

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR

0043935 Report Period Beginning: 1/1/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	70,878	3,254	1,523	75,655	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,878	3,254	1,523	75,655	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.31%

D. How many bed-hold days during this year were paid by the Department? 397 (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

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

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 Date 1994 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 213 and days of care provided 1,233

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	327,183	46,778	7,385	381,346		381,346		381,346		1
2	Food Purchase		450,027		450,027		450,027	(1,978)	448,049		2
3	Housekeeping	272,087	40,315		312,402		312,402		312,402		3
4	Laundry		22,718		22,718		22,718		22,718		4
5	Heat and Other Utilities			265,196	265,196		265,196	3,682	268,878		5
6	Maintenance	196,101	248	128,592	324,941		324,941	4,394	329,335		6
7	Other (specify):*										7
8	TOTAL General Services	795,371	560,086	401,173	1,756,630		1,756,630	6,098	1,762,728		8
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	2,504,805	84,023	19,035	2,607,863		2,607,863		2,607,863		10
10a	Therapy	126,773			126,773		126,773		126,773		10a
11	Activities		3,839	1,326	5,165		5,165		5,165		11
12	Social Services	239,318			239,318		239,318		239,318		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,870,896	87,862	56,361	3,015,119		3,015,119		3,015,119		16
	C. General Administration										
17	Administrative	251,807		648,000	899,807		899,807	(144,986)	754,821		17
18	Directors Fees										18
19	Professional Services			223,270	223,270		223,270	79,268	302,538		19
20	Dues, Fees, Subscriptions & Promotions			21,109	21,109		21,109	(13,424)	7,685		20
21	Clerical & General Office Expenses	172,260	21,655	115,103	309,018		309,018	59,151	368,169		21
22	Employee Benefits & Payroll Taxes			543,052	543,052		543,052		543,052		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,319	5,319		5,319	654	5,973		24
25	Other Admin. Staff Transportation			6,308	6,308		6,308	3,771	10,079		25
26	Insurance-Prop.Liab.Malpractice			207,789	207,789		207,789	18,041	225,830		26
27	Other (specify):*							26,334	26,334		27
28	TOTAL General Administration	424,067	21,655	1,769,950	2,215,672		2,215,672	28,809	2,244,481		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,090,334	669,603	2,227,484	6,987,421		6,987,421	34,907	7,022,328		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:

1/1/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			133,949	133,949		133,949	104,014	237,963			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,190	57,190		57,190	251,374	308,564			32
33	Real Estate Taxes							369,520	369,520			33
34	Rent-Facility & Grounds			1,291,984	1,291,984		1,291,984	(1,212,245)	79,739			34
35	Rent-Equipment & Vehicles			48,894	48,894		48,894	4,798	53,692			35
36	Other (specify):*											36
37	TOTAL Ownership			1,532,017	1,532,017		1,532,017	(482,539)	1,049,478			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,300		48,300		48,300		48,300			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			571,135	571,135		571,135		571,135			42
43	Other (specify):*							(9,606)	(9,606)			43
44	TOTAL Special Cost Centers		48,300	571,135	619,435		619,435	(9,606)	609,829			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,090,334	717,903	4,330,636	9,138,873		9,138,873	(457,238)	8,681,635			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,898)	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	(60,792)	30		9
10	Interest and Other Investment Income	(60)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(80)	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				18
19	Entertainment				19
20	Contributions	(5,250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,390)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,711)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(64,611)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (136,792)		\$	30

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	2	
		Amount	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)	(320,446)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (320,446)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (457,238)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

WOOD GLEN NRSING & REHAB CTR

ID# 0043935

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	MISC INCOME	\$ (2,258)	21	1
2	IL COUNCIL LTC - COPE	(12,232)	20	2
3	BANK FEES	(40,290)	21	3
4	DAMAGE/THEFT/LOSS	(225)	21	4
5	MARKETING - SALARY	(8,480)	43	5
6	MARKETING - EB	(1,126)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(64,611)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR# 0043935

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,978)	0	0	0	0	0	0	0	0	0	0	(1,978)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,682	0	0	0	0	0	0	0	0	3,682	5
6	Maintenance	0	0	4,394	0	0	0	0	0	0	0	0	4,394	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,978)	0	8,076	0	6,098	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	(144,986)	0	0	0	0	0	0	0	0	(144,986)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	60,481	18,787	0	0	0	0	0	0	0	0	79,268	19
20	Fees, Subscriptions & Promotions	(14,622)	0	1,198	0	0	0	0	0	0	0	0	(13,424)	20
21	Clerical & General Office Expenses	(49,734)	0	108,885	0	0	0	0	0	0	0	0	59,151	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	0	654	0	0	0	0	0	0	0	0	654	24
25	Other Admin. Staff Transportation	0	0	3,771	0	0	0	0	0	0	0	0	3,771	25
26	Insurance-Prop.Liab.Malpractice	0	17,002	1,039	0	0	0	0	0	0	0	0	18,041	26
27	Other (specify):*	0	0	26,334	0	0	0	0	0	0	0	0	26,334	27
28	TOTAL General Administration	(64,356)	77,483	15,682	0	28,809	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(66,334)	77,483	23,758	0	34,907	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR# 0043935

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(60,792)	161,313	3,493	0	0	0	0	0	0	0	0	104,014	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(60)	250,098	1,336	0	0	0	0	0	0	0	0	251,374	32
33	Real Estate Taxes	0	368,167	1,353	0	0	0	0	0	0	0	0	369,520	33
34	Rent-Facility & Grounds	0	(1,212,865)	620	0	0	0	0	0	0	0	0	(1,212,245)	34
35	Rent-Equipment & Vehicles	0	0	4,798	0	0	0	0	0	0	0	0	4,798	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(60,852)	(433,287)	11,600	0	(482,539)	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):*	(9,606)	0	0	0	0	0	0	0	0	0	0	(9,606)	43
44	TOTAL Special Cost Centers	(9,606)	0	0	0	0	0	0	0	0	0	0	(9,606)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(136,792)	(355,804)	35,358	0	(457,238)	45							

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 HEALTH CARE, LLC	SKOKIE, IL	MANAGEMENT
MIRIAM KLEIN	4.95					
KENNETH KLEIN	2.475	THE BRIDGE CARE SUITES	SPRINGFIELD	WOOD GLEN PAVILION REALTY, LLC		BUILDING
RONNIE CKEIN	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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENTAL INCOME	\$ 1,212,865	WOOD GLEN PAVILION REALTY, LLC		\$	\$ (1,212,865)	1
2	V	30 DEPRECIATION				161,313	161,313	2
3	V	32 INTEREST				250,098	250,098	3
4	V	33 RE TAXES				368,167	368,167	4
5	V	26 INSURANCE				17,002	17,002	5
6	V							6
7	V							7
8	V							8
9	V	19 PROFESSIONAL FEES	110,400	PHC CONSULTANTS, LLC		170,881	60,481	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,323,265			\$ 967,461	\$ * (355,804)	14

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 HOME OFFICE	\$ 168,000	PLATINUM HEALTH CARE, LLC	100.00%	\$	\$ (168,000)
16	V	5 Utilities				3,682	3,682
17	V	6 Repairs & Maintenance				4,394	4,394
18	V	17 Administrative Salary				23,014	23,014
19	V	19 Professional Fees				18,787	18,787
20	V	20 Fees, Subscriptions				1,198	1,198
21	V	21 Clerical Salaries				96,518	96,518
22	V	21 Office Expenses				12,367	12,367
23	V	24 Education & Seminars				654	654
24	V	25 Travel				3,771	3,771
25	V	26 Insurance				1,039	1,039
26	V	27 Employee Benefits				26,334	26,334
27	V	30 Depreciation				2,543	2,543
28	V	35 Equipment Rental				4,798	4,798
29	V	31 Amortization					
30	V	30 Depreciation				950	950
31	V	32 Interest				1,336	1,336
32	V	33 Real Estate Taxes				1,353	1,353
33	V	34 Office Rent				620	620
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 168,000			\$ 203,358	\$ * 35,358

* 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:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number WOOD GLEN NRSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	1,199,558	48	\$ 58,374	\$ 75,655	\$ 3,682	1
2	6	Repairs and Maintenance	Patient Days	1,199,558	48	69,662	75,655	4,394	2
3	17	Administrative Salary	Patient Days	1,199,558	48	364,898	364,898	23,014	3
4	19	Professional Fees	Patient Days	1,199,558	48	297,886	75,655	18,787	4
5	20	Fees, Subscriptions	Patient Days	1,199,558	48	18,990	75,655	1,198	5
6	21	Clerical Salaries	Patient Days	1,199,558	48	1,530,349	1,530,349	96,518	6
7	21	Office Expenses	Patient Days	1,199,558	48	196,089	75,655	12,367	7
8	24	Education & Seminars	Patient Days	1,199,558	48	10,377	75,655	654	8
9	25	Travel	Patient Days	1,199,558	48	59,795	75,655	3,771	9
10	26	Insurance	Patient Days	1,199,558	48	16,479	75,655	1,039	10
11	27	Employee Benefits	Patient Days	1,199,558	48	417,545	75,655	26,334	11
12	30	Depreciation	Patient Days	1,199,558	48	40,325	75,655	2,543	12
13	35	Equipment Rental	Patient Days	1,199,558	48	76,076	75,655	4,798	13
14	31	Amortization	Patient Days	1,199,558	48		75,655	0	14
15	30	Depreciation	Patient Days	1,199,558	48	15,062	75,655	950	15
16	32	Interest	Patient Days	1,199,558	48	21,179	75,655	1,336	16
17	33	Real Estate Taxes	Patient Days	1,199,558	48	21,452	75,655	1,353	17
18	34	Office Rent	Patient Days	1,199,558	48	9,830	75,655	620	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,224,368	\$ 1,895,247	\$ 203,358	25

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	Name of Lender	2		3	4	5	6		8	9	10						
		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			X	MORTGAGE			\$	\$			\$ 250,098						
2																	
3																	
4																	
5																	
Working Capital																	
6	HFG		X	LINE OF CREDIT							57,190						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 307,288						
B. Non-Facility Related*																	
10	INTEREST INCOME OFFSET										(60)						
11																	
12																	
13	ALLOCATION FROM PLATINUM										1,336						
14	TOTAL Non-Facility Related						\$	\$			\$ 1,276						
15	TOTALS (line 9+line14)						\$	\$			\$ 308,564						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 20,817 Line # 32

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 report.		\$	322,078		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.)		\$	345,123		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	23,045		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	336,000		4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	359,045		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>286,692</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>290,022</u>	9																
	2011	<u>307,219</u>	10																
	2012	<u>322,078</u>	11																
	2013	<u>345,123</u>	12																

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.

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. **Tax Bills**

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

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

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. (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? (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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1994	\$ 465,000	1
2					2
3	TOTALS			\$ 465,000	3

Facility Name & ID Number **WOOD GLEN NRSING & REHAB CTR**

0043935

Report Period Beginning:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1995	1995	\$ 3,067,125	\$ 78,645	35	\$ 87,632	\$ 8,987	\$ 1,663,811
5									
6									
7									
8									
Improvement Type**									
9	FENCE		1998	5,042		15			5,042
10	FIRE ALARM		2002	44,058		20	439	439	44,058
11									
12	Various		1995	25,326		20	1,266	1,266	24,800
13	Various		1996	16,672		20	834	834	15,219
14	Various		1997	20,310		20	1,016	1,016	17,816
15	Various		1998	22,766		20	1,138	1,138	20,876
16					1,423			(1,423)	
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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:

1/1/14

Ending:

12/31/14**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LOBBY IMPROVEMENTS	1999	\$ 3,750	\$	20	\$ 188	\$ 188	\$ 2,848	37
38	WATER HEATER	1999	4,100		20	205	205	3,106	38
39	CONTRACTOR	1999	919		20	46	46	713	39
40	PUMP	1999	1,887		20	94	94	1,416	40
41	MATV SYSTEM	1999	752		20	38	38	570	41
42	PRESSURE SWITCH	1999	1,341		20	67	67	1,005	42
43	BOILER	1999	1,964		20	98	98	1,470	43
44	AIR CONDITIONER	1999	612		20	31	31	465	44
45	SMOKE DETECTOR	1999	3,118		20	156	156	2,340	45
46	FIRE ALARM SYSTEM	1999	693		20	35	35	624	46
47	2 WATER HEATERS	2000	8,400		20	420	420	6,230	47
48	FLOORING	2000	1,284		20	64	64	917	48
49	CARPET	2000	1,284		20	64	64	912	49
50	FLOORING	2000	3,740		20	187	187	2,665	50
51	CARPET	2000	5,225		20	261	261	3,676	51
52	FIXTURES (\$31,000 REMOVED 2008 CAP COST AUDIT)	2000							52
53	FLUID PUMP	2000	2,429		20	121	121	1,775	53
54	FLUID PUMP	2000	905		20	45	45	660	54
55	FLUID PUMP SVC	2000	2,412		20	121	121	1,754	55
56	WATER LINES & DRAIN	2001	3,870		39	99	99	1,382	56
57	BURNER PILOT & PARTS	2001	1,593		39	41	41	572	57
58	4 DUPLEX OUTLETS	2001	2,275		39	58	58	810	58
59	WATER HEATER PIPING	2001	8,997		39	231	231	3,186	59
60	FLUES - WATER BOILER	2001	3,580		39	92	92	1,231	60
61	BRICK WALL	2001	4,515		39	116	116	1,532	61
62	EXPANSION MODULE	2001	947		20	47	47	638	62
63	CABLES	2001	1,031		20	52	52	680	63
64	CABLE WORK	2001	767		20	38	38	497	64
65	PHONES/CABLES	2001	544		20	27	27	378	65
66	LIGHTING	2001	1,022		20	51	51	667	66
67	LAMPS (\$742 TO MME PER '08 CAP COST AUDIT)	2001			20				67
68	FIRE PUMP WORK	2001	750		20	38	38	497	68
69	HEATING/COOLING WORK	2001	649		20	32	32	419	69
70	TOTAL (lines 4 thru 69)		\$ 3,276,654	\$ 80,068		\$ 95,488	\$ 15,420	\$ 1,837,257	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:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,276,654	\$ 80,068		\$ 95,488	\$ 15,420	\$ 1,837,257	1
2	LIGHTING	2001	903		20	45	45	596	2
3	MOTOR	2001	547		20	27	27	374	3
4	LIGHTING ENHANCEMENT	2001	903		20	45	45	611	4
5	REFRIGERATOR WORK	2001	1,044		20	52	52	689	5
6	PIPE WORK	2001	500		20	25	25	331	6
7	CONCRETE ANCHOR	2001	5,332		20	267	267	3,627	7
8	REFRIGERATOR WORK	2001	532		20	27	27	365	8
9	REFRIGERATOR WORK	2001	585		20	29	29	387	9
10	LIGHTING	2001	903		20	45	45	630	10
11	LIGHTING	2001	903		20	45	45	626	11
12	LIGHTING	2001	903		20	45	45	623	12
13	LIGHTING	2001	903		20	45	45	619	13
14	LIGHTING	2001	903		20	45	45	615	14
15	PUMP	2001	571		20	29	29	379	15
16	HEAT PUMP MOTOR	2001	1,409		20	70	70	922	16
17	PLUMBING	2001	1,038		20	52	52	728	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	377	27
28	FIRE PUMP WORK	2002	750		20	38	38	494	28
29	SERVICE PUMP	2002	540		20	27	27	351	29
30	ELECTRICAL SYSTEM	2002	528		20	26	26	338	30
31	PIPE WORK	2002	1,213		20	61	61	793	31
32	LIGHTING ENHANCEMENT	2002	12,442		20	622	622	8,086	32
33	MAIN ENTRANCE CAMERA	2003	13,445		5			13,445	33
34	TOTAL (lines 1 thru 33)		\$ 3,338,920	\$ 80,068		\$ 97,184	\$ 17,116	\$ 1,888,145	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:

1/1/14

Ending:

12/31/14**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,338,920	\$ 80,068		\$ 97,184	\$ 17,116	\$ 1,888,145	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	28	28	1,454	5
6	CI RANG STEAM	2003	869		10			869	6
7	CI RANG STEAM	2003	2,289		10	171	171	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	149	149	8,714	10
11	INSTALL NEW COIL	2004	3,800		10	127	127	3,800	11
12	CONDENSING UNIT	2004	4,200		15	280	280	2,940	12
13	PLUMBING-DIALYSIS ROOM	2004	5,390		20	270	270	2,835	13
14	WATER HEATER	2004	6,748		10	336	336	6,748	14
15	SERVICE PUMP	2004	7,565		20	378	378	3,938	15
16	BOILER & STORAGE TANKS	2004	6,200		20	310	310	3,307	16
17	CHASE WALLS	2004	4,570		15	305	305	3,126	17
18	CARPETING	2004	12,311		5			12,311	18
19	HOT WATER TANK	2004	11,242		10	845	845	11,242	19
20	WATER TANK	2004	34,751		20	1,738	1,738	17,670	20
21	HOT WATER VALVE	2004	3,609		20	180	180	1,845	21
22	CARPETING	2004	28,726		5			28,726	22
23	HOT WATER BOILER	2004	7,344		20	367	367	3,670	23
24	ALUMINUM STREET SIGN DISP	2005	3,700		10	370	370	3,700	24
25	FIRE ALARMS/SMOKE DETECTORS	2005	2,134		10	213	213	2,113	25
26	TURNBURY INSULATED DOME	2005	1,545		10	155	155	1,537	26
27	STEEL PEDESTRIAN DOORS	2005	4,630		20	232	232	2,300	27
28	RED OAK UNFINISHED DOO	2005	1,580		15	105	105	1,033	28
29	FIRE DAMPERS	2005	5,294		10	529	529	5,158	29
30	SECURITY SYSTEM	2005	16,519		10	1,652	1,652	15,969	30
31	SMOKE DAMPER MOTORS	2005	7,524		10	752	752	7,270	31
32	ASPHALT REPLACEMENT	2005	10,862		8			10,862	32
33	SMOKE DAMPER MOTORS	2005	2,585		10	259	259	2,482	33
34	TOTAL (lines 1 thru 33)		\$ 3,558,361	\$ 80,068		\$ 106,935	\$ 26,867	\$ 2,069,339	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:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,558,361	\$ 80,068		\$ 106,935	\$ 26,867	\$ 2,069,339	1
2	BOILER REPLACEMENT	2005	18,998		20	950	950	8,867	2
3	SECURITY SYSTEM	2005	2,400		10	240	240	2,220	3
4	FIRE ALARM DEVICES INSTALL	2005	4,687		10	469	469	4,338	4
5	HOT WATER HEATER EXCHAN	2005	27,374		10	2,737	2,737	25,089	5
6	VINYL FENCE & WALK GATE	2005	3,844		10	384	384	3,520	6
7	SATELLITE TV & INTERNET (\$12,699 TO MME '08 CC AUDI	2005							7
8	DOOR HOLDERS	2006	3,324		10	332	332	2,961	8
9	HOT WATER COILS-OFFICE	2006	4,472		10	447	447	3,949	9
10	ADD CONCRETE TO PATIO	2006	8,476		15	565	565	4,897	10
11	ROOF WORK	2006	4,560		20	228	228	1,957	11
12	EGRESS DOORS	2006	1,651		10	165	165	1,403	12
13	DOORS	2006	1,631		10			1,631	13
14	CABLE,SPLITTERS, WALL PLA	2006	16,577		20	829	829	6,632	14
15	ALARM & SPRINKLER INSPECTION (\$3,640 REMOVED '08 C	2007							15
16	FAN COIL UNIT	2007	5,215		10	522	522	3,958	16
17	PEERLESS FENCE	2007	2,576		15	172	172	1,304	17
18	SEALCOATING & CRACK SEALING	2007	4,525		8	566	566	4,103	18
19	PS-35 PYROTRONICS POWER SUPPLY (41,992 REM '08 CC A	2007							19
20	DOORS	2007	2,585		10	259	259	1,835	20
21	CHILLER	2008	106,846		10	10,685	10,685	68,562	21
22	AIR HANDLER/PNEUMATIC CONTROL	2008	3,300		10	330	330	2,282	22
23	INSTALL DOORS (1ST-3RD FLOOR)	2008	2,597		10	260	260	1,798	23
24	COMDIAL MP5000	2008	14,730		10	1,473	1,473	10,188	24
25	CHILLER REPLACEMENT PROJ	2008	9,740		10	974	974	6,656	25
26	INSTALL DOORS (LINEN/GARBAGE))	2008	2,212		10	221	221	1,492	26
27	FIRE SPRINKLER SUBCONTRACTOR	2008	6,965		10	697	697	4,646	27
28	INSTALL NEW CONDENSER & EVAPORATOR	2008	6,191		10	619	619	4,127	28
29	SECURTY UNIT	2008	6,740		10	674	674	4,437	29
30	REPAIR FIRE PUMP RUN TIMER	2008	6,318		10	632	632	4,055	30
31	POWER SUPPLY & DOME CAMERA	2008	1,099		10	110	110	660	31
32	REPAIR/REPLACE THERMOSTATIC VALVE-HOT WATER S	2008	3,086		10	309	309	1,854	32
33	BOILER REPAIR	2009	33,860		10	3,386	3,386	18,200	33
34	TOTAL (lines 1 thru 33)		\$ 3,874,940	\$ 80,068		\$ 136,170	\$ 56,102	\$ 2,276,960	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:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,874,940	\$ 80,068		\$ 136,170	\$ 56,102	\$ 2,276,960	1
2	CHILLER REPLACEMENT	2009	136,577		10	13,658	13,658	76,621	2
3	REMOVE/REPLACE RUBBER WALL DETAIL	2009	2,900		10	290	290	1,450	3
4	INSTALL NEW DOORS & MAGNETIC CLOSERS	2009	6,987		10	699	699	3,495	4
5	BACKUP GENSET-REPLACE COOLANT, HTR HOSES, FILTE	2009	1,205		10	121	121	605	5
6	PLUMBING-TWIST N CLOSE BATH WASTE	2009	1,086		10	109	109	545	6
7	ENTRY HEAT REMOVED/CLEANED BLOWERS	2009	2,547		10	255	255	1,275	7
8	BOILER #1 REPAIR	2009	4,138		10	414	414	2,070	8
9	FIRE ALARM REPAIR	2009	8,413		10	841	841	4,205	9
10	SPRINKLER REPAIR/REPLACE HEADS	2009	5,593		10	559	559	2,795	10
11	SPRINKLER INSPECTION	2009	2,282		10	228	228	1,140	11
12	REPAIR PLUMBING LEAKS	2009	776		10	78	78	390	12
13	PAINTING-DINING ROOM & PANTRY-CONTRACT-E&L PAI	2011	5,730		5	1,146	1,146	4,584	13
14	VINYL FLOORING & BASEBOARD-HALLWAYS/COMMON A	2011	117,197		10	11,720	11,720	44,926	14
15	CCTV INSTALLATION	2011	14,936		5	2,987	2,987	10,455	15
16	WATER PUMP REPAIR, THERMOSTAT, HOSES & BELTS	2011	4,044		10	404	404	1,380	16
17	FIRE DAMPERS & FIRE/SMOKE DAMPERS	2012	73,946		10	7,395	7,395	19,720	17
18	DRYWALL REPAIR DINING ROOM 1ST FLOOR-CONTRACT	2012	2,800		10	280	280	770	18
19	WATER PUMP REPLACEMENT	2012	3,892		15	259	259	691	19
20	FIRE DAMPER CONSTRUCTION	2012	75,000		10	7,500	7,500	17,500	20
21	FIRE DAMPER UPDATES	2012	50,000		10	5,000	5,000	10,833	21
22	REPLACE CPU	2012	6,016		10	602	602	1,254	22
23	FIRE DAMPER CONSTRUCTION	2013	88,335		10	8,834	8,834	15,459	23
24	REMODEL 2 RESIDENT ROOMS-CONTRACT-GF BUILDERS	2013	63,900		15	4,260	4,260	7,455	24
25	MOTOR/STARTER	2013	7,350		10	735	735	1,225	25
26	MOTORS/FUSE	2013	4,315		10	432	432	468	26
27	FIRE SAFETY EQUIP-FIRE PUMP	2013	4,499		10	450	450	900	27
28	ELECTRICAL - MMB-3	2013	6,436		10	644	644	1,288	28
29	NURSING SMOKE ADD	2013	5,550		10	555	555	925	29
30	HVAC-REPLACE COILS	2013	44,895		10	4,490	4,490	4,864	30
31	BACKFLOW PREVENTER DEVICES	2013	2,938		10	294	294	539	31
32	AIR DUCT DETECTOR	2013	3,742		10	374	374	686	32
33	NEW ELEVATOR VALVE	2014	10,204		20	468	468	468	33
34	TOTAL (lines 1 thru 33)		\$ 4,643,169	\$ 80,068		\$ 212,251	\$ 132,183	\$ 2,517,941	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,643,169	\$ 80,068		\$ 212,251	\$ 132,183	\$ 2,517,941	1
2	FACE DAMPERS	2014	11,454		20	1,050	1,050	20	2
3	FREEZER CURTAIN	2014	3,018		10	75	75	10	3
4	BOILER TUBES	2014	35,832		20	299	299	20	4
5	CONDUIT & WIRING	2014	23,275		20	97	97	20	5
6				103,410			(103,410)		6
7				77,865			(77,865)		7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,716,748	\$ 261,343		\$ 213,772	\$ (47,571)	\$ 2,518,011	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:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,716,748	\$ 261,343		\$ 213,772	\$ (47,571)	\$ 2,518,011	1
2	ALLOCATIONS FROM PLATINUM (HO):								2
3	BUILDING (CONSTRUCTED 1955; PURCH 2004)	2004	17,870						3
4	FIRE ALARM & SECURITY SYSTEM	2004	111						4
5	PAINTING	2004	120						5
6	CARPETING	2004	250						6
7	BLINDS	2004	59						7
8	BLINDS	2005	86						8
9	REMODELING-FLOORS, LIGHTS, PLUMBING & WALLS	2005	857						9
10	REMODELING-WALLS	2005	34						10
11	BATHROOM REMODELING	2005	86						11
12	BATHROOM REMODELING	2005	125						12
13	BATHROOM REMODELING	2006	489						13
14	WINDOWS	2006	214						14
15	TUCK POINTING	2008	72						15
16	REMODEL PARESH'S OFFICE	2008							16
17	HEAT EXCHANGER	2009							17
18	RENZOR UNIT HEATER	2009	264						18
19	RELOCATION OF STAT FOR NW UNIT HEATER	2009	245						19
20	REMODEL BOOKKEEPING OFFICE	2009	246						20
21	AWNING	2009	48						21
22	PARKING LOT REPAIR	2009	264						22
23	ROOF TOP UNIT	2010	521						23
24	COMPRESSOR AC UNIT	2010	202						24
25	OFFICE FURNITURE	2013	1,040						25
26			139						26
27			241						27
28				792			(792)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,740,331	\$ 262,135		\$ 213,772	\$ (48,363)	\$ 2,518,011	34

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

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	\$ 462,161	\$ 4,347	\$ 18,704	\$ 14,357		\$ 392,273	71
72	Current Year Purchases	31,051	27,897	2,786	(25,111)		2,786	72
73	Fully Depreciated Assets							73
74	ALLOCATION FROM PLATINUM		2,701	2,701				74
75	TOTALS	\$ 493,212	\$ 34,945	\$ 24,191	\$ (10,754)		\$ 395,059	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)	\$ 5,764,129	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 298,755	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 237,963	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (60,792)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,939,852	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.

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. 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

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. 2015 \$ 1,839,511

13. 2016 \$ 1,876,301

14. 2017 \$ 1,913,827

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: _____ *

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: \$ 26,743 Description: Beds 10,971; Dish machine 3,572; Postage meter 936; CPAP 3,279; Printer/Copier 7,985

(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		<u>2011 ESCALADE</u>	\$	\$ <u>14,955</u>	17
18		<u>2012 HONDA CIVIC</u>	<u>599.76</u>	<u>7,196</u>	18
19					19
20					20
21	TOTAL		\$ <u>599.76</u>	\$ <u>22,151</u>	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: 1/1/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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				44,717		44,717	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					3,583		3,583	13
14	TOTAL			\$		\$	48,300		\$ 48,300	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.

Facility Name & ID Number **WOOD GLEN NRSING & REHAB CTR**# **0043935**Report Period Beginning: **1/1/14**

Ending:

12/31/14**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/14**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (200,276)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,983,599		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,184		6
7	Other Prepaid Expenses	10,122		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,899,629	\$	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	734,423		15
16	Equipment, at Historical Cost	413,630		16
17	Accumulated Depreciation (book methods)	(860,772)		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): <u>Deposits/Reserve</u>	621,793		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 909,074	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,808,703	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 227,311	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9		28
29	Short-Term Notes Payable	(35,110)		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	84,182		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	336,000		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	194,118		36
37	<u>Due Others</u>	275,798		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,082,308	\$	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)	\$ 1,082,308	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,726,395	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,808,703	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,837,681	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,837,681	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	964,902	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	(730,498)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) CAPITAL STOCK	654,309	15
16	Other (describe) ROUNDING	1	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 888,714	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)	\$ 2,726,395	24 *

* This must agree with page 17, line 47.

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,654,842	1
2	Discounts and Allowances for all Levels	61,287	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,716,129	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	347,574	6
7	Oxygen	5	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 347,579	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	1,898	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	33,635	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,146	19
20	Radiology and X-Ray	1,070	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 37,749	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	60	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 60	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	2,258	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,258	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,103,775	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,756,630	31
32	Health Care	3,015,119	32
33	General Administration	2,215,672	33
B. Capital Expense			
34	Ownership	1,532,017	34
C. Ancillary Expense			
35	Special Cost Centers	48,300	35
36	Provider Participation Fee	571,135	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,138,873	40
41	Income before Income Taxes (line 30 minus line 40)**	964,902	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 964,902	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,951,651	44
45	Private Pay - Net Inpatient Revenue	667,519	45
46	Medicare - Net Inpatient Revenue	212,305	46
47	Other-(specify) Other	(115,346)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,716,129	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:

1/1/14

Ending:

12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,960	2,120	\$ 138,359	\$ 65.26	1
2	Assistant Director of Nursing	3,856	4,160	175,565	42.20	2
3	Registered Nurses	17,463	18,527	644,641	34.79	3
4	Licensed Practical Nurses	17,750	18,743	501,608	26.76	4
5	CNAs & Orderlies	67,784	70,829	972,033	13.72	5
6	CNA Trainees					6
7	Licensed Therapist	432	432	22,267	51.54	7
8	Rehab/Therapy Aides	2,587	2,719	104,506	38.44	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	12,443	13,057	239,318	18.33	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,080	83,227	40.01	13
14	Head Cook	2,294	2,432	28,456	11.70	14
15	Cook Helpers/Assistants	19,994	20,620	215,500	10.45	15
16	Dishwashers					16
17	Maintenance Workers	12,776	13,226	196,101	14.83	17
18	Housekeepers	27,012	28,761	272,087	9.46	18
19	Laundry					19
20	Administrator	1,896	2,080	251,807	121.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,960	5,200	172,260	33.13	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	3,961	4,106	72,599	17.68	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	199,096	209,092	\$ 4,090,334 *	\$ 19.56	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	134	\$ 7,385	1.3	35
36	Medical Director	MONTHLY	36,000	9.3	36
37	Medical Records Consultant	QUARTERLY	1,200	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		17,835	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	19	1,326	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	153	\$ 63,746		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JEFFERY WHITE	ADMINISTRATOR		\$ 251,807	Workers' Compensation Insurance	\$ 84,847	IDPH License Fee	\$	
				Unemployment Compensation Insurance	21,725	Advertising: Employee Recruitment	689	
				FICA Taxes	299,219	Health Care Worker Background Check		
				Employee Health Insurance	39,774	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	80 1,883	
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING & MARKETING	2,390	
				401K	700	DUE & SUBSCRIPTIONS	1,021	
				EMPLOYEE BENEFITS - OTHER	96,564	LICENSES	2,894	
				EMPLOYEE PHYSICAL EXAM	223			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 251,807	TOTAL (agree to Schedule V, line 22, col.8)		\$ 543,052		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	5,319
C. Professional Services				TOTAL			\$	
Vendor/Payee	Type		Amount				ALLOCATION FROM PLATINUM	
SEE ATTACHED SCHEDULE			\$ 223,270				654	
							Entertainment Expense	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 5,973	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 223,270					

* Attach copy of IMRF notifications

**See instructions.

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	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:

1/1/14

Ending:

12/31/14

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 \$10,442
- (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? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,237 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. \$ 571,135
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? 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? _____
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? _____
Firm Name: NO _____
- (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.