
25	Various			2004	45,982		20	2,299	2,299	24,141	25
26	Various			2005	62,611		20	3,131	3,131	29,497	26
27	Various			2006	23,234		20	1,162	1,162	9,874	27
28	Various			2007	24,901		20	1,245	1,245	9,749	28
29	Various			2008	29,343		20	1,467	1,467	9,593	29
30	Various			2009	91,559		20	5,088	5,088	27,590	30
31	Various			2010	104,397		20	6,905	6,905	29,979	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 Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		35,863	8,588		1,597	(6,991)	25,390	68
69	Financial Statement Depreciation			215,578			(215,578)		69
70	TOTAL (lines 4 thru 69)		$ 6,541,771	$ 361,016		$ 190,328	$ (170,688)	$ 2,950,072	70

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,541,771	$ 361,016		$ 190,328	$ (170,688)	$ 2,950,072	1
2	Thru Wall Ac Units	2011	3,000		20	600	600	2,400	2
3	Base Tank - Generator Repair	2011	7,768		20	388	388	1,521	3
4	Outside Sign On Steel Pole	2011	5,760		20	384	384	1,440	4
5	Fascia And Soffitt On Roof	2011	16,120		20	806	806	2,955	5
6	Kitchen Dietary Trap	2011	4,614		20	923	923	3,384	6
7	Cove Base/Handrails/Bumper Guards/Wallcovering/Wall Tile - D (	2011	43,694		20	2,185	2,185	8,011	7
8	Lighting Retrofit - Entire Facility	2011	17,284		20	864	864	3,097	8
9	Roof Insulation	2011	30,000		20	1,500	1,500	5,375	9
10	Outside Generator Pad	2011	2,923		20	195	195	698	10
11	Vinyl Tile Installation/Prep & Paint/Closet Doors & Interior-Dishr	2011	76,135		20	3,807	3,807	13,641	11
12	Ceramic Tile/Plumbing Fixtures/Tile & Crack/Cove Base/Laminat	2011	119,074		20	5,954	5,954	20,838	12
13	Nurses' Station	2011	10,520		20	2,104	2,104	7,013	13
14	Thru Wall A/C Units	2011	3,000		20	600	600	2,000	14
15	Dish Room & Sink Area Floor - Ceramic Tile	2011	8,416		20	421	421	1,543	15
16	Lock Replacement And Repair	2011	9,311		20	466	466	1,862	16
17	Doors	2012	13,173		20	659	659	1,976	17
18	Hallways - Remove And Replace Wallcovering, Millwod, Paint	2012	49,245		20	2,462	2,462	6,156	18
19	Doors And Hallway Project	2012	11,335		20	567	567	1,417	19
20	Wallcovering, Corner Guards, Grab Bars, Signage - Kitchen, Bath	2012	3,414		20	171	171	484	20
21	Flooring, Corner Guards, Doors, Window Treatments-Rms A-3, A	2012	12,391		20	620	620	1,497	21
22	Paving	2012	3,100		20	207	207	465	22
23	Cove Base In Kitchen	2012	3,767		20	753	753	1,632	23
24	Rooftop Hvac	2012	6,600		20	330	330	715	24
25	New Hot Water Heater	2012	6,010		20	301	301	626	25
26	Flat Roof Replacement	2012	7,800		20	390	390	1,170	26
27	Overhead Door	2013	3,800		20	190	190	348	27
28	Roof Repair	2013	2,995		20	150	150	275	28
29	Parking Lot Sealcoat And Restriping	2013	3,217		20	214	214	357	29
30	Walls, Paint, Rails	2013	16,500		20	825	825	1,100	30
31	Ac/Heat Window Unit	2013	4,124		20	825	825	1,237	31
32	Energy Services - Hvac	2013	13,770		20	689	689	861	32
33	2 New Condensing Units And 2 New Air Handlers	2013	6,400		20	320	320	373	33
34	TOTAL (lines 1 thru 33)		$ 7,067,031	$ 361,016		$ 221,195	$ (139,821)	$ 3,046,539	34

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,067,031	$ 361,016		$ 221,195	$ (139,821)	$ 3,046,539	1
2	2 Condensing Units Out Of 10	2014	46,200		20	2,310	2,310	2,310	2
3	Replace Kitchen Drain	2014	10,920		20	546	546	546	3
4	New Water Heater	2014	9,952		20	498	498	498	4
5	Additonal Work For New Water Heater	2014	3,362		20	154	154	154	5
6	Walk In Cooler Door Repalcement	2014	2,698		20	112	112	112	6
7	Install New Grease Separator	2014	5,980		20	249	249	249	7
8	New Kitchen Floor	2014	3,673		20	138	138	138	8
9	D Wing Bathroom:Replace Tiles, Repaint,Replace Tub Drain	2014	33,256		20	1,109	1,109	1,109	9
10	Alarm System	2014	2,526		20	84	84	84	10
11	New Power Generator	2014	3,510		20	117	117	117	11
12	Reclining Tub/Disinfecting System	2014	12,695		20	317	317	317	12
13	Roof Repair	2014	40,338		20	1,008	1,008	1,008	13
14	Ac Units Openings	2014	5,280		20	88	88	88	14
15	Dialyis Unit Electric Equipment	2014	7,150		20	477	477	477	15
16	Dialyis Unit Plumbing Equipment	2014	4,490		20	75	75	75	16
17	Parking Lot Sealcoat	2014	3,375		20	75	75	75	17
18	Water Heater	2014	7,575		20	95	95	95	18
19	Hvac Testing	2014	3,650		20	30	30	30	19
20	Water Heater	2014	3,761		20	110	110	110	20
21	18Ga Wire W/Connectors For Fire Damper	2014	2,655		20	133	133	133	21
22	Heating /Furnace Upgrade	2014	6,583		20	329	329	134	22
23	Drywall Replacement	2014	2,633		20	132	132	135	23
24	Slop Sink Work	2014	4,821		20	241	241	136	24
25	Security Door	2014	3,780		20	189	189	137	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,297,894	$ 361,016		$ 229,811	$ (131,205)	$ 3,054,806	34

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,297,894	$ 361,016		$ 229,811	$ (131,205)	$ 3,054,806	1
2									2
3									3
4									4
5									5
6									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	TOTAL (lines 1 thru 33)		$ 7,297,894	$ 361,016		$ 229,811	$ (131,205)	$ 3,054,806	34

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,297,894	$ 361,016		$ 229,811	$ (131,205)	$ 3,054,806	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 7,297,894	$ 361,016		$ 229,811	$ (131,205)	$ 3,054,806	34

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								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	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$	$		$	$	$	34

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated - Certified Health Management	1997	27,993	718	20	1,400	682	25,193	9
10	Allocated - Certified Health Management	2014	7,870	7,870	20	197	(7,673)	197	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	TOTAL (lines 1 thru 33)		$ 35,863	$ 8,588		$ 1,597	$ (6,991)	$ 25,390	34

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 35,863	$ 8,588		$ 1,597	$ (6,991)	$ 25,390	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 35,863	$ 8,588		$ 1,597	$ (6,991)	$ 25,390	34

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 342,746	$ 1,200	$ 59,758	$ 58,558	10	$ 213,434	71
72	Current Year Purchases	26,088	2,606	4,289	1,683	10	4,289	72
73	Fully Depreciated Assets	804,047		917	917	10	804,047	73
74								74
75	TOTALS	$ 1,172,881	$ 3,806	$ 64,965	$ 61,159		$ 1,021,770	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2010 HONDA ACCORD	2013	$ 13,769	$	$ 3,511	$ 3,511	5	$ 5,576	76
77										77
78										78
79										79
80	TOTALS			$ 13,769	$	$ 3,511	$ 3,511		$ 5,576	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)	$ 8,806,544	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 364,822	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 298,286	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (66,536)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,082,153	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 Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Alloc. Certified Health Management				10,695			5
6								6
7	TOTAL				$ 10,695 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 17,321 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	Alloc. Certified Health Management		$	$ 6,895	17
18	Auto Lease			11,187	18
19					19
20					20
21	TOTAL		$	$ 18,082	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 Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	39 - 03	hrs	$		$ 181,416	$		$ 181,416	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			27,753			27,753	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			245,353			245,353	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				114,964		114,964	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					1,300	224,940		226,240	13
14	TOTAL			$		$ 455,822	$ 339,904		$ 795,726	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.

STATE OF ILLINOIS

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 100,972	$ 644,491	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,420,391	4,420,391	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	70,639	70,639	5
6	Prepaid Insurance	258,919	258,919	6
7	Other Prepaid Expenses	3,032	3,595	7
8	Accounts Receivable (owners or related parties)	1,339	1,339	8
9	Other(specify):	95,008	95,008	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,950,300	$ 5,494,382	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		322,000	13
14	Buildings, at Historical Cost		5,474,000	14
15	Leasehold Improvements, at Historical Cost	1,779,733	1,779,733	15
16	Equipment, at Historical Cost	985,418	1,261,418	16
17	Accumulated Depreciation (book methods)	(1,525,678)	(4,978,185)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		223,636	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(177,217)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,128,044	7,776,262	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,367,517	$ 11,681,647	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,317,817	$ 17,176,029	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 990,422	$ 990,422	26
27	Officer's Accounts Payable	44,320	44,320	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,269,683	1,269,683	29
30	Accrued Salaries Payable	207,204	207,204	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,654	30,654	31
32	Accrued Real Estate Taxes(Sch.IX-B)	377,000	377,000	32
33	Accrued Interest Payable	6,683	65,388	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,500	2,500	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,928,466	$ 2,987,171	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,825,789	1	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,825,789	$ 16,500,001	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,754,255	$ 19,487,172	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,563,562	$ (2,311,143)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,317,817	$ 17,176,029	48

*(See instructions.)

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,066,060	1
2	Restatements (describe):		2
3	**Prior Year Adjustments**	279,841	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,345,901	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	417,661	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	(200,000)	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)**	$ 217,661	17
	B. Transfers (Itemize):		
18			18
19	59519		19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,563,562	24 *

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

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,534,192	1
2	Discounts and Allowances for all Levels	1,182,214	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,716,406	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	75,729	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 75,729	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,185	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,258	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,852	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,852	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	179,020	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 179,020	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,978,265	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,403,232	31
32	Health Care	3,069,800	32
33	General Administration	2,852,961	33
	B. Capital Expense		
34	Ownership	1,926,398	34
	C. Ancillary Expense		
35	Special Cost Centers	931,384	35
36	Provider Participation Fee	376,829	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,560,604	40
41	**Income before Income Taxes (line 30 minus line 40)****	417,661	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 417,661	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,389,824	44
45	Private Pay - Net Inpatient Revenue	141,540	45
46	Medicare - Net Inpatient Revenue	2,339,096	46
47	Other-(specify) Managed Care	444,931	47
48	Other-(specify) Hospice	401,015	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,716,406	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **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.**

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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	1,696	1,815	$ 101,921	$ 56.15	1
2	Assistant Director of Nursing	1,795	1,921	51,038	26.57	2
3	Registered Nurses	17,979	19,238	542,285	28.19	3
4	Licensed Practical Nurses	31,623	33,837	779,138	23.03	4
5	CNAs & Orderlies	104,524	111,841	1,044,510	9.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,965	5,313	61,088	11.50	8
9	Activity Director	2,032	2,174	39,620	18.22	9
10	Activity Assistants	9,996	10,695	113,290	10.59	10
11	Social Service Workers	8,047	8,610	143,007	16.61	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,097	42,377	20.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,837	21,226	220,992	10.41	15
16	Dishwashers					16
17	Maintenance Workers	5,152	5,513	105,685	19.17	17
18	Housekeepers	17,664	18,901	208,227	11.02	18
19	Laundry	9,994	10,694	108,932	10.19	19
20	Administrator	1,800	1,926	112,758	58.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,247	17,384	281,625	16.20	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	1,973	2,111	39,344	18.64	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,120	5,418	135,658	25.04	33
34	TOTAL (lines 1 - 33)	262,404	280,714	$ 4,131,495 *	$ 14.72	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	206	$ 9,280	01-03	35
36	Medical Director	Monthly	35,200	09-03	36
37	Medical Records Consultant	51	2,338	10-03	37
38	Nurse Consultant	13	972	10-03	38
39	Pharmacist Consultant	170	10,221	10-03	39
40	Physical Therapy Consultant	2	104	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	24	1,085	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	83	4,074	12-03	45
46	Other(specify) Rehab Consultant	107	5,222	03-10A	46
47	Psychosocial Consulting	20	869	03-12	47
48	Neuropsychology	Monthly	3,000	03-10	48
49	TOTAL (lines 35 - 48)	676	$ 72,365		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Stoudt	Administrator	0	$ 112,758
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,758

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
Certified Health Management	Home Office Expense	$ 537,160
FROST,Ruttenberg & Rothblatt	Accounting	13,510
See Attached	Legal Fees	31,529
Wescom	Data Processing	29,197
Personnel Planners	Unemployment Consulting	7,792
Achieve Accreditation	Consulting	3,628
Peterson Healthcare	Consulting	28,741
eHealth	MDS Software	5,161
Hamlin & Burton	Professional Services	429
Richard Peelo	Accounting Fees	3,750
Paychex	Payroll Services	16,055
See Supplemental Schedule		44,855
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 721,807

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,788
Unemployment Compensation Insurance	130,643
FICA Taxes	308,217
Employee Health Insurance	198,363
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	20,335
Employee Benefits - Other	27
TOTAL (agree to Schedule V, line 22, col.8)	$ 777,373

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 134)	1,342
Patient Background Checks	
Employee Hiring Costs	27,643
Dues and Subscriptions	9,792
Liscenses & Permits	21,229
Alloc. Certified Health Management	6,300
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,306

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,278
Alloc. Certified Health Management	548
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,826

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

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

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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? **No**
If YES, give association name and amount. **N/A**

(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. $ **1,085** Line **10-02**

(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. $ **376,829**
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. $ 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? **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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
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? 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? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.