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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0032839

Facility Name: Glenwood Healthcare & Rehab.

Address: 19330 South Cottage Grove (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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 01/01/15 Ending: 12/31/15

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	1,537		6,213	7,750	8
9	SNF/PED					9
10	ICF	36,902	1,271	933	39,106	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,439	1,271	7,146	46,856	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.77%

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 4,206

Medicare Intermediary National Government Serivces

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Glenwood Healthcare & Rehab. # 0032839 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	252,061	26,339	10,868	289,268		289,268		289,268			1
2	Food Purchase		249,475		249,475		249,475	82	249,557			2
3	Housekeeping	215,040	42,554		257,594		257,594		257,594			3
4	Laundry	94,905	28,944		123,849		123,849		123,849			4
5	Heat and Other Utilities			192,431	192,431		192,431	1,509	193,940			5
6	Maintenance	106,598	24,359	73,922	204,879		204,879	(3,817)	201,062			6
7	Other (specify):*											7
8	**TOTAL General Services**	668,604	371,671	277,221	1,317,496		1,317,496	(2,226)	1,315,270			8
	B. Health Care and Programs											
9	Medical Director			40,800	40,800		40,800		40,800			9
10	Nursing and Medical Records	2,463,726	73,506	21,820	2,559,052		2,559,052	10,680	2,569,732			10
10a	Therapy	60,286	1,888	1,327	63,501		63,501		63,501			10a
11	Activities	147,964	16,755		164,719		164,719		164,719			11
12	Social Services	118,249		3,401	121,650		121,650		121,650			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							10,009	10,009			15
16	**TOTAL Health Care and Programs**	2,790,225	92,149	67,348	2,949,722		2,949,722	20,690	2,970,412			16
	C. General Administration											
17	Administrative	99,633			99,633		99,633	78,922	178,555			17
18	Directors Fees											18
19	Professional Services			717,028	717,028		717,028	(529,183)	187,845			19
20	Dues, Fees, Subscriptions & Promotions			51,109	51,109		51,109	(7,116)	43,993			20
21	Clerical & General Office Expenses	248,652	7,188	492,986	748,826		748,826	(228,892)	519,934			21
22	Employee Benefits & Payroll Taxes			652,127	652,127		652,127		652,127			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,228	2,228		2,228	412	2,640			24
25	Other Admin. Staff Transportation			7,678	7,678		7,678	15,192	22,870			25
26	Insurance-Prop.Liab.Malpractice			384,070	384,070		384,070	1,801	385,871			26
27	Other (specify):*							40,368	40,368			27
28	**TOTAL General Administration**	348,285	7,188	2,307,226	2,662,699		2,662,699	(628,495)	2,034,204			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,807,114	471,008	2,651,795	6,929,917		6,929,917	(610,031)	6,319,886			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: 01/01/15 Ending: 12/31/15

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			214,999	214,999		214,999	124,628	339,627			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,900	48,900		48,900	720,229	769,129			32
33	Real Estate Taxes			534,409	534,409		534,409		534,409			33
34	Rent-Facility & Grounds			951,837	951,837		951,837	(943,381)	8,456			34
35	Rent-Equipment & Vehicles			27,817	27,817		27,817	(1,476)	26,341			35
36	Other (specify):*											36
37	TOTAL Ownership			1,777,962	1,777,962		1,777,962	(100,000)	1,677,962			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		405,283	612,912	1,018,195		1,018,195		1,018,195			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			356,882	356,882		356,882		356,882			42
43	Other (specify):*	150,004			150,004		150,004	(150,004)	0			43
44	TOTAL Special Cost Centers	150,004	405,283	969,794	1,525,081		1,525,081	(150,004)	1,375,077			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,957,118	876,291	5,399,551	10,232,960		10,232,960	(860,035)	9,372,925			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: 01/01/15 Ending: 12/31/15

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	(17,660)	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	(15,116)	30		9
10	Interest and Other Investment Income	(3,116)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(68)	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	(68,893)	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	(322,418)	21		24
25	Fund Raising, Advertising and Promotional	(12,721)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(271,032)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (711,023)		$	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)	(149,012)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (149,012)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (860,035)		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: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (161)	21	1
2	Purchased Services - Veterans	(54,954)	10	2
3	Marketing Salary	(74,949)	43	3
4	Marketing Liason	(75,055)	43	4
5	Bank Charges	(12,715)	21	5
6	Theft & Damage Loss	(104)	21	6
7	Building Company - Accounting Fees	(3,280)	19	7
8	Building Company - Amortization	(46,418)	36	8
9	Building Company - Bank Charges	(1,104)	21	9
10	Additional R&M	13,833	06	10
11	Non-Allowable Legal	(7,078)	19	11
12	Non-Allowable Auto Lease	(9,048)	35	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(271,032)		49

Glenwood Healthcare & Rehab.

ID# 0032839

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Glenwood Healthcare & Rehab. **#** 0032839 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(68)		150									82	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,509									1,509	5
6	Maintenance	(3,827)		10									(3,817)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(3,895)		1,669									(2,226)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(54,954)		65,634									10,680	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			10,009									10,009	15
16	**TOTAL Health Care and Programs**	(54,954)		75,643									20,690	16
	C. General Administration													
17	Administrative			78,922									78,922	17
18	Directors Fees													18
19	Professional Services	(10,358)	3,280	(522,106)									(529,183)	19
20	Fees, Subscriptions & Promotions	(12,721)		5,605									(7,116)	20
21	Clerical & General Office Expenses	(405,395)	1,104	175,399									(228,892)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			412									412	24
25	Other Admin. Staff Transportation			15,192									15,192	25
26	Insurance-Prop.Liab.Malpractice			1,801									1,801	26
27	Other (specify):*			40,368									40,368	27
28	**TOTAL General Administration**	(428,473)	4,384	(204,405)									(628,495)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(487,322)	4,384	(127,093)									(610,031)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Glenwood Healthcare & Rehab.** **#** **0032839** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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	(15,116)	136,850	2,893									124,628	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,116)	723,310	35									720,229	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(951,837)	8,456									(943,381)	34
35	Rent-Equipment & Vehicles	(9,048)		7,572									(1,476)	35
36	Other (specify):*	(46,418)	46,418											36
37	**TOTAL Ownership**	(73,698)	(45,259)	18,956									(100,000)	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):*	(150,004)											(150,004)	43
44	**TOTAL Special Cost Centers**	(150,004)											(150,004)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(711,023)	(40,875)	(108,137)									(860,035)	45

Facility Name & ID Number Glenwood Healthcare & Rehab. # 0032839 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 951,837	Glenwood Terrace, LLC	100.00%	$	$ (951,837)	1
2	V	32	Interest	1,365	Glenwood Terrace, LLC	100.00%	724,675	723,310	2
3	V	19	Accounting Fees		Glenwood Terrace, LLC	100.00%	3,280	3,280	3
4	V	36	Amortization		Glenwood Terrace, LLC	100.00%	46,418	46,418	4
5	V	21	Bank Charges		Glenwood Terrace, LLC	100.00%	1,104	1,104	5
6	V	30	Depreciation		Glenwood Terrace, LLC	100.00%	136,850	136,850	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 953,202			$ 912,327	$ * (40,875)	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: 01/01/15 Ending: 12/31/15

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			$			$	$	15
16	V	2	FOOD		CERTIFIED HEALTH MANAGEMENT	100.00%	150	150	16
17	V	5	UTILITIES		CERTIFIED HEALTH MANAGEMENT	100.00%	1,509	1,509	17
18	V	6	REPAIRS AND MAINTENANCE		CERTIFIED HEALTH MANAGEMENT	100.00%	10	10	18
19	V	10	NURSING		CERTIFIED HEALTH MANAGEMENT	100.00%	65,634	65,634	19
20	V	15	EMP. BEN. HEALTHCARE		CERTIFIED HEALTH MANAGEMENT	100.00%	10,009	10,009	20
21	V	17	ADMINISTRATIVE SALARIES		CERTIFIED HEALTH MANAGEMENT	100.00%	31,945	31,945	21
22	V	19	PROFESSIONAL FEES		CERTIFIED HEALTH MANAGEMENT	100.00%	15,051	15,051	22
23	V	20	DUES, FEES, SUBSCRIPTIONS		CERTIFIED HEALTH MANAGEMENT	100.00%	5,605	5,605	23
24	V	21	SALARIES - CLERICAL		CERTIFIED HEALTH MANAGEMENT	100.00%	158,214	158,214	24
25	V	21	OFFICE EXPENSES		CERTIFIED HEALTH MANAGEMENT	100.00%	17,184	17,184	25
26	V	24	SEMINAR EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	412	412	26
27	V	25	AUTO & TRAVEL EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	15,192	15,192	27
28	V	26	INSURANCE		CERTIFIED HEALTH MANAGEMENT	100.00%	1,801	1,801	28
29	V	27	EMP. BEN. GEN. ADMIN.		CERTIFIED HEALTH MANAGEMENT	100.00%	30,908	30,908	29
30	V	30	DEPRECIATION		CERTIFIED HEALTH MANAGEMENT	100.00%	2,893	2,893	30
31	V	32	INTEREST		CERTIFIED HEALTH MANAGEMENT	100.00%	35	35	31
32	V	34	RENT		CERTIFIED HEALTH MANAGEMENT	100.00%	8,456	8,456	32
33	V	35	EQUIPMENT RENTAL		CERTIFIED HEALTH MANAGEMENT	100.00%	1,093	1,093	33
34	V	35	AUTO LEASE		CERTIFIED HEALTH MANAGEMENT	100.00%	6,479	6,479	34
35	V								35
36	V	17	ADMIN COMP - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	46,977	46,977	36
37	V	27	EMP. BEN. - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	9,460	9,460	37
38	V	19	HOME OFFICE EXPENSE	537,157	CERTIFIED HEALTH MANAGEMENT	100.00%		(537,157)	38
39	Total			$ 537,157			$ 429,020	$ * (108,137)	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	BRADLEY M. ALTER	22.826%	DANVILLE CARE CENTER, LTD.	DANVILLE	GLENWOOD TERRACE, LLC	SKOKIE	BUILDING CO.	1
2	ESBT FOR JULIE T.Y. BRUM 12/17/02	19.565%	PRAIRIE VIEW CARE CENTER OF LEWISTOWN, INC	LEWISTOWN	CERTIFIED HEALTH MGMT.	SKOKIE ILLINOIS	MANAGEMENT	2
3	ESBT FOR JENNIFER T.W. CHOW 12/17/02	19.565%	RENAISSANCE CARE CENTER, INC	CANTON				3
4	HOWARD D. GELLER TRUST	38.044%	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bradley Alter	Owner	Administration	22.83%	See Attached	11.74	23.48%	Alloc. Salary	$ 46,977	17-7	1
2	Daniel Alter	Relative	Clerical	0%	See Attached	8.22	23.49%	Alloc. Salary	8,513	21-7	2
3	Zev Geller	Relative	Clerical	0%	See Attached	2.06	23.54%	Alloc. Salary	2,437	21-7	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	$ 57,927		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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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						$	$		$	1
2	2	FOOD	PATIENT DAYS	199,483	6	639		46,856	150	2
3	5	UTILITIES	PATIENT DAYS	199,483	6	6,424		46,856	1,509	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	199,483	6	43		46,856	10	4
5	10	NURSING	PATIENT DAYS	199,483	6	279,428	279,428	46,856	65,634	5
6	15	EMP. BEN. HEALTHCARE	PATIENT DAYS	199,483	6	42,613		46,856	10,009	6
7	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	199,483	6	136,000	136,000	46,856	31,945	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	199,483	6	64,080		46,856	15,051	8
9	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	199,483	6	23,865		46,856	5,605	9
10	21	SALARIES - CLERICAL	PATIENT DAYS	199,483	6	673,576	673,576	46,856	158,214	10
11	21	OFFICE EXPENSES	PATIENT DAYS	199,483	6	73,160		46,856	17,184	11
12	24	SEMINAR EXPENSE	PATIENT DAYS	199,483	6	1,756		46,856	412	12
13	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	199,483	6	64,679		46,856	15,192	13
14	26	INSURANCE	PATIENT DAYS	199,483	6	7,669		46,856	1,801	14
15	27	EMP. BEN. GEN. ADMIN.	PATIENT DAYS	199,483	6	131,588		46,856	30,908	15
16	30	DEPRECIATION	PATIENT DAYS	199,483	6	12,317		46,856	2,893	16
17	32	INTEREST	PATIENT DAYS	199,483	6	148		46,856	35	17
18	34	RENT	PATIENT DAYS	199,483	6	36,000		46,856	8,456	18
19	35	EQUIPMENT RENTAL	PATIENT DAYS	199,483	6	4,652		46,856	1,093	19
20	35	AUTO LEASE	PATIENT DAYS	199,483	6	27,586		46,856	6,479	20
21										21
22	17	ADMIN COMP - B. ALTER	AVERAGE HOURS WORKE	50	6	200,000	200,000	11.74	46,977	22
23	27	EMP. BEN. - B. ALTER	AVERAGE HOURS WORKE	50	6	40,273		11.74	9,460	23
24										24
25	TOTALS					$ 1,826,494	$ 1,289,004		$ 429,020	25

Facility Name & ID Number Glenwood Healthcare & Rehab. # 0032839 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	Cole Taylor Bank		X	Mortgage Payable			$	$ 11,000,000			$ 438,388	1
2	Cole Taylor Bank		X	Mortgage Payable				5,500,000			118,708	2
3												3
4												4
5												5
	Working Capital											
6	Swap Interest		X								167,580	6
7	Bank Financial		X	Line of Credit							42,015	7
8	See Supplemental Schedule										6,885	8
9	TOTAL Facility Related						$	$ 16,500,000			$ 773,575	9
	B. Non-Facility Related*											
10	Interest Income		X								(3,116)	10
11	Interest Income - Bldg Co.		X								(1,365)	11
12	Allocated - Certified Health	X									35	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,446)	14
15	TOTALS (line 9+line14)						$	$ 16,500,000			$ 769,129	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: 01/01/15 Ending: 12/31/15

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	Enloe		X	Note Payable			$	$			$ 846	8
9	Insurance Financing		X								6,039	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										6,885	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:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 377,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 521,409	2
3. Under or (over) accrual (line 2 minus line 1).		$ 144,409	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 390,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 534,409	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	347,366	8
	2011	405,014	9
	2012	356,263	10
	2013	366,092	11
	2014	521,409	12

2015 Accrual = 2013 Taxes 366,092 x 1.07 = $390,000 (Rounded)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 521,408.75	$ 521,408.75
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 521,408.75	$ 521,408.75

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	$ 2,386,103	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			17,594	15
16	Various			1995	31,602		20	790	790	31,602	16
17	Various			1996	39,136		20	1,957	1,957	38,061	17
18	Various			1997	43,166		20	2,158	2,158	40,094	18
19	Various			1998	163,365		20	8,168	8,168	142,944	19
20	Various			1999	136,071		20	6,804	6,804	112,826	20
21	Various			2000	36,744		20	1,837	1,837	28,813	21
22	Various			2001	7,300		20	365	365	5,445	22
23	Various			2002	13,080		20	654	654	8,775	23
24	Various			2003	62,327		20	3,116	3,116	38,716	24
25	Various			2004	45,982		20	2,299	2,299	26,440	25
26	Various			2005	62,611		20	3,131	3,131	32,628	26
27	Various			2006	23,234		20	1,162	1,162	11,036	27
28	Various			2007	24,901		20	1,245	1,245	10,994	28
29	Various			2008	29,343		20	1,467	1,467	11,060	29
30	Various			2009	91,559		20	4,387	4,387	31,977	30
31	Various			2010	104,397		20	6,848	6,848	36,827	31
32	Various			2011	357,619		20	21,196	21,196	96,974	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: 01/01/15 Ending: 12/31/15

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)		811,183			40,559	40,559	40,250	67
68	Related Party Allocations (Pages 12H & 12I)		28,355	1,797		1,418	(379)	21,492	68
69	Financial Statement Depreciation			214,999			(214,999)		69
70	TOTAL (lines 4 thru 69)		$ 7,703,065	$ 353,646		$ 249,920	$ (103,726)	$ 3,270,145	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: 01/01/15 Ending: 12/31/15

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		$ 7,703,065	$ 353,646		$ 249,920	$ (103,726)	$ 3,270,145	1
2	Doors	2012	13,173		20	659	659	2,635	2
3	Hallways - Remove And Replace Wallcovering, Millwod, Paint	2012	49,245		20	2,462	2,462	8,618	3
4	Doors And Hallway Project	2012	11,335		20	567	567	1,984	4
5	Wallcovering, Corner Guards, Grab Bars, Signage - Kitchen, Bath	2012	3,414		20	171	171	654	5
6	Flooring, Corner Guards, Doors, Window Treatments-Rms A-3, A	2012	12,391		20	620	620	2,117	6
7	Paving	2012	3,100		20	207	207	672	7
8	Cove Base In Kitchen	2012	3,767		20	753	753	2,386	8
9	Rooftop Hvac	2012	6,600		20	330	330	1,045	9
10	New Hot Water Heater	2012	6,010		20	301	301	927	10
11	Flat Roof Replacement	2012	7,800		20	390	390	1,560	11
12	Overhead Door	2013	3,800		20	190	190	538	12
13	Roof Repair	2013	2,995		20	150	150	424	13
14	Parking Lot Sealcoat And Restriping	2013	3,217		20	214	214	572	14
15	Walls, Paint, Rails	2013	16,500		20	825	825	1,925	15
16	Ac/Heat Window Unit	2013	4,124		20	825	825	2,062	16
17	Energy Services - Hvac	2013	13,770		20	689	689	1,549	17
18	2 New Condensing Units And 2 New Air Handlers	2013	6,400		20	320	320	693	18
19	2 Condensing Units Out Of 10	2014	46,200		20	2,310	2,310	4,620	19
20	Replace Kitchen Drain	2014	10,920		20	546	546	1,092	20
21	New Water Heater	2014	9,952		20	498	498	995	21
22	Additonal Work For New Water Heater	2014	3,362		20	168	168	322	22
23	Walk In Cooler Door Repalcement	2014	2,698		20	135	135	247	23
24	Install New Grease Separator	2014	5,980		20	299	299	548	24
25	New Kitchen Floor	2014	3,673		20	184	184	321	25
26	D Wing Shower Room - Replacement	2014	33,256		20	1,663	1,663	2,771	26
27	Alarm System	2014	2,526		20	126	126	211	27
28	New Power Generator	2014	3,510		20	175	175	292	28
29	Reclining Tub/Disinfecting System	2014	12,695		20	635	635	952	29
30	Roof Repair	2014	40,338		20	2,017	2,017	3,025	30
31	Ac Units Openings	2014	5,280		20	264	264	352	31
32	Dialyis Unit Electric Equipment	2014	7,150		20	1,430	1,430	1,907	32
33	Dialyis Unit Plumbing Equipment	2014	4,490		20	225	225	299	33
34	TOTAL (lines 1 thru 33)		$ 8,062,737	$ 353,646		$ 270,265	$ (83,381)	$ 3,318,462	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: 01/01/15 Ending: 12/31/15

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		$ 8,062,737	$ 353,646		$ 270,265	$ (83,381)	$ 3,318,462	1
2	Parking Lot Sealcoat	2014	3,375		20	225	225	300	2
3	Water Heater	2014	7,575		20	379	379	473	3
4	Hvac Testing	2014	3,650		20	183	183	213	4
5	Water Heater	2014	3,761		20	188	188	298	5
6	18Ga Wire With Connectors For Fire Damper	2014	2,655		20	133	133	210	6
7	Heating / Furnace Upgrade	2014	6,583		20	329	329	658	7
8	Drywall Replacement	2014	2,633		20	132	132	241	8
9	Slop Sink Work	2014	4,821		20	241	241	422	9
10	Security Door	2014	3,780		20	189	189	362	10
11	Heat/Cool 230V System Qty.4	2015	2,642		20	264	264	264	11
12	Replacement Of Hot Water Heater	2015	6,950		20	319	319	319	12
13	Roof Top Unit Replacement	2015	7,987		20	133	133	133	13
14	Light Fixtures For Dialysis	2015	3,700		20	185	185	185	14
15	Installation And Set Up Of Fire System	2015	2,880		20	72	72	72	15
16	Replace Two Roof Drains On East Roof	2015	5,221		20	44	44	44	16
17	Phone System Setup	2015	4,700		20	157	157	157	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)		$ 8,135,649	$ 353,646		$ 273,436	$ (80,210)	$ 3,322,813	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: 01/01/15 Ending: 12/31/15

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		$ 8,135,649	$ 353,646		$ 273,436	$ (80,210)	$ 3,322,813	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)		$ 8,135,649	$ 353,646		$ 273,436	$ (80,210)	$ 3,322,813	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: 01/01/15 Ending: 12/31/15

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		$ 8,135,649	$ 353,646		$ 273,436	$ (80,210)	$ 3,322,813	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)		$ 8,135,649	$ 353,646		$ 273,436	$ (80,210)	$ 3,322,813	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: 01/01/15 Ending: 12/31/15

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	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Design/Construct Front Entry for PT & Office Addition/Renovatio	2015	22,140		20	1,107	1,107	1,107	9
10	Dialysis Unit-Carpentry/Electrical & Lighting/Drywall/Demo	2015	268,304		20	13,415	13,415	13,415	10
11	C & D Wing Corridors/Shower Room/Therapy Room/Nurse Statio	2015	315,748		20	15,787	15,787	15,478	11
12	C-Wing Roof	2015	143,414		20	7,171	7,171	7,171	12
13	Install Storm Sewer Drain	2015	19,375		20	969	969	969	13
14	Install Backflow	2015	6,500		20	325	325	325	14
15	Roof Work	2015	35,702		20	1,785	1,785	1,785	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)		$ 811,183	$		$ 40,559	$ 40,559	$ 40,250	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: 01/01/15 Ending: 12/31/15

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		$ 811,183	$		$ 40,559	$ 40,559	$ 40,250	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
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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)		$ 811,183	$		$ 40,559	$ 40,559	$ 40,250	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: 01/01/15 Ending: 12/31/15

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Certified Health Management	1997	22,132	553	20	1,107	554	21,025	9
10	Allocated from Certified Health Management	2014	6,223	1,244	20	311	(933)	467	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)		$ 28,355	$ 1,797		$ 1,418	$ (379)	$ 21,492	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: 01/01/15 Ending: 12/31/15

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		$ 28,355	$ 1,797		$ 1,418	$ (379)	$ 21,492	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
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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)		$ 28,355	$ 1,797		$ 1,418	$ (379)	$ 21,492	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: 01/01/15 Ending: 12/31/15

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	$ 337,431	$ 1,064	$ 60,495	$ 59,431	10	$ 248,024	71
72	Current Year Purchases	27,239	31	3,185	3,154	10	3,185	72
73	Fully Depreciated Assets	821,453		51	51	10	821,391	73
74								74
75	TOTALS	$ 1,186,123	$ 1,095	$ 63,732	$ 62,637		$ 1,072,601	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	$	$ 2,458	$ 2,458	5	$ 8,034	76
77										77
78										78
79										79
80	TOTALS			$ 13,769	$	$ 2,458	$ 2,458		$ 8,034	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)	$ 9,657,541	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 354,741	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 339,625	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (15,116)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,403,448	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	Land - 2015	$ 143,230	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 143,230	$	$	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: 01/01/15 Ending: 12/31/15

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	Allocated from Certified Health Mgmt				8,456			5
6								6
7	TOTAL				$ 8,456 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 16,152 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	Facility	2011 Ford Elkhart Coach	$ 309.13	$ 3,710	17
18	Allocated from Certified Health Mgmt			6,479	18
19					19
20					20
21	TOTAL		$ 309.13	$ 10,189	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 201,294	$		$ 201,294	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			56,504			56,504	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			273,697			273,697	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				143,677		143,677	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					81,334	261,606		342,940	13
14	TOTAL			$		$ 612,829	$ 405,283		$ 1,018,112	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:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 221,237	$ 1,007,575	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,218,994	4,188,636	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	70,639	70,639	5
6	Prepaid Insurance	183,526	183,526	6
7	Other Prepaid Expenses	3,823	4,386	7
8	Accounts Receivable (owners or related parties)	129,053	129,053	8
9	Other(specify):	2,156	198,786	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,829,428	$ 5,782,601	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		465,230	13
14	Buildings, at Historical Cost		5,474,000	14
15	Leasehold Improvements, at Historical Cost	1,804,578	2,505,420	15
16	Equipment, at Historical Cost	1,035,416	1,311,416	16
17	Accumulated Depreciation (book methods)	(1,740,677)	(4,343,127)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	911,938	6,573,871	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,011,255	$ 11,986,810	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,840,683	$ 17,769,411	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 671,130	$ 678,725	26
27	Officer's Accounts Payable	44,320	44,320	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	196,802	196,802	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,823	21,067	31
32	Accrued Real Estate Taxes(Sch.IX-B)	390,000	390,000	32
33	Accrued Interest Payable	1,117	59,822	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	390,566	390,566	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,707,758	$ 1,781,302	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	1,467,535	481,480	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,467,535	$ 16,981,480	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,175,293	$ 18,762,782	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,665,390	$ (993,371)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,840,683	$ 17,769,411	48

***(See instructions.)**

Facility Name & ID Number Glenwood Healthcare & Rehab. # 0032839 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,563,562	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,563,559	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	201,831	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	(100,000)	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)**	$ 101,831	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,665,390	24 *

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

Facility Name & ID Number Glenwood Healthcare & Rehab. # 0032839 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 9,105,051	1
2	Discounts and Allowances for all Levels	1,164,649	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,269,700	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	156,886	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 156,886	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	977	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	80	20
21	Other Medical Services	1,247	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,304	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,116	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,116	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,785	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,785	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,434,791	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,317,496	31
32	Health Care	2,949,722	32
33	General Administration	2,662,699	33
	B. Capital Expense		
34	Ownership	1,777,962	34
	C. Ancillary Expense		
35	Special Cost Centers	1,168,199	35
36	Provider Participation Fee	356,882	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,232,960	40
41	**Income before Income Taxes (line 30 minus line 40)****	201,831	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 201,831	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,513,132	44
45	Private Pay - Net Inpatient Revenue	147,838	45
46	Medicare - Net Inpatient Revenue	2,297,808	46
47	Other-(specify) Managed Care	758,929	47
48	Other-(specify) Hospice	551,993	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,269,700	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.**

Facility Name & ID Number Glenwood Healthcare & Rehab. # 0032839 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,314	1,406	$ 70,322	$ 50.02	1
2	Assistant Director of Nursing	1,607	1,720	43,161	25.09	2
3	Registered Nurses	14,248	15,246	456,923	29.97	3
4	Licensed Practical Nurses	28,479	30,474	838,921	27.53	4
5	CNAs & Orderlies	78,420	83,918	1,013,625	12.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,981	5,332	60,286	11.31	8
9	Activity Director	1,795	1,920	41,744	21.74	9
10	Activity Assistants	8,225	8,803	106,220	12.07	10
11	Social Service Workers	6,425	6,875	118,249	17.20	11
12	Dietician					12
13	Food Service Supervisor	1,832	1,960	43,574	22.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,639	17,811	208,487	11.71	15
16	Dishwashers					16
17	Maintenance Workers	4,912	5,257	106,598	20.28	17
18	Housekeepers	15,020	16,073	215,040	13.38	18
19	Laundry	7,459	7,985	94,905	11.89	19
20	Administrator	1,738	1,860	99,633	53.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,448	14,388	248,652	17.28	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	1,923	2,057	40,774	19.82	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,814	6,152	150,004	24.38	33
34	TOTAL (lines 1 - 33)	214,279	229,237	$ 3,957,118 *	$ 17.26	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	241	$ 10,868	01-03	35
36	Medical Director	Monthly	40,800	09-03	36
37	Medical Records Consultant	45	2,070	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	255	15,312	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	29	1,327	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	38	1,874	12-03	45
46	Other(specify) Neuropsychology	Monthly	4,438	10-03	46
47	Psychosocial Consulting	35	1,527	12-03	47
48					48
49	TOTAL (lines 35 - 48)	643	$ 78,216		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	$ 55,794
Mary Ellen McDevitt	Administrator	0	43,839
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,633

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
The Joint Commission	Accreditation	$ 2,800
Achieve Accreditation	Accreditation	1,810
Certified Health Management	Home Office Expense	537,157
FRR / Marcum	Accounting	14,280
Richard Peelo & Assoc Inc	Accounting	3,750
eHealth Data Solutions	MDS Software	5,161
Peterson Healthcare Consulting	Healthcare Consulting	9,258
Paychex	Payroll Processing	22,746
Personnel Planners	Unemployment Consulting	10,211
Legal	See Attached	66,077
Wescom Solutions	Data Processing	43,779
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 717,028

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,238
Unemployment Compensation Insurance	70,427
FICA Taxes	294,937
Employee Health Insurance	165,528
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	4,045
Pension Plan	15,952
TOTAL (agree to Schedule V, line 22, col.8)	$ 652,127

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	3,284
Health Care Worker Background Check	
(Indicate # of checks performed 145)	1,450
Patient Background Checks	
Dues and Subscriptions	27,454
License and Permits	6,200
Allocated from Certified Health Mgmt	5,605
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,993

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,228
Allocated from Certified Health Mgmt	412
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,640

**See instructions.

Facility Name & ID Number Glenwood Healthcare & Rehab. # 0032839 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Glenwood Healthcare & Rehab. # 0032839 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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. $ None Line N/A

(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. $ 356,882
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? No 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? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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.