FOR BHF USE

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0043935

Facility Name: WOOD GLEN NRSING & REHAB CTR

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

County: DUPAGE

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/15 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) CAMILLE B. LOCKHART, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 _____

	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	213	Skilled (SNF)	213	77,745	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	213	TOTALS	213	77,745	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	71,449	3,703	615	75,767	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,449	3,703	615	75,767	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.46%

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)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 2/12/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 213 and days of care provided 533

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	334,359	36,270	11,169	381,798		381,798		381,798			1
2	Food Purchase		501,776		501,776		501,776	(1,125)	500,651			2
3	Housekeeping	282,380	66,642		349,022		349,022		349,022			3
4	Laundry		18,970		18,970		18,970		18,970			4
5	Heat and Other Utilities			276,111	276,111		276,111	3,311	279,422			5
6	Maintenance	197,479	834	105,832	304,145		304,145	4,181	308,326			6
7	Other (specify):*											7
8	TOTAL General Services	814,218	624,492	393,112	1,831,822		1,831,822	6,367	1,838,189			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,527,598	83,598	17,478	2,628,674		2,628,674		2,628,674			10
10a	Therapy	123,792			123,792		123,792		123,792			10a
11	Activities	39,748	2,854	1,088	43,690		43,690		43,690			11
12	Social Services	249,011			249,011		249,011		249,011			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,940,149	86,452	54,566	3,081,167		3,081,167		3,081,167			16
	C. General Administration											
17	Administrative	214,686		480,000	694,686		694,686	27,073	721,759			17
18	Directors Fees											18
19	Professional Services			479,305	479,305		479,305	(370,472)	108,833			19
20	Dues, Fees, Subscriptions & Promotions			41,986	41,986		41,986	(13,866)	28,120			20
21	Clerical & General Office Expenses	222,402	22,411	130,931	375,744		375,744	180,653	556,397			21
22	Employee Benefits & Payroll Taxes			536,095	536,095		536,095		536,095			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,862	3,862		3,862	3,247	7,109			24
25	Other Admin. Staff Transportation			4,147	4,147		4,147	14,540	18,687			25
26	Insurance-Prop.Liab.Malpractice			262,321	262,321		262,321	1,510	263,831			26
27	Other (specify):*							47,746	47,746			27
28	TOTAL General Administration	437,088	22,411	1,938,647	2,398,146		2,398,146	(109,569)	2,288,577			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,191,455	733,355	2,386,325	7,311,135		7,311,135	(103,202)	7,207,933			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR #0043935 Report Period Beginning: 1/1/15 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			18,560	18,560		18,560	39,916	58,476			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			924	924		924	343	1,267			32
33	Real Estate Taxes			367,333	367,333		367,333	1,298	368,631			33
34	Rent-Facility & Grounds			1,839,513	1,839,513		1,839,513	1,586	1,841,099			34
35	Rent-Equipment & Vehicles			58,206	58,206		58,206	4,603	62,809			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,284,536	2,284,536		2,284,536	47,746	2,332,282			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,227		32,227		32,227		32,227			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			573,738	573,738		573,738		573,738			42
43	Other (specify):*							(9,488)	(9,488)			43
44	**TOTAL Special Cost Centers**		32,227	573,738	605,965		605,965	(9,488)	596,477			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,191,455	765,582	5,244,599	10,201,636		10,201,636	(64,944)	10,136,692			45

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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	(1,021)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(924)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(104)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,594)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,162)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,998)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,697)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(24,330)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,830)		$	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)	(1,114)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,114)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (64,944)		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

WOOD GLEN NRSING & REHAB CTR

ID# 0043935

Report Period Beginning: 1/1/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISC INCOME	$ (8,419)	21	1
2	VENDING INCOME	(98)	21	2
3	BANK FEES	(33,854)	21	3
4	MARKETING - SALARY	(8,412)	43	4
5	MARKETING - EB	(1,076)	43	5
6	IL COUNCIL LTC - LOBBYING EXPENSE	(8,556)	20	6
7	ADJ TO S/L DEPR	36,085	30	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,330)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,125)	0	0	0	0	0	0	0	0	0	0	(1,125)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	12	3,299	0	0	0	0	0	0	0	0	3,311	5
6	Maintenance	0	215	3,966	0	0	0	0	0	0	0	0	4,181	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,125)	227	7,265	0	0	0	0	0	0	0	0	6,367	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	27,073	0	0	0	0	0	0	0	0	27,073	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,162)	(375,148)	19,838	0	0	0	0	0	0	0	0	(370,472)	19
20	Fees, Subscriptions & Promotions	(14,554)	102	586	0	0	0	0	0	0	0	0	(13,866)	20
21	Clerical & General Office Expenses	(58,662)	106,681	132,634	0	0	0	0	0	0	0	0	180,653	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,101	1,146	0	0	0	0	0	0	0	0	3,247	24
25	Other Admin. Staff Transportation	0	9,258	5,282	0	0	0	0	0	0	0	0	14,540	25
26	Insurance-Prop.Liab.Malpractice	0	38	1,472	0	0	0	0	0	0	0	0	1,510	26
27	Other (specify):*	0	16,403	31,343	0	0	0	0	0	0	0	0	47,746	27
28	**TOTAL General Administration**	(88,378)	(240,565)	219,374	0	0	0	0	0	0	0	0	(109,569)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(89,503)	(240,338)	226,639	0	0	0	0	0	0	0	0	(103,202)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 **Report Period Beginning:** 1/1/15 **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	36,085	0	3,831	0	0	0	0	0	0	0	0	39,916	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(924)	0	1,267	0	0	0	0	0	0	0	0	343	32
33	Real Estate Taxes	0	0	1,298	0	0	0	0	0	0	0	0	1,298	33
34	Rent-Facility & Grounds	0	0	1,586	0	0	0	0	0	0	0	0	1,586	34
35	Rent-Equipment & Vehicles	0	0	4,603	0	0	0	0	0	0	0	0	4,603	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	35,161	0	12,585	0	0	0	0	0	0	0	0	47,746	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(9,488)	0	0	0	0	0	0	0	0	0	0	(9,488)	43
44	**TOTAL Special Cost Centers**	(9,488)	0	0	0	0	0	0	0	0	0	0	(9,488)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,830)	(240,338)	239,224	0	0	0	0	0	0	0	0	(64,944)	45

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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
BEN KLEIN	70.1	RIVER VALLEY SUPPORTIVE LIV RESIDENCE	KANKAKEE	PLATINUM HEALTI	SKOKIE, IL	MANAGEMENT
MIRIAM KLEIN	4.95			CARE, LLC		
KENNETH KLEIN	2.475	THE BRIDGE CARE SUITES	SPRINGFIELD			
RONNIE KLEIN	2.475			PHC CONSULTANTS	SKOKIE	CONSULTING
ABM LIMITED PARTNERSHIP	10.3					
ABRAHAM STERN	4.8					
SUSAN STERN	4.9					

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	19	PROFESSIONAL FEES	$ 375,600	PHC CONSULTANTS, LLC		$	$ (375,600)	1
2	V	5	Utilities				12	12	2
3	V	6	Repairs & Maintenance				215	215	3
4	V	19	Professional Fees				452	452	4
5	V	20	Fees, Subscriptions				102	102	5
6	V	21	Office				106,681	106,681	6
7	V	24	Education & Seminars				2,101	2,101	7
8	V	25	Travel				9,258	9,258	8
9	V	26	Insurance				38	38	9
10	V	27	Employee Benefits				16,403	16,403	10
11	V								11
12	V								12
13	V								13
14	Total			$ 375,600			$ 135,262	$ * (240,338)	14

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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	17	HOME OFFICE	$	PLATINUM HEALTH CARE, LLC	100.00%	$	$	15
16	V	5	Utilities				3,299	3,299	16
17	V	6	Repairs & Maintenance				3,966	3,966	17
18	V	17	Administrative Salary				27,073	27,073	18
19	V	19	Professional Fees				19,838	19,838	19
20	V	20	Fees, Subscriptions				586	586	20
21	V	21	Clerical Salaries				129,578	129,578	21
22	V	21	Office Expenses				3,056	3,056	22
23	V	24	Education & Seminars				1,146	1,146	23
24	V	25	Travel				5,282	5,282	24
25	V	26	Insurance				1,472	1,472	25
26	V	27	Employee Benefits				31,343	31,343	26
27	V	30	Depreciation				3,277	3,277	27
28	V	35	Equipment Rental				4,603	4,603	28
29	V	31	Amortization						29
30	V	30	Depreciation				554	554	30
31	V	32	Interest				1,267	1,267	31
32	V	33	Real Estate Taxes				1,298	1,298	32
33	V	34	Office Rent				1,586	1,586	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 239,224	$ * 239,224	39

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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			$			$ 0	$ *	39

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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			$			$ 0	$ *	39

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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			$			$ 0	$ *	39

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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			$			$ 0	$ *	39

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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			$			$ 0	$ *	39

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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			$			$ 0	$ *	39

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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			$			$ 0	$ *	39

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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			$			$ 0	$ *	39

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BEN KLEIN		ADMINISTRATIV	70.10	SEE ATTACHED	1	0.03	Mgt Fees	$ 480,000	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 480,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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: PLATINUM HEALTH CARE, LLC
Street Address: 7444 LONG AVENUE
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-4100
Fax Number: (847) 329-7652

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	1,138,812	45	$ 49,578	$	75,767	$ 3,299	1
2	6	Repairs and Maintenance	Patient Days	1,138,812	45	59,617		75,767	3,966	2
3	17	Administrative Salary	Patient Days	1,138,812	45	406,913	406,913	75,767	27,073	3
4	19	Professional Fees	Patient Days	1,138,812	45	298,171		75,767	19,838	4
5	20	Fees, Subscriptions	Patient Days	1,138,812	45	8,815		75,767	586	5
6	21	Clerical Salaries	Patient Days	1,138,812	45	1,947,619	1,947,619	75,767	129,578	6
7	21	Office Expenses	Patient Days	1,138,812	45	45,932		75,767	3,056	7
8	24	Education & Seminars	Patient Days	1,138,812	45	17,224		75,767	1,146	8
9	25	Travel	Patient Days	1,138,812	45	79,393		75,767	5,282	9
10	26	Insurance	Patient Days	1,138,812	45	22,131		75,767	1,472	10
11	27	Employee Benefits	Patient Days	1,138,812	45	471,092		75,767	31,343	11
12	30	Depreciation	Patient Days	1,138,812	45	49,248		75,767	3,277	12
13	35	Equipment Rental	Patient Days	1,138,812	45	69,180		75,767	4,603	13
14	31	Amortization	Patient Days	1,138,812	45			75,767	0	14
15	30	Depreciation	Patient Days	1,138,812	45	8,330		75,767	554	15
16	32	Interest	Patient Days	1,138,812	45	19,037		75,767	1,267	16
17	33	Real Estate Taxes	Patient Days	1,138,812	45	19,512		75,767	1,298	17
18	34	Office Rent	Patient Days	1,138,812	45	23,840		75,767	1,586	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,595,632	$ 2,354,532		$ 239,224	25

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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**		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
	Working Capital											
6	HFG		X	LINE OF CREDIT							924	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 924	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET (TO EXTENT OF INTEREST EXP)										(924)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										1,267	13
14	TOTAL Non-Facility Related						$	$			$ 343	14
15	TOTALS (line 9+line14)						$	$			$ 1,267	15

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

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

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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.**	$ 336,000	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.)		$ 345,927	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,927	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 357,406	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.		$ 367,333	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	290,022	8
	2011	307,219	9
	2012	322,078	10
	2013	345,123	11
	2014	345,927	12

	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 WOOD GLEN NRSING & REHAB CTR COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0043935

CONTACT PERSON REGARDING THIS REPORT CAMILLE LOCKHART

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

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

Enter the tax index number and real estate tax assessed for 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.	01-28-401-085	Long Term Care	$ 345,927.14	$ 345,927.14
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 345,927.14	$ 345,927.14

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 WOOD GLEN NRSING & REHAB CTR COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0043935

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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	LOBBY IMPROVEMENTS	1999	$ 3,750	$	20	$ 188	$ 188	$ 3,036	37
38	WATER HEATER	1999	4,100		20	205	205	3,311	38
39	CONTRACTOR	1999	919		20	46	46	759	39
40	PUMP	1999	1,887		20	94	94	1,510	40
41	MATV SYSTEM	1999	752		20	38	38	608	41
42	PRESSURE SWITCH	1999	1,341		20	67	67	1,072	42
43	BOILER	1999	1,964		20	98	98	1,568	43
44	AIR CONDITIONER	1999	612		20	31	31	496	44
45	SMOKE DETECTOR	1999	3,118		20	156	156	2,496	45
46	FIRE ALARM SYSTEM	1999	693		20	35	35	659	46
47	2 WATER HEATERS	2000	8,400		20	420	420	6,650	47
48	FLOORING	2000	1,284		20	64	64	981	48
49	CARPET	2000	1,284		20	64	64	976	49
50	FLOORING	2000	3,740		20	187	187	2,852	50
51	CARPET	2000	5,225		20	261	261	3,937	51
52	FIXTURES ($31,000 REMOVED 2008 CAP COST AUDIT)	2000							52
53	FLUID PUMP	2000	2,429		20	121	121	1,896	53
54	FLUID PUMP	2000	905		20	45	45	705	54
55	FLUID PUMP SVC	2000	2,412		20	121	121	1,875	55
56	WATER LINES & DRAIN	2001	3,870		39	99	99	1,481	56
57	BURNER PILOT & PARTS	2001	1,593		39	41	41	613	57
58	4 DUPLEX OUTLETS	2001	2,275		39	58	58	868	58
59	WATER HEATER PIPING	2001	8,997		39	231	231	3,417	59
60	FLUES - WATER BOILER	2001	3,580		39	92	92	1,323	60
61	BRICK WALL	2001	4,515		39	116	116	1,648	61
62	EXPANSION MODULE	2001	947		20	47	47	685	62
63	CABLES	2001	1,031		20	52	52	732	63
64	CABLE WORK	2001	767		20	38	38	535	64
65	PHONES/CABLES	2001	544		20	27	27	405	65
66	LIGHTING	2001	1,022		20	51	51	718	66
67	LAMPS ($742 TO MME PER '08 CAP COST AUDIT)	2001			20				67
68	FIRE PUMP WORK	2001	750		20	38	38	535	68
69	HEATING/COOLING WORK	2001	649		20	32	32	451	69
70	TOTAL (lines 4 thru 69)		$ 75,355	$		$ 3,163	$ 3,163	$ 48,798	70

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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		$ 75,355	$		$ 3,163	$ 3,163	$ 48,798	1
2	LIGHTING	2001	903		20	45	45	641	2
3	MOTOR	2001	547		20	27	27	401	3
4	LIGHTING ENHANCEMENT	2001	903		20	45	45	656	4
5	REFRIGERATOR WORK	2001	1,044		20	52	52	741	5
6	PIPE WORK	2001	500		20	25	25	356	6
7	CONCERTE ANCHOR	2001	5,332		20	267	267	3,894	7
8	REFRIGERATOR WORK	2001	532		20	27	27	392	8
9	REFRIGERATOR WORK	2001	585		20	29	29	416	9
10	LIGHTING	2001	903		20	45	45	675	10
11	LIGHTING	2001	903		20	45	45	671	11
12	LIGHTING	2001	903		20	45	45	668	12
13	LIGHTING	2001	903		20	45	45	664	13
14	LIGHTING	2001	903		20	45	45	660	14
15	PUMP	2001	571		20	29	29	408	15
16	HEAT PUMP MOTOR	2001	1,409		20	70	70	992	16
17	PLUMBING	2001	1,038		20	52	52	780	17
18	PATIO	2002	2,250		10			2,250	18
19	A/C REPAIR	2002	3,529		10			3,529	19
20	A/C REPAIR	2002	1,305		10			1,305	20
21	A/C REPAIR	2002	1,240		10			1,240	21
22	A/C REPAIR	2002	888		10			888	22
23	A/C REPAIR	2002	846		10			846	23
24	A/C REPAIR	2002	664		10			664	24
25	WATER HEATERS	2002	1,700		10			1,700	25
26	WATER HEATERS	2002	2,460		10			2,460	26
27	FREEZER REPAIR	2002	587		20	29	29	406	27
28	FIRE PUMP WORK	2002	750		20	38	38	532	28
29	SERVICE PUMP	2002	540		20	27	27	378	29
30	ELECTRICAL SYSTEM	2002	528		20	26	26	364	30
31	PIPE WORK	2002	1,213		20	61	61	854	31
32	LIGHTING ENHANCEMENT	2002	12,442		20	622	622	8,708	32
33	MAIN ENTRANCE CAMERA	2003	13,445		5			13,445	33
34	TOTAL (lines 1 thru 33)		$ 137,621	$		$ 4,859	$ 4,859	$ 101,382	34

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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		$ 137,621	$		$ 4,859	$ 4,859	$ 101,382	1
2	PROXIMITY READERS	2003	2,074		5			2,074	2
3	PROXIMITY READERS/SMART	2003	3,805		5			3,805	3
4	WALL DECORATION	2003	1,063		5			1,063	4
5	KITCHEN WORK	2003	1,454		10			1,454	5
6	CI RANG STEAM	2003	869		10			869	6
7	CI RANG STEAM	2003	2,289		10			2,289	7
8	DRAPES	2003	2,525		5			2,525	8
9	FROZEN COIL IN AIR HANDLER	2004	3,819		10			3,819	9
10	WATER HEATER	2004	8,714		10			8,714	10
11	INSTALL NEW COIL	2004	3,800		10			3,800	11
12	CONDENSING UNIT	2004	4,200		15			2,940	12
13	PLUMBING-DIALYSIS ROOM	2004	5,390		20	270	270	3,105	13
14	WATER HEATER	2004	6,748		10			6,748	14
15	SERVICE PUMP	2004	7,565		20	378	378	4,316	15
16	BOILER & STORAGE TANKS	2004	6,200		20	310	310	3,617	16
17	CHASE WALLS	2004	4,570		15	305	305	3,431	17
18	CARPETING	2004	12,311		5			12,311	18
19	HOT WATER TANK	2004	11,242		10			11,242	19
20	WATER TANK	2004	34,751		20	1,738	1,738	19,408	20
21	HOT WATER VALVE	2004	3,609		20	180	180	2,025	21
22	CARPETING	2004	28,726		5			28,726	22
23	HOT WATER BOILER	2004	7,344		20	367	367	4,037	23
24	ALUMINUM STREET SIGN DISP	2005	3,700		10			3,700	24
25	FIRE ALARMS/SMOKE DETECTORS	2005	2,134		10	21	21	2,134	25
26	TURNBURY INSULATED DOME	2005	1,545		10	8	8	1,545	26
27	STEEL PEDESTRIAN DOORS	2005	4,630		20	232	232	2,532	27
28	RED OAK UNFINISHED DOO	2005	1,580		15	105	105	1,138	28
29	FIRE DAMPERS	2005	5,294		10	136	136	5,294	29
30	SECURITY SYSTEM	2005	16,519		10	550	550	16,519	30
31	SMOKE DAMPER MOTORS	2005	7,524		10	254	254	7,524	31
32	ASPHALT REPLACEMENT	2005	10,862		8			10,862	32
33	SMOKE DAMPER MOTORS	2005	2,585		10	103	103	2,585	33
34	TOTAL (lines 1 thru 33)		$ 357,062	$		$ 9,816	$ 9,816	$ 287,533	34

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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		$ 357,062	$		$ 9,816	$ 9,816	$ 287,533	1
2	BOILER REPLACEMENT	2005	18,998		20	950	950	9,817	2
3	SECURITY SYSTEM	2005	2,400		10	180	180	2,400	3
4	FIRE ALARM DEVICES INSTALL	2005	4,687		10	349	349	4,687	4
5	HOT WATER HEATER EXCHAN	2005	27,374		10	2,285	2,285	27,374	5
6	VINYL FENCE & WALK GATE	2005	3,844		10	324	324	3,844	6
7	SATELLITE TV & INTERNET ($12,699 TO MME '08 CC AUDIT	2005							7
8	DOOR HOLDERS	2006	3,324		10	332	332	3,293	8
9	HOT WATER COILS-OFFICE	2006	4,472		10	447	447	4,396	9
10	ADD CONCRETE TO PATIO	2006	8,476		15	565	565	5,462	10
11	ROOF WORK	2006	4,560		20	228	228	2,185	11
12	EGRESS DOORS	2006	1,651		10	165	165	1,568	12
13	DOORS	2006	1,631		10			1,631	13
14	CABLE,SPLITTERS, WALL PLA	2006	16,577		20	829	829	7,461	14
15	ALARM & SPRINKLER INSPECTION ($3,640 REMOVED '08 C	2007							15
16	FAN COIL UNIT	2007	5,215		10	522	522	4,480	16
17	PEERLESS FENCE	2007	2,576		15	172	172	1,476	17
18	SEALCOATING & CRACK SEALING	2007	4,525		8	422	422	4,525	18
19	PS-35 PYROTRONICS POWER SUPPLY (41,992 REM '08 CC A	2007							19
20	DOORS	2007	2,585		10	259	259	2,094	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	POWER SUPPLY & DOME CAMERA	2008	1,099		10	110	110	770	31
32	REPAIR/REPLACE THERMOSTATIC VALVE-HOT WATER S	2008	3,086		10	309	309	2,163	32
33									33
34	TOTAL (lines 1 thru 33)		$ 474,142	$		$ 18,264	$ 18,264	$ 377,159	34

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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		$ 474,142	$		$ 18,264	$ 18,264	$ 377,159	1
2		2009							2
3	REMOVE/REPLACE RUBBER WALL DETAIL	2009	2,900		10	290	290	1,740	3
4	INSTALL NEW DOORS & MAGNETIC CLOSERS	2009	6,987		10	699	699	4,194	4
5	BACKUP GENSET-REPLACE COOLANT, HTR HOSES, FILTE	2009	1,205		10	121	121	726	5
6	PLUMBING-TWIST N CLOSE BATH WASTE	2009	1,086		10	109	109	654	6
7	ENTRY HEAT REMOVED/CLEANED BLOWERS	2009	2,547		10	255	255	1,530	7
8	BOILER #1 REPAIR	2009	4,138		10	414	414	2,484	8
9	FIRE ALARM REPAIR	2009	8,413		10	841	841	5,046	9
10	SPRINKLER REPAIR/REPLACE HEADS	2009	5,593		10	559	559	3,354	10
11	SPRINKLER INSPECTION	2009	2,282		10	228	228	1,368	11
12	REPAIR PLUMBING LEAKS	2009	776		10	78	78	468	12
13		2011							13
14		2011							14
15		2011							15
16		2011							16
17		2012							17
18		2012							18
19		2012							19
20		2012							20
21	FIRE DAMPER UPDATES	2012	50,000		10	5,000	5,000	15,833	21
22	REPLACE CPU	2012	6,016		10	602	602	1,856	22
23		2013							23
24		2013							24
25		2013							25
26		2013							26
27	FIRE SAFETY EQUIP-FIRE PUMP	2013	4,499		10	450	450	1,350	27
28	ELECTRICAL - MMB-3	2013	6,436		10	644	644	1,932	28
29	NURSING SMOKE ADD	2013	5,550		10	555	555	1,480	29
30	HVAC-REPLACE COILS	2013	44,895		10	4,490	4,490	9,354	30
31	BACKFLOW PREVENTER DEVICES	2013	2,938		10	294	294	833	31
32	AIR DUCT DETECTOR	2013	3,742		10	374	374	1,060	32
33	NEW ELEVATOR VALVE	2014	10,204		20	510	510	978	33
34	TOTAL (lines 1 thru 33)		$ 644,349	$		$ 34,777	$ 34,777	$ 433,399	34

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 12E, Carried Forward		$ 644,349	$		$ 34,777	$ 34,777	$ 433,399	1
2	FACE DAMPERS	2014	11,454		20	573	573	593	2
3	FREEZER CURTAIN	2014	3,018		10	302	302	312	3
4	BOILDER TUBES	2014	35,832		20	1,792	1,792	1,812	4
5	CONDUIT & WIRING	2014	23,275		20	1,164	1,164	1,184	5
6	ELEVATOR MOTOR	2015	9,711		20	202	202	202	6
7	CUBICLE CURTAIN	2015	3,069		7	37	37	37	7
8				15,100			(15,100)		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)		$ 730,708	$ 15,100		$ 38,847	$ 23,747	$ 437,539	34

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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		$ 730,708	$ 15,100		$ 38,847	$ 23,747	$ 437,539	1
2	ALLOCATIONS FROM PLATINUM (HO):								2
3	BUILDING (CONSTRUCTED 1955; PURCH 2004)	2004	18,851						3
4	FIRE ALARM & SECURITY SYSTEM	2004	118						4
5	PAINTING	2004	127						5
6	CARPETING	2004	264						6
7	BLINDS	2004	62						7
8	BLINDS	2005	90						8
9	REMODELING-FLOORS, LIGHTS, PLUMBING & WALLS	2005	905						9
10	REMODELING-WALLS	2005	36						10
11	BATHROOM REMODELING	2005	90						11
12	BATHROOM REMODELING	2005	132						12
13	BATHROOM REMODELING	2006	516						13
14	WINDOWS	2006	226						14
15	TUCK POINTING	2008	76						15
16	REMODEL PARESH'S OFFICE	2008	279						16
17	HEAT EXCHANGER	2009	259						17
18	RENZOR UNIT HEATER	2009	260						18
19	RELOCATION OF STAT FOR NW UNIT HEATER	2009	51						19
20	REMODEL BOOKKEEPING OFFICE	2009	279						20
21	AWNING	2009	550						21
22	PARKING LOT REPAIR	2009	213						22
23	ROOF TOP UNIT	2010	1,097						23
24	COMPRESSOR AC UNIT	2010	147						24
25	OFFICE FURNITURE	2013	254						25
26				836			(836)		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 755,590	$ 15,936		$ 38,847	$ 22,911	$ 437,539	34

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 12G, Carried Forward		$ 755,590	$ 15,936		$ 38,847	$ 22,911	$ 437,539	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 755,590	$ 15,936		$ 38,847	$ 22,911	$ 437,539	34

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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		$ 755,590	$ 15,936		$ 38,847	$ 22,911	$ 437,539	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 755,590	$ 15,936		$ 38,847	$ 22,911	$ 437,539	34

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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	$ 465,840	$ 1,785	$ 16,634	$ 14,849		$ 398,022	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	ALLOCATION FROM PLATINUM		2,995	2,995				74
75	TOTALS	$ 465,840	$ 4,780	$ 19,629	$ 14,849		$ 398,022	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	2002	$ 8,447	$	$	$	5	$	76
77		GMC SIERRA	2004	30,357				4		77
78		WG VAN	2005	26,782	1,675		(1,675)	4	26,782	78
79										79
80	TOTALS			$ 65,586	$ 1,675	$	$ (1,675)		$ 26,782	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)	$ 1,287,016	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,391	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 58,476	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 36,085	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 862,343	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ARHC WGWCHIL01, LLC
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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

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

10. Effective dates of current rental agreement:
    Beginning 12/16/2014
    Ending 12/31/2029

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$ 1,839,511
13.	/2017	$ 1,876,301
14.	/2018	$ 1,913,827

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 34,543 Description: Beds/med equip $19,940; Oxygen $1,309; Dish mach $3,063; Mailing $921; Printer/copier $9,310
    (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		2015 Cadillac	$ #######	$ 17,066	17
18		2014 Subaru Outback 2	599.76	6,597	18
19					19
20					20
21	TOTAL		$ #######	$ 23,663	21

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

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				30,410		30,410	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab & X-ray	39-02					1,817		1,817	13
14	TOTAL			$		$	$ 32,227		$ 32,227	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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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	$ (182,044)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,224,974		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	117,167		6
7	Other Prepaid Expenses	8,961		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,169,058	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	747,202		15
16	Equipment, at Historical Cost	413,630		16
17	Accumulated Depreciation (book methods)	(879,331)		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):	323,293		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 604,794	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,773,852	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 305,115	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	(1,354,195)		29
30	Accrued Salaries Payable	102,374		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	357,406		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	1,568,097		36
37	Due Medicaid	195,113		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,173,910	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,173,910	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,599,942	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,773,852	$	48

***(See instructions.)**

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,726,395	1	
2	Restatements (describe):		2	
3	**PRIOR PERIOD ADJUSTMENT**	7	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,726,402	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,093,330)	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	(33,130)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,126,460)	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)**	$ 1,599,942	24	*

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

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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	$ 9,092,287	1
2	Discounts and Allowances for all Levels	(301,182)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,791,105	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	276,432	6
7	Oxygen	1,174	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 277,606	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	1,021	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	17,296	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	521	19
20	Radiology and X-Ray	595	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 19,433	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,645	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,645	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME/MISC INCOME	8,517	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,517	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,108,306	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,831,822	31
32	Health Care	3,081,167	32
33	General Administration	2,398,146	33
	B. Capital Expense		
34	Ownership	2,284,536	34
	C. Ancillary Expense		
35	Special Cost Centers	32,227	35
36	Provider Participation Fee	573,738	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,201,636	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,093,330)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,093,330)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,488,706	44
45	Private Pay - Net Inpatient Revenue	479,137	45
46	Medicare - Net Inpatient Revenue	75,710	46
47	Other-(specify) Other	(252,448)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,791,105	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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	1,864	2,081	$ 138,118	$ 66.37	1
2	Assistant Director of Nursing	3,864	4,160	178,968	43.02	2
3	Registered Nurses	17,568	18,435	657,678	35.68	3
4	Licensed Practical Nurses	17,914	18,938	518,206	27.36	4
5	CNAs & Orderlies	60,792	67,435	959,414	14.23	5
6	CNA Trainees					6
7	Licensed Therapist	386	388	21,633	55.76	7
8	Rehab/Therapy Aides	2,391	2,585	102,159	39.52	8
9	Activity Director					9
10	Activity Assistants	3,586	3,614	39,748	11.00	10
11	Social Service Workers	11,655	12,255	249,011	20.32	11
12	Dietician					12
13	Food Service Supervisor	1,880	2,080	85,147	40.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,568	22,877	249,212	10.89	15
16	Dishwashers					16
17	Maintenance Workers	12,051	12,547	197,479	15.74	17
18	Housekeepers	27,692	29,438	282,380	9.59	18
19	Laundry					19
20	Administrator	1,936	2,082	214,686	103.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,687	7,312	222,402	30.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,706	4,096	75,214	18.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	195,540	210,323	$ 4,191,455 *	$ 19.93	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	192	$ 11,169	1.3	35
36	Medical Director	Monthly	36,000	9.3	36
37	Medical Records Consultant		2,000	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		15,478	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,088	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	208	$ 65,735		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
JEFFREY WHITE	ADMINISTRATOR		$ 214,686
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 214,686

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 479,305
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 479,305

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,044
Unemployment Compensation Insurance	21,262
FICA Taxes	308,405
Employee Health Insurance	48,342
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	800
EMPLOYEE BENEFITS - OTHER	72,038
EMPLOYEE PHYSICAL EXAM	204
TOTAL (agree to Schedule V, line 22, col.8)	$ 536,095

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	280
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	2,978
ADVERTISING & MARKETING	5,998
DUE & SUBSCRIPTIONS	20,133
LICENSES	4,041
ALLOCATION FROM PLATINUM/PHC C	688
Less: Public Relations Expense	( )
Non-allowable advertising	(5,998)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,120

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,862
ALLOC FROM PLATINUM/PHC CONSUL	3,247
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,109

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/15 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? **YES**
If YES, give association name and amount. **IL COUNCIL ON LTC $25,929**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,805** Line **10.2**

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

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

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **573,738**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

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

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

(19) 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.