



Facility Name & ID Number Twin Willows Nursing Center

# 0014753 Report Period Beginning: 01-01-05 Ending: 12-31-05

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 29skilled 45 ICF

	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	29	Skilled (SNF)	29	10,585	1
2		Skilled Pediatric (SNF/PED)			2
3	45	Intermediate (ICF)	45	16,425	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	4,717	1,542	2,310	8,569	8	
9	SNF/PED					9	
10	ICF	10,679	2,677		13,356	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	15,396	4,219	2,310	21,925	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.17%

D. How many bed-hold days during this year were paid by the Department? 0 (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 01-01-73

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 29 and days of care provided \_\_\_\_\_

Medicare Intermediary Administar Federal Kentucky

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

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**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	107,198	10,811	4,455	122,464		122,464		122,464		1
2	Food Purchase		123,339		123,339		123,339	(4,165)	119,174		2
3	Housekeeping	44,133	6,309		50,442		50,442		50,442		3
4	Laundry	13,615	7,483		21,098		21,098		21,098		4
5	Heat and Other Utilities			57,539	57,539		57,539	(2,614)	54,925		5
6	Maintenance	24,989	8,280	16,380	49,649		49,649		49,649		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	189,935	156,222	78,374	424,531		424,531	(6,779)	417,752		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	627,867	55,640	3,010	686,517		686,517		686,517		10
10a	Therapy										10a
11	Activities	21,803	3,312		25,115		25,115		25,115		11
12	Social Services	12,824		2,234	15,058		15,058		15,058		12
13	CNA Training	5,688	576	1,257	7,521		7,521		7,521		13
14	Program Transportation			7,250	7,250		7,250		7,250		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	668,182	59,528	14,951	742,661		742,661		742,661		16
	<b>C. General Administration</b>										
17	Administrative	45,000			45,000		45,000		45,000		17
18	Directors Fees										18
19	Professional Services			16,403	16,403		16,403		16,403		19
20	Dues, Fees, Subscriptions & Promotions			5,181	5,181		5,181		5,181		20
21	Clerical & General Office Expenses		14,677	4,354	19,031		19,031		19,031		21
22	Employee Benefits & Payroll Taxes			136,272	136,272		136,272		136,272		22
23	Inservice Training & Education			833	833		833		833		23
24	Travel and Seminar			1,053	1,053		1,053		1,053		24
25	Other Admin. Staff Transportation		752		752		752		752		25
26	Insurance-Prop.Liab.Malpractice			54,750	54,750		54,750		54,750		26
27	Other (specify):* <b>bad debt</b>			70,997	70,997		70,997	(70,997)			27
28	<b>TOTAL General Administration</b>	45,000	15,429	289,843	350,272		350,272	(70,997)	279,275		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	903,117	231,179	383,168	1,517,464		1,517,464	(77,776)	1,439,688		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.

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			31,723	31,723		31,723		31,723			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,116	27,116		27,116	(5,508)	21,608			32
33	Real Estate Taxes			30,010	30,010		30,010		30,010			33
34	Rent-Facility & Grounds			1,200	1,200		1,200		1,200			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			90,049	90,049		90,049	(5,508)	84,541			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,990	152,837	203,827		203,827		203,827			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		6,180		6,180		6,180		6,180			41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		57,170	193,352	250,522		250,522		250,522			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	903,117	288,349	666,569	1,858,035		1,858,035	(83,284)	1,774,751			45

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

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**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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	3,801	2-7		4
5	Telephone, TV & Radio in Resident Rooms	2,614	5-7		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	2,749	32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	364	2-7		13
14	Non-Care Related Interest	2,759	32-7		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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	70,997	27-3		24
25	Fund Raising, Advertising and Promotional				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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 83,284		\$	30

OHF 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	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 83,284		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	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	<b>Total</b>	0	49





**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Helen Woodruff	95	n/a	n/a	Motel Developments	Salem	motel
Jeffrey Woodruff	5	n/a	n/a	Woodruff Services	Carbondale	ac/heaters

**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		\$					1
2	V	34 office storage	1,200	Motel Developments	100.00%	1,200		2
3	V	32 interest	18,507	Todd Woodruff		18,507		3
4	V	20 background checks	690	Woodruff Services	100.00%	690		4
5	V	32 interest	904	Jeffrey Woodruff		904		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		\$ 21,301			\$ 21,301	\$ *	0 14

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

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## 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	Todd Woodruff	Administrator	management	0.00	0	60	100.00	interest	\$ 18,507	32-3	1
2	Todd Woodruff	Administrator	management	0.00	0	60	100.00	wages	45,000	17-1	2
3	Helen Woodruff	audit accounting		95.00	0	20	30.00	fees	14,000	19-3	3
4	Jeffrey Woodruff	Woodruff Service	background checks	5.00	0			background ck	690	20-3/10-2	4
5	Jeffrey Woodruff	n/a		5.00	0			interest	904		5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 79,101		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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Bonds		x	working capital	n/a	11-2-72	\$ 8,000	\$ 8,000	12-31-84	10.0000	\$ 800	1							
2	Bonds		x	purchase facility	n/a	11-2-72	36,450	5,150	-12-31-84	10.0000	515	2							
3	Todd Woodruff	x		working capital	n/a	1-87	252,097	224,748	12-31-05	8.7500	18,507	3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Financing Charges		x	insurance policy finance	n/a						1,827	6							
7	Jeffrey Woodruff/acc.pay	x	x	accounts payable/workingcap.	n/a						1,405	7							
8	Guardian Insurance		x	working capital	n/a	8-4-05	41,215	41,215		7.4000	1,303	8							
9	TOTAL Facility Related						\$ 337,762	\$ 279,113			\$ 24,357	9							
<b>B. Non-Facility Related*</b>																			
10	Motel Developments	x		purchase office building		4-1-86	56,000	34,295	12-31-05	8.7500	2,759	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$ 56,000	\$ 34,295			\$ 2,759	14							
15	TOTALS (line 9+line14)						\$ 393,762	\$ 313,408			\$ 27,116	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # n/a

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

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





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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,250 B. General Construction Type: Exterior brick Frame fireproof construction Number of Stories 1

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>facility</u>	<u>87,000</u>	<u>1973</u>	<u>\$ 28,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	87,000		\$ 28,000	3

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	74	1973	1966	\$ 380,183	\$ 11,406	33.33	\$ 11,406	\$	\$ 376,398
5									
6									
7									
8									
<b>Improvement Type**</b>									
9									
10									
11	water heater		1977	1,024		10			1,024
12	fire exit lights		1978	695		5			695
13	emergency power		1978	1,695		5			1,695
14	emergency power		1979	1,359		5			1,359
15	compressor		1979	372		5			372
16	battery units		1980	570		3			570
17	compressor		1980	533		5			533
18	mixing valve		1981	780		10			780
19	central air		1981	771		10			771
20	disposal		1982	745		10			745
21	storage shed		1982	600		8			600
22	3 heat pumps		1983	2,245		10			2,245
23	phone system		1985	3,318		20			3,318
24	2 heat pumps		1985	1,400		8			1,400
25	driveway		1988	2,767		3			2,767
26	seal coat patch driveway		1997	1,850		3			1,850
27	door monitor system		1999	7,590	759	10	759		4,744
28	3 central air systems		1999	12,588		5			12,588
29	roof		1999	64,580	4,305	15	4,305		26,189
30	asphalt top coat driveway		1999	16,136	2,017	8	2,017		12,354
31	outside walkway lights		1999	600		5			600
32	south wing sewer line		2000	1,046	105	10	105		586
33	3 outside hydrants		2000	525	52	10	52		264
34	asphalt sidewalks-wings		2005	6,270	71	8	71		71
35									
36									

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 510,242	\$ 18,715		\$ 18,715	\$	\$ 454,518	70

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

Facility Name & ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning:

01-01-05

Ending:

12-31-05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 108,802	\$ 11,311	\$ 11,311	\$		\$ 71,274	71
72	Current Year Purchases	7,895	812	812			812	72
73	Fully Depreciated Assets	120,682	885	885			110,999	73
74								74
75	TOTALS	\$ 237,379	\$ 13,008	\$ 13,008	\$		\$ 183,085	75

D. Vehicle Depreciation (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		wagon	1987	\$ 10,990	\$	\$	\$	4	\$ 10,990	76
77										77
78										78
79										79
80	TOTALS			\$ 10,990	\$	\$	\$		\$ 10,990	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)	\$ 786,611	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,723	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,723	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 648,593	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	aluminum trailer	\$ 10,000	\$	\$ 10,000	86
87	216 S. Broadway	56,000		56,000	87
88	schedule	12,307	258	11,568	88
89	driveway 216	6,119	285	3,321	89
90					90
91	TOTALS	\$ 84,426	\$ 543	\$ 80,889	91

G. Construction-in-Progress

	Description	Cost	
92		\$ n/a	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: Motel Developments Inc. rents storage space

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

If NO, see instructions.

		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:				\$ <u>1,200</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>1,200</u>			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: \_\_\_\_\_ \*

**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: \$ n/a Description: \_\_\_\_\_

(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			\$ _____	\$ _____	17
18			<u>n/a</u>		18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 01/01/05

Ending 12/31/05

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

Fiscal Year Ending Annual Rent

12. /2006 \$ 1,200

13. /2007 \$ \_\_\_\_\_

14. /2008 \$ \_\_\_\_\_

\* 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.

**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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>45</u></p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 419	\$ 838	\$	\$ 1,257
2	Books and Supplies	80	194		274
3	Classroom Wages (a)	572	3,171		3,743
4	Clinical Wages (b)	146	1,799		1,945
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		302		302
9	<b>TOTALS</b>	\$ 1,217	\$ 6,304	\$	\$ 7,521
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 7,521			

**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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>9</b>

- (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	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	\$	2,585	\$ 45,391	\$	2,585	\$ 45,391	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		374	14,777		374	14,777	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		5,157	92,669		5,157	92,669	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 prescripts				49,618		49,618	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>x-ray-lab</u>	39-2					1,372		1,372	13
14	TOTAL			\$	8,116	\$ 152,837	\$ 50,990	8,116	\$ 203,827	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 **Twin Willows Nursing Center**

# **0014753**

Report Period Beginning: **01-01-05**

Ending:

**12-31-05**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12-31-05**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 149,390	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	963,373		3
4	Supply Inventory (priced at )	12,900		4
5	Short-Term Investments	23,890		5
6	Prepaid Insurance	21,081		6
7	Other Prepaid Expenses	3,523		7
8	Accounts Receivable (owners or related parties)	11,573		8
9	Other(specify): <b>1120 tax deposits</b>	9,000		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,194,730	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable	73,578		11
12	Long-Term Investments			12
13	Land	32,000		13
14	Buildings, at Historical Cost	436,183		14
15	Leasehold Improvements, at Historical Cost	95,077		15
16	Equipment, at Historical Cost	311,777		16
17	Accumulated Depreciation (book methods)	(729,482)		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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 219,133	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,413,863	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 138,390	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	81,215		29
30	Accrued Salaries Payable	31,891		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,816		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,379		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 283,691	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	357,020		39
40	Mortgage Payable			40
41	Bonds Payable	13,150		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<b>stock</b>	3,500		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 373,670	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 657,361	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 756,502	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,413,863	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>332,769</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>332,769</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>229,595</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>carry forward loss taken</b>	<b>194,308</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>423,903</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>non deductible</b>	<b>(170)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(170)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>756,502</b>	<b>24</b> *

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

Facility Name &amp; ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning: 01-01-05

Ending: 12-31-05

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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,302,412	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,302,412	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,720	11
12	Gift and Coffee Shop	7,840	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,801	14
15	Telephone, Television and Radio	1,656	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	934	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 17,951	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	200	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 200	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	216 rental	5,400	28
28a	workmencomp refund05 139/lawncare 900	1,039	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,439	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,327,002	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	417,752	31
32	Health Care	742,661	32
33	General Administration	279,275	33
<b>B. Capital Expense</b>			
34	Ownership	84,541	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	210,007	35
36	Provider Participation Fee	40,515	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,774,751	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	552,251	41
42	<b>Income Taxes</b>	(88,367)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 552,251	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? no 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 Twin Willows Nursing Center

# 0014753

Report Period Beginning:

01-01-05

Ending:

12-31-05

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	2,032	2,176	\$ 47,895	\$ 22.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,484	7,781	131,950	16.96	3
4	Licensed Practical Nurses	10,104	10,660	156,784	14.71	4
5	CNAs & Orderlies	37,311	38,317	277,869	7.25	5
6	CNA Trainees	863	863	5,688	6.59	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,268	1,383	10,053	7.27	9
10	Activity Assistants	1,657	1,765	11,750	6.66	10
11	Social Service Workers	1,645	1,767	12,824	7.26	11
12	Dietician					12
13	Food Service Supervisor	1,770	1,879	14,924	7.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,935	6,092	40,835	6.70	15
16	Dishwashers	7,424	7,802	51,439	6.59	16
17	Maintenance Workers	1,669	2,033	24,989	12.29	17
18	Housekeepers	6,401	6,540	44,133	6.75	18
19	Laundry	1,934	2,054	13,615	6.63	19
20	Administrator	2,915	2,963	45,000	15.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,675	1,769	13,369	7.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	92,087	95,844	\$ 903,117 *	\$ 9.42	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	96	\$ 4,455	1-3	35
36	Medical Director	12	1,200	9-3	36
37	Medical Records Consultant	12	306	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	45	1,500	10-3	39
40	Physical Therapy Consultant	21	1,159	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	43	2,234	12-3	45
46	Other(specify) <u>dentist</u>	1	45	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	230	\$ 10,899		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)	n/a	\$	53

Facility Name & ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning: 01-01-05

Ending: 12-31-05

**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	
Todd Woodruff	Administrator	0	\$ 45,000	Workers' Compensation Insurance	\$ 51,427	IDPH License Fee	\$ 750	
				Unemployment Compensation Insurance	11,480	Advertising: Employee Recruitment	633	
				FICA Taxes	69,088	Health Care Worker Background Check (Indicate # of checks performed <u>49</u> )	490	
				Employee Health Insurance		IHCA	2,966	
				Employee Meals		State Fire Marshall	100	
				Illinois Municipal Retirement Fund (IMRF)* employee recognition	4,277	MES	242	
						yellow page advertising	10,453	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 45,000			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	(10,453)	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 136,272	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,181	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Helen Woodruff	audit-accounting		\$ 14,000			\$	Out-of-State Travel	\$
h&r block	tax return		340					
RM McGladrey	Medicare consult		2,063				In-State Travel	
							Seminar Expense	1,053
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 16,403	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,053

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning:

01-01-05

Ending:

12-31-05

## 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. IHCA 2966
- (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? 5.66
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,471 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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,515  
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? yes 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? yes Indicate the amount. \$ 3,801
- (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? <10%  
d. Have vehicle usage logs been maintained? no  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? no  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes  
**g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a**
- (17) Has an audit been performed by an independent certified public accounting firm? no  
Firm Name: n/a The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. none done
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a  
Attach invoices and a summary of services for all architect and appraisal fees.