FOR BHF USE

LL1

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

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0032839

Facility Name: Glenwood Healthcare & Rehab

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 12/14/87

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/16 to 12/31/16 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	184	Skilled (SNF)	184	67,344	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	184	TOTALS	184	67,344	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,247	14	6,984	17,245	8
9	SNF/PED					9
10	ICF	27,415	1,191		28,606	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,662	1,205	6,984	45,851	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.08%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 12/14/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/14/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 184 and days of care provided 4,057

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: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	235,218	30,035	15,978	281,231		281,231		281,231			1
2	Food Purchase		290,671		290,671		290,671		290,671			2
3	Housekeeping	251,143	24,982		276,125		276,125		276,125			3
4	Laundry	75,193	52,360		127,553		127,553		127,553			4
5	Heat and Other Utilities			204,392	204,392		204,392	(710)	203,682			5
6	Maintenance	102,802	53,487	36,528	192,817		192,817	258	193,075			6
7	Other (specify):* Waste Removal			13,922	13,922		13,922		13,922			7
8	TOTAL General Services	664,356	451,535	270,820	1,386,711		1,386,711	(452)	1,386,259			8
	B. Health Care and Programs											
9	Medical Director			30,800	30,800		30,800		30,800			9
10	Nursing and Medical Records	2,655,953	288,994	15,309	2,960,256		2,960,256	110,502	3,070,758			10
10a	Therapy	71,758		1,795	73,553		73,553		73,553			10a
11	Activities	155,820		13,992	169,812		169,812		169,812			11
12	Social Services	125,597		3,677	129,274		129,274		129,274			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. Emp Benefits							18,871	18,871			15
16	TOTAL Health Care and Programs	3,009,128	288,994	65,573	3,363,695		3,363,695	129,373	3,493,068			16
	C. General Administration											
17	Administrative	110,224		537,156	647,380		647,380	(458,282)	189,098			17
18	Directors Fees											18
19	Professional Services			155,498	155,498		155,498	5,806	161,304			19
20	Dues, Fees, Subscriptions & Promotions			55,329	55,329		55,329	(5,316)	50,013			20
21	Clerical & General Office Expenses	198,187	9,147	82,023	289,357		289,357	172,965	462,322			21
22	Employee Benefits & Payroll Taxes			678,939	678,939		678,939		678,939			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,146	6,146		6,146	11,138	17,284			24
25	Other Admin. Staff Transportation			9,843	9,843		9,843	5,462	15,305			25
26	Insurance-Prop.Liab.Malpractice			283,918	283,918		283,918	1,070	284,988			26
27	Other (specify):* Alloc. Emp Benefits							38,252	38,252			27
28	TOTAL General Administration	308,411	9,147	1,808,852	2,126,410		2,126,410	(228,905)	1,897,505			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,981,895	749,676	2,145,245	6,876,816		6,876,816	(99,984)	6,776,832			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Glenwood Healthcare & Rehab #0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			216,000	216,000		216,000	107,429	323,429			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,911	27,911		27,911	652,441	680,352			32
33	Real Estate Taxes			498,079	498,079		498,079		498,079			33
34	Rent-Facility & Grounds			966,000	966,000		966,000	(957,676)	8,324			34
35	Rent-Equipment & Vehicles			24,966	24,966		24,966	3,911	28,877			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,732,956	1,732,956		1,732,956	(193,895)	1,539,061			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		106,713	633,594	740,307		740,307		740,307			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			360,000	360,000		360,000		360,000			42
43	Other (specify):* See Att Sch 4A	88,379		280,480	368,859		368,859	(357,020)	11,839			43
44	**TOTAL Special Cost Centers**	88,379	106,713	1,274,074	1,469,166		1,469,166	(357,020)	1,112,146			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,070,274	856,389	5,152,275	10,078,938		10,078,938	(650,899)	9,428,039			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Glenwood Healthcare & Rehab

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			8,184	8,184		8,184		8,184			
	Radiology Expenses			3,655	3,655		3,655		3,655			
	Non-Allowable Expenses	88,379		268,641	357,020		357,020	(357,020)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	88,379	0	280,480	368,859	0	368,859	(357,020)	11,839			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,991)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	107,429	30		9
10	Interest and Other Investment Income	(1,591)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	43		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	(2,754)	20		17
18	Fines and Penalties	(16,435)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,157)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(222,500)	43		24
25	Fund Raising, Advertising and Promotional	(16,671)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(98,969)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (266,683)		$	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)	(384,216)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (384,216)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (650,899)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Glenwood Healthcare & Rehab

ID# 0032839

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Wages	(17,080)	43	1
2	Marketing Liason	(71,299)	43	2
3	Marketer Car Lease	(3,400)	35	3
4	PAC Dues	(3,749)	20	4
5	Offset Com Ed Refund Against Expense	(1,683)	5	5
6	Offset Miscellaneous Income Against Expense	(83)	21	6
7	Disallow All Scripts	(688)	20	7
8				8
9				9
10				10
11				11
12				12
13	Building Co.			13
14	Bank Charges	(987)	21	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**	(98,969)		49

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Clerical & Gen Office Expenses	$	Glenwood Terrace LLC	100.00%	$ 987	$ 987	1
2	V	32	Interest		Glenwood Terrace LLC	100.00%	654,032	654,032	2
3	V	34	Rent-Facility & Grounds	966,000	Glenwood Terrace LLC	100.00%		(966,000)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 966,000			$ 655,019	$ * (310,981)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	5	Heat and Other Utilities	$	Certified Health Management, Inc.	100.00%	$ 973	$ 973	15
16	V	6	Maintenance		Certified Health Management, Inc.	100.00%	258	258	16
17	V	10	Nursing and Medical Records		Certified Health Management, Inc.	100.00%	110,502	110,502	17
18	V	15	Emp Benefit Alloc-Healthcare		Certified Health Management, Inc.	100.00%	18,871	18,871	18
19	V	17	Administrative	537,156	Certified Health Management, Inc.	100.00%	78,874	(458,282)	19
20	V	19	Professional Services		Certified Health Management, Inc.	100.00%	7,963	7,963	20
21	V	20	Dues, Fees, Subs & Promo		Certified Health Management, Inc.	100.00%	1,875	1,875	21
22	V	21	Clerical & Gen Office Expenses		Certified Health Management, Inc.	100.00%	173,048	173,048	22
23	V	24	Travel and Seminar		Certified Health Management, Inc.	100.00%	11,138	11,138	23
24	V	25	Other Admin Staff Transportation		Certified Health Management, Inc.	100.00%	5,462	5,462	24
25	V	26	Ins.-Prop, Liab, Malpractice		Certified Health Management, Inc.	100.00%	1,070	1,070	25
26	V	27	Emp Benefit Alloc-Gen Admin		Certified Health Management, Inc.	100.00%	38,252	38,252	26
27	V	34	Rent-Facility & Grounds		Certified Health Management, Inc.	100.00%	8,324	8,324	27
28	V	35	Rent-Equipment & Vehicle		Certified Health Management, Inc.	100.00%	7,311	7,311	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			$ 537,156			$ 463,921	$ * (73,235)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Howard D. Geller Trust	38.044%	Danville Care Center	Danville	Glenwood Terrace	Skokie	Lessor	1
2	Bradley M. Alter	22.826%	Prairie View Care Center of Lewistown	Lewistown	LLC			2
3	ESBT Jennifer T. W. Chow	19.565%	Renaissance Care Center	Canton	Certified Health	Skokie	Management	3
4	ESBT Julie Brum	19.565%	Paxton Healthcare and Rehab	Paxton	Management, Inc.			4
5			Pontiac Healthcare and Rehab	Pontiac				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Daniel Alter	Relative	Financial	0.00	See Att Sch 7A	9.25	23.13	Alloc. Salary	$ 11,709	L21, C7	1
2	Zev Geller	Relative	Clerical	0.00	See Att Sch 7A	9.25	23.13	Alloc. Salary	15,456	L21, C7	2
3	Bradley Alter	Owner	Administration	22.826%	See Att Sch 7A	11.56	23.12	Alloc. Salary	42,777	L17, C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 69,942		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Certified Health Management, Inc.
Street Address: 3856 W. Oakton
City / State / Zip Code: Skokie, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Census Days	198,295	6	$ 4,208	$	45,851	$ 973	1
2	6	Maintenance	Census Days	198,295	6	1,116		45,851	258	2
3	10	Nursing and Medical Records	Census Days	198,295	6	477,896	477,896	45,851	110,502	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	198,295	6	81,613		45,851	18,871	4
5	17	Administrative	Census Days	198,295	6	341,110	341,110	45,851	78,874	5
6	19	Professional Services	Census Days	198,295	6	34,439		45,851	7,963	6
7	20	Dues, Fees, Subs & Promo	Census Days	198,295	6	8,110		45,851	1,875	7
8	21	Clerical & Gen Office Expenses	Census Days	198,295	6	748,394	627,598	45,851	173,048	8
9	24	Travel and Seminar	Census Days	198,295	6	48,168		45,851	11,138	9
10	25	Other Admin Staff Transportatior	Census Days	198,295	6	23,623		45,851	5,462	10
11	26	Ins.-Prop, Liab, Malpractice	Census Days	198,295	6	4,628		45,851	1,070	11
12	27	Emp Benefit Alloc-Gen Admin	Census Days	198,295	6	165,432		45,851	38,252	12
13	34	Rent-Facility & Grounds	Census Days	198,295	6	36,000		45,851	8,324	13
14	35	Rent-Equipment & Vehicle	Census Days	198,295	6	31,619		45,851	7,311	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,006,356	$ 1,446,604		$ 463,921	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cole Taylor Bank		X	Mortgage			$	$ 11,000,000			$ 493,257	1
2	Cole Taylor Bank		X	Mortgage				5,500,000			83,875	2
3	Swap Interest										76,900	3
4												4
5												5
	Working Capital											
6	Bank Financial		X	Line of Credit				1,288,826			23,397	6
7	Insurance Financing										4,514	7
8												8
9	TOTAL Facility Related						$	$ 17,788,826			$ 681,943	9
	B. Non-Facility Related*											
10												10
11												11
12								Offset Interest Income			(1,591)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,591)	14
15	TOTALS (line 9+line14)						$	$ 17,788,826			$ 680,352	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 390,000	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.)	2015	$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (390,000)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 930,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 21,156	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** $ 63,077 **For** 2013 **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$ (63,077)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 498,079	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	405,014	8
	2012	356,263	9
	2013	366,092	10
	2014	521,409	11
	2015	530,658	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glenwood Healthcare & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032839

CONTACT PERSON REGARDING THIS REPORT Bruce Harris

TELEPHONE (847) 674-4700 FAX #: (847) 674-4733

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-10-201-009-0000	Long Term Care Property	$ 530,657.52	$ 530,657.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 530,657.52	$ 530,657.52

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 98,010 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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

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

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1999	$ 322,000	1
2					2
3	TOTALS			$ 322,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	184		1999	1975	$ 5,474,000	$	39	$ 140,359	$ 140,359	$ 2,526,462	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	20,662		20			20,662	9
10	Various			1989	4,071		20			4,071	10
11	Various			1990	28,171		20			28,171	11
12	Various			1991	31,712		20			31,712	12
13	Various			1992	10,071		20			10,071	13
14	Various			1993	4,809		20			4,809	14
15	Various			1994	17,594		20			17,594	15
16	Various			1995	31,602		20			31,602	16
17	Various			1996	39,136		20	1,957	1,957	40,018	17
18	Various			1997	43,166		20	2,158	2,158	42,252	18
19	Various			1998	163,365		20	8,168	8,168	151,112	19
20	Various			1999	136,071		20	6,804	6,804	119,630	20
21	Various			2000	36,744		20	1,837	1,837	30,650	21
22	Various			2001	7,300		20	365	365	5,810	22
23	Various			2002	13,080		20	654	654	9,429	23
24	Various			2003	62,327		20	3,116	3,116	41,832	24
25	Various			2004	45,982		20	2,299	2,299	28,739	25
26	Various			2005	62,611		20	3,131	3,131	35,759	26
27	Various			2006	23,234		20	1,162	1,162	12,198	27
28	Various			2007	24,901		20	1,245	1,245	12,239	28
29	Various			2008	29,343		20	1,467	1,467	12,527	29
30	Various			2009	91,559		20	4,578	4,578	36,555	30
31	Various			2010	104,397		20	5,220	5,220	42,047	31
32	Various			2011	357,619		20	17,881	17,881	114,855	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Doors	2012	$ 13,173	$	20	$ 659	$ 659	$ 3,294	37
38	Hallways - Remove And Replace Wallcovering, Millwod, Paint	2012	49,245		20	2,462	2,462	11,080	38
39	Doors And Hallway Project	2012	11,335		20	567	567	2,551	39
40	Wallcovering, Corner Guards, Grab Bars, Signage - Kitchen, Bath	2012	3,414		20	171	171	825	40
41	Flooring, Corner Guards, Doors, Window Treatments-Rms A-3, A	2012	12,391		20	620	620	2,737	41
42	Paving	2012	3,100		20	155	155	827	42
43	Cove Base In Kitchen	2012	3,767		20	188	188	2,574	43
44	Rooftop Hvac	2012	6,600		20	330	330	1,375	44
45	New Hot Water Heater	2012	6,010		20	301	301	1,228	45
46	Flat Roof Replacement	2012	7,800		20	390	390	1,950	46
47	Overhead Door	2013	3,800		20	190	190	728	47
48	Roof Repair	2013	2,995		20	150	150	574	48
49	Parking Lot Sealcoat And Restriping	2013	3,217		20	161	161	733	49
50	Walls, Paint, Rails	2013	16,500		20	825	825	2,750	50
51	Ac/Heat Window Unit	2013	4,124		20	206	206	2,268	51
52	Energy Services - Hvac	2013	13,770		20	689	689	2,238	52
53	2 New Condensing Units And 2 New Air Handlers	2013	6,400		20	320	320	1,013	53
54	2 Condensing Units Out Of 10	2014	46,200		20	2,310	2,310	6,930	54
55	Replace Kitchen Drain	2014	10,920		20	546	546	1,638	55
56	New Water Heater	2014	9,952		20	498	498	1,493	56
57	Additonal Work For New Water Heater	2014	3,362		20	168	168	490	57
58	Walk In Cooler Door Repalcement	2014	2,698		20	135	135	382	58
59	Install New Grease Separator	2014	5,980		20	299	299	847	59
60	New Kitchen Floor	2014	3,673		20	184	184	505	60
61	D Wing Shower Room - Replacement	2014	33,256		20	1,663	1,663	4,434	61
62	Alarm System	2014	2,526		20	126	126	337	62
63	New Power Generator	2014	3,510		20	176	176	468	63
64	Reclining Tub/Disinfecting System	2014	12,695		20	635	635	1,587	64
65	Roof Repair	2014	40,338		20	2,017	2,017	5,042	65
66	Ac Units Openings	2014	5,280		20	264	264	616	66
67	Dialyis Unit Electric Equipment	2014	7,150		20	358	358	2,265	67
68	Dialyis Unit Plumbing Equipment	2014	4,490		20	225	225	524	68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,223,198	$		$ 220,389	$ 220,389	$ 3,477,109	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,223,198	$		$ 220,389	$ 220,389	$ 3,477,109	1
2	Parking Lot Sealcoat	2014	3,375		20	169	169	469	2
3	Water Heater	2014	7,575		20	379	379	852	3
4	Hvac Testing	2014	3,650		20	183	183	396	4
5	Water Heater	2014	3,761		20	188	188	486	5
6	18Ga Wire With Connectors For Fire Damper	2014	2,655		20	133	133	343	6
7	Heating / Furnace Upgrade	2014	6,583		20	329	329	987	7
8	Drywall Replacement	2014	2,633		20	132	132	373	8
9	Slop Sink Work	2014	4,821		20	241	241	663	9
10	Security Door	2014	3,780		20	189	189	551	10
11	Heat/Cool 230V System Qty.4	2015	2,642		20	132	132	396	11
12	Replacement Of Hot Water Heater	2015	6,950		20	348	348	667	12
13	Roof Top Unit Replacement	2015	7,987		20	399	399	532	13
14	Light Fixtures For Dialysis	2015	3,700		20	185	185	370	14
15	Installation And Set Up Of Fire System	2015	2,880		20	144	144	216	15
16	Replace Two Roof Drains On East Roof	2015	5,221		20	261	261	305	16
17	Phone System Setup	2015	4,700		20	235	235	392	17
18	Replace Door-Maglock Clear Aluminum Finish	2016	2,577		20	129	129	129	18
19	Remove and Install Concrete and Relocate Drainage	2016	5,000		20	250	250	250	19
20	Landscaping-Various Bushes and Flowers	2016	5,000		20	250	250	250	20
21	Design, Permitting and Pricing of Project-See P12C, Line 19	2016	6,800		20	340	340	340	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,315,488	$		$ 225,005	$ 225,005	$ 3,486,076	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,315,488	$		$ 225,005	$ 225,005	$ 3,486,076	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements (Real Estate Entity):								8
9	Design/Construct Front Entry for PT & Office Addition/Renovatic	2015	22,140		20	1,107	1,107	2,214	9
10	Dialysis Unit-Carpentry/Electrical & Lighting/Drywall/Demo	2015	268,304		20	13,415	13,415	26,830	10
11	C & D Wing Corridors/Shower Room/Therapy Room/Nurse Static	2015	315,748		20	15,787	15,787	31,265	11
12	C-Wing Roof	2015	143,414		20	7,171	7,171	14,342	12
13	Install Storm Sewer Drain	2015	19,375		20	969	969	1,938	13
14	Install Backflow	2015	6,500		20	325	325	650	14
15	Roof Work	2015	35,702		20	1,785	1,785	3,570	15
16	Patio Overhang	2016	8,561		20	428	428	428	16
17	Roof-East Slope Elevations Wings A & C	2016	72,434		20	3,622	3,622	3,622	17
18	Lounge and Conference Area Remodeling-Partitions								18
19	Bathrooms, Paint, Carpet, Light Fixtures, Sprinklers	2016	192,750		20	9,638	9,638	9,638	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27	Allocated from Certified Health Management	1997	21,784		20			21,784	27
28	Allocated from Certified Health Management	2014	6,125		20	306	306	1,072	28
29									29
30									30
31	Financial Statement Depreciation			216,000			(216,000)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,428,325	$ 216,000		$ 279,558	$ 63,558	$ 3,603,429	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 364,670	$	$ 36,467	$ 36,467	10	$ 287,615	71
72	Current Year Purchases	46,500		4,650	4,650	10	4,650	72
73	Fully Depreciated Assets	821,453				10	821,453	73
74								74
75	TOTALS	$ 1,232,623	$	$ 41,117	$ 41,117		$ 1,113,718	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2010 Honda Accord	2013	$ 13,769	$	$ 2,754	$ 2,754	5	$ 10,788	76
77										77
78										78
79										79
80	TOTALS			$ 13,769	$	$ 2,754	$ 2,754		$ 10,788	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,996,717	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 216,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 323,429	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 107,429	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,727,935	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	Land - 2015	143,230			87
88	Demolition	26,000			88
89					89
90					90
91	TOTALS	$ 169,230	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				8,324			5
6								6
7	TOTAL				$ 8,324 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 13,149 Description: Copier
(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	Resident Transportation	2011 Ford Elkhart Coach	$ 754.00	$ 8,417	17
18					18
19	Allocated from Management Co.			7,311	19
20					20
21	TOTAL		$ 754.00	$ 15,728	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$		$ 186,116	$		$ 186,116	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			58,853			58,853	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), 39(3)	hrs			239,545	3,185		242,730	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				79,185		79,185	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Dialysis					149,080			149,080	12
13	Other (specify): Ancillaries-Veternas						24,343		24,343	13
14	TOTAL			$		$ 633,594	$ 106,713		$ 740,307	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab **#** 0032839 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16 **(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	$ (280,963)	$ (274,388)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	4,478,309	4,478,309	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	153,223	153,223	6
7	Other Prepaid Expenses	3,366	3,366	7
8	Accounts Receivable (owners or related parties)	1,076,972	7,800,441	8
9	Other(specify): See Attached Schedule 17A	2,156	1,757,519	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,433,063	$ 13,918,470	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		322,000	13
14	Buildings, at Historical Cost		5,474,000	14
15	Leasehold Improvements, at Historical Cost	1,823,955	2,954,325	15
16	Equipment, at Historical Cost	1,081,916	1,246,392	16
17	Accumulated Depreciation (book methods)	(1,956,677)	(4,727,935)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Att Sch 17A	70,639	239,869	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,019,833	$ 5,508,651	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,452,896	$ 19,427,121	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 676,029	$ 706,147	26
27	Officer's Accounts Payable	44,320	44,320	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,288,826	1,288,826	29
30	Accrued Salaries Payable	260,193	260,193	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,471	14,471	31
32	Accrued Real Estate Taxes(Sch.IX-B)	930,000	930,000	32
33	Accrued Interest Payable	1,117	59,822	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	393,235	393,235	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,608,191	$ 3,697,014	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 16,500,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,608,191	$ 20,197,014	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,844,705	$ (769,893)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,452,896	$ 19,427,121	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Glenwood Healthcare & Rehab**
IDPH License ID Number: **0032839**
Fiscal Year End: **12/31/16**

Schedule 17A

XV. Balance Sheet
Line 9 Other Current Assets (specify):

Description	Operating	After Consolidation
TAXES ON DEPOSIT	2,156	2,719
SINKING FUND		1,001,103
CAP EX FUND		(16)
REAL ESTATE TAX ESCROW		753,713
Total - Line 9	**2,156**	**1,757,519**

XV. Balance Sheet
Line 22 Other Long-Term Assets (specify):

Description	Operating	After Consolidation
LTC Mgmt Stock	70,639	70,639
Non-Care Assets		169,230
Total - Line 22	**70,639**	**239,869**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
EXCHANGE-GARNISHMENTS	396	396
DUE TO IDPA	387,839	387,839
PATIENT SECURITY DEPOSITS	5,000	5,000
Total - Line 36	**393,235**	**393,235**

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,665,390	1
2	Restatements (describe): Bad Debt Expense		2
3	**Rent Expense**	(90,000)	3
4	**Rounding**	6	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,575,396	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	269,309	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 269,309	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,844,705	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 10,306,718	1
2	Discounts and Allowances for all Levels	(86,975)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,219,743	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	111,764	6
7	Oxygen	1	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 111,765	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	10,396	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	370	19
20	Radiology and X-Ray	40	20
21	Other Medical Services	2,576	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 13,382	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,591	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,591	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,766	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,766	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,348,247	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,386,711	31
32	Health Care	3,363,695	32
33	General Administration	2,126,410	33
	B. Capital Expense		
34	Ownership	1,732,956	34
	C. Ancillary Expense		
35	Special Cost Centers	1,109,166	35
36	Provider Participation Fee	360,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,078,938	40
41	**Income before Income Taxes (line 30 minus line 40)****	269,309	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 269,309	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,632,896	44
45	Private Pay - Net Inpatient Revenue	258,493	45
46	Medicare - Net Inpatient Revenue	2,315,492	46
47	Other-(specify) Managed Care	138,668	47
48	Other-(specify) Hospice (271,259)/Veterans (602,935)	874,194	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,219,743	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	1,571	1,611	$ 79,901	$ 49.60	1
2	Assistant Director of Nursing	783	783	38,367	49.00	2
3	Registered Nurses	10,381	10,929	376,353	34.44	3
4	Licensed Practical Nurses	30,266	31,773	866,808	27.28	4
5	CNAs & Orderlies	80,394	84,516	1,001,281	11.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,851	4,570	71,758	15.70	8
9	Activity Director	1,984	2,190	43,237	19.74	9
10	Activity Assistants	9,046	10,107	112,583	11.14	10
11	Social Service Workers	5,411	5,712	113,129	19.81	11
12	Dietician					12
13	Food Service Supervisor	1,560	1,785	43,091	24.14	13
14	Head Cook	5,865	6,165	63,397	10.28	14
15	Cook Helpers/Assistants	10,947	11,861	128,730	10.85	15
16	Dishwashers					16
17	Maintenance Workers	4,678	4,929	102,802	20.86	17
18	Housekeepers	19,678	21,104	251,143	11.90	18
19	Laundry	5,419	6,083	75,193	12.36	19
20	Administrator	1,840	2,150	110,224	51.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,609	12,453	198,187	15.91	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	4,416	4,659	146,591	31.46	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	9,016	9,693	247,499	25.53	33
34	TOTAL (lines 1 - 33)	218,715	233,073	$ 4,070,274 *	$ 17.46	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	355	$ 15,978	L1,C3	35
36	Medical Director	Monthly	30,800	L9,C3	36
37	Medical Records Consultant	40	1,871	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,438	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	49	1,350	L12,C3	45
46	Other(specify) Psychosocial	43	2,327	L12,C3	46
47	Rehab Consultant	36	1,795	L10A,C3	47
48					48
49	TOTAL (lines 35 - 48)	523	$ 67,559		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Glenwood Healthcare & Rehab

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		4,337	4,600	146,652	31.88
Transportation		1,070	1,219	12,468	10.23
Marketing		3,609	3,874	88,379	22.81
	TOTAL	9,016	9,693	247,499	

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Ellen McDevitt	Administrator	0	$ 60,878
Chris Correll	Administrator	0	49,346
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 110,224

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 537,156
TOTAL (agree to Schedule V, line 17, col. 3)	$ 537,156
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Service	22,559
Richard Peelo & Assoc Inc	Accounting Service	3,750
eHealth Data Solutions	Data Processing	1,290
MPRO	Peer Review Consulting	3,005
Paychex	Payroll Processing	29,583
Personnel Planners	Unemployment Consulting	9,530
Wescom Solutions	Data Processing	43,018
On Shift	Data Processing	1,481
Ability Network	Data Processing	2,335
SpyGlass Group	Cost Reduction Consulting	3,829
See Attached Legal Schedule	Legal Fees	35,118
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 155,498

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,502
Unemployment Compensation Insurance	60,569
FICA Taxes	303,153
Employee Health Insurance	204,228
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	5,578
Pension Plan Contribution	16,909
TOTAL (agree to Schedule V, line 22, col.8)	$ 678,939

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	38,834
Health Care Worker Background Check	
(Indicate # of checks performed 102)	1,020
Patient Background Checks	
IL Council on LTC	11,248
Dues & Subscriptions	76
Licenses & Permits	759
Allocated from Management Co.	1,875
Less Disallowed PAC Dues/Reversed Inv.	(5,789)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,013

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,146
Allocated from Management Co.	11,138
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,284

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Glenwood Healthcare & Rehab # 0032839 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. **11,248 IL Council on LTC**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,051** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **360,000**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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