



Facility Name & ID Number Twin Willows Nursing Center

# 0014753 Report Period Beginning: 01-01-09 Ending: 12-31-09

**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

29 Skilled 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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,572	1,499	2,903	6,974	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	8,584	809	0	9,393	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,156	2,308	2,903	16,367	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.60%

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 01/01/1973

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 2,903

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name &amp; ID Number

Twin Willows Nursing Center

# 0014753

Report Period Beginning:

01-01-09

Ending:

12-31-09

## 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
	<b>A. General Services</b>										
1	Dietary	144,560	13,805	4,519	162,884		162,884		162,884		1
2	Food Purchase		148,873		148,873		148,873	(6,853)	142,020		2
3	Housekeeping	48,488	9,838		58,326		58,326		58,326		3
4	Laundry	24,504	4,106		28,610		28,610		28,610		4
5	Heat and Other Utilities			78,356	78,356		78,356	(2,428)	75,928		5
6	Maintenance	29,453	13,663	29,526	72,642		72,642		72,642		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	247,005	190,285	112,401	549,691		549,691	(9,281)	540,410		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	770,973	76,695	2,800	850,468		850,468	(173)	850,295		10
10a	Therapy										10a
11	Activities	39,691	6,382		46,073		46,073		46,073		11
12	Social Services	13,618		2,455	16,073		16,073		16,073		12
13	CNA Training										13
14	Program Transportation		858		858		858		858		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	824,282	83,935	7,655	915,872		915,872	(173)	915,699		16
	<b>C. General Administration</b>										
17	Administrative	66,480			66,480		66,480		66,480		17
18	Directors Fees										18
19	Professional Services			5,848	5,848		5,848	(3,229)	2,619		19
20	Dues, Fees, Subscriptions & Promotions			20,415	20,415		20,415	(15,099)	5,316		20
21	Clerical & General Office Expenses		11,104	3,141	14,245		14,245		14,245		21
22	Employee Benefits & Payroll Taxes			207,496	207,496		207,496		207,496		22
23	Inservice Training & Education			471	471		471		471		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			57,670	57,670		57,670		57,670		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	66,480	11,104	295,041	372,625		372,625	(18,328)	354,297		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,137,767	285,324	415,097	1,838,188		1,838,188	(27,782)	1,810,406		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 &amp; ID Number

Twin Willows Nursing Center

#0014753

Report Period Beginning:

01-01-09

Ending:

12-31-09

## 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	
	<b>D. Ownership</b>											
30	Depreciation			28,894	28,894		28,894		28,894			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,201	2,201		2,201	(2,201)				32
33	Real Estate Taxes			40,256	40,256		40,256		40,256			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>			72,551	72,551		72,551	(2,201)	70,350			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation		207		207		207		207			38
39	Ancillary Service Centers		122,097	309,585	431,682		431,682		431,682			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		6,781		6,781		6,781		6,781			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>		129,085	350,100	479,185		479,185		479,185			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,137,767	414,409	837,748	2,389,924		2,389,924	(29,983)	2,359,941			45

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

Facility Name & ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning:

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Ending:

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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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	6,619	2-7		4
5	Telephone, TV & Radio in Resident Rooms	2,428	5-7		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	173	10-7		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	2,201	32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	234	2-7		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				20
21	Owner or Key-Man Insurance	3,229	19-7		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	9,088	20-7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	6,011	20-7		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 29,983		\$	30

BHF USE ONLY							
48		49		50		51	
							52

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	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
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 29,983		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.**

		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Twin Willows Nursing Center

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning:

01-01-09

Ending:

12-31-09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>8</b>											
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>16</b>											
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>28</b>											
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>0</b>	<b>29</b>											

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Twin Willows Nursing Center# 0014753

Report Period Beginning:

01-01-09

Ending:

12-31-09

## 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)
	<b>D. Ownership</b>												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	0	0	0	0	0	0	0	0	0	0	0	0 37
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0 44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0 45

Facility Name & ID Number Twin Willows Nursing Center

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Report Period Beginning: 01-01-09 Ending: 12-31-09

**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		Motel Developments, Inc.	Salem, IL	Motel
Jeffrey Woodruff	5%	N/A		Woodruff Management	Carbondale, IL	HVAC, Equip & Repair, Background Checks

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	Rent	\$ 1,200	Motel Developments, Inc.	100.00%	\$ 1,200	\$ 0	1	
2	V	Background Checks	570	Woodruff Management	100.00%	570	0	2	
3	V	Air Conditioners	2,131	Woodruff Management	100.00%	2,131	0	3	
4	V							4	
5	V							5	
6	V							6	
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 3,901			\$ 3,901	\$ *	0	14

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

Facility Name &amp; ID Number

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Report Period Beginning:

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Ending:

12-31-09

## VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1								\$		1	
2	Todd Woodruff	Administrator	Management	0.00	0	60	100.00	Wages	60,670	17-1	2
3	Helen Woodruff	Audit Acctg	Accounting	0.95	0	15	30.00	Fees	2,164	19-3	3
4	Deborah Woodruff	Attorney	Legal Services	0.00	0	N/A		Fees	3,229	19-3	4
5	Deborah Woodruff	Admin. Asst.	Acctg/Clerical	0.00	0	3	1.00	Wages	5,810	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 71,873		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

Facility Name & ID Number Twin Willows Nursing Center

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01-01-09

Ending:

12-31-09

**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	Purchase Facility	n/a	11/2/72	\$ 5,150	\$ 5,150	12/31/84	10.0000	\$ 515	1							
2												2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Guardian Insurance	X		Working Capital	n/a	11/28/09	54,051	54,051	11/28/10	7.4000	402	6							
7	Finance Charges	X		Insurance Policy	n/a	05/02/09	39,833	9,234	1/30/10	10.2400	1,719	7							
8	Finance Charges	X		Account Payable	n/a						80	8							
9	TOTAL Facility Related						\$ 99,034	\$ 68,435			\$ 2,716	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 99,034	\$ 68,435			\$ 2,716	15							

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

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

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

**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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>36,254</b>	<b>1</b>
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.)		\$	<b>38,884</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>2,630</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>37,626</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>40,256</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>26,513</b>	<b>8</b>
	2005	<b>27,380</b>	<b>9</b>
	2006	<b>28,396</b>	<b>10</b>
	2007	<b>36,985</b>	<b>11</b>
	2008	<b>38,884</b>	<b>12</b>

**Actual tx bill for 09 pd in 10 37,626.00**

	<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

Facility Name & ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning:

01-01-09

Ending:

12-31-09

**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 windows	2009	\$ 5,989	\$ 27	39	\$ 27	\$	\$ 27	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)		\$ 522,324	\$ 6,389		\$ 6,389	\$	\$ 486,735	70

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2008 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Twin Willows Nursing Center COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0014753

CONTACT PERSON REGARDING THIS REPORT Todd C. Woodruff

TELEPHONE 618-548-0842 FAX #: 618-548-5893

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

Enter the tax index number and real estate tax assessed for 2008 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2008.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>11-02-000-027</u>	<u>Pt. SE NE</u>	<u>\$ 38,884.10</u>	<u>\$ 38,884.10</u>
2.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
3.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
4.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
5.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
6.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
7.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
8.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
9.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
10.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
		<b>TOTALS</b>	<u>\$ 38,884.10</u>	<u>\$ 38,884.10</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning:

01-01-09

Ending:

12-31-09

**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).

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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		87,000	1973	\$ 28,000	1
2					2
3	TOTALS	87,000		\$ 28,000	3

Facility Name &amp; ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning:

01-01-09

Ending:

12-31-09

**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	83		1973	1966	\$ 380,183	\$	33.33	\$	\$	\$ 380,183	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11	water heater		1977		1,024		10			1,024	11
12	fire exit lights		1978		695		5			695	12
13	emergency power		1978		1,695		5			1,695	13
14	emergency power		1979		1,359		5			1,395	14
15	compressor		1979		372		5			372	15
16	battery units		1980		570		5			570	16
17	compressor		1980		533		3			533	17
18	mixing valve		1981		780		10			780	18
19	central air		1982		771		10			771	19
20	disposal		1982		745		10			745	20
21	storage shed		1983		600		8			600	21
22	3 heat pumps		1983		2,245		10			2,245	22
23	phone system		1985		3,318		20			3,318	23
24	2 heat pumps		1985		1,400		8			1,400	24
25	driveway		1988		2,767		3			2,767	25
26	seal coat patch driveway		1997		1,850		3			1,850	26
27	door monitor system		1999		7,590	569	10	569		7,590	27
28	3 central air systems		1999		12,588		5			12,588	28
29	roof		1999		64,580	4,305	15	4,305		43,409	29
30	asphalt top coat driveway		1999		16,136		8			16,136	30
31	outside walkway lights		1999		600		5			600	31
32	south wing sewer line		2000		1,046	105	10	105		1,006	32
33	3 outside hydrants		2000		525	52	10	52		472	33
34	asphalt sidewalks-wings		2005		6,270	784	8	784		3,207	34
35	asphalt driveway -north		2008		3,358	420	8	420		630	35
36	sewer line- north		2009		2,735	127	10	127		127	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 Twin Willows Nursing Center

# 0014753

Report Period Beginning:

01-01-09

Ending:

12-31-09

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	\$ 115,988	\$ 14,753	\$ 14,753	\$		\$ 65,668	71
72	Current Year Purchases	8,820	507	507		7	507	72
73	Fully Depreciated Assets	186,144	1,342	1,342			186,144	73
74								74
75	TOTALS	\$ 310,952	\$ 16,602	\$ 16,602	\$		\$ 252,319	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		2007 Chevy Intervan	2006	\$ 41,318	\$ 5,903	\$ 5,903	\$		\$ 17,754	76
77										77
78										78
79										79
80	TOTALS			\$ 41,318	\$ 5,903	\$ 5,903	\$		\$ 17,754	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)	\$ 902,594	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,894	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,894	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)	\$ 756,883	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		\$ 10,000	\$	\$ 10,000	86
87		56,000		56,000	87
88		12,307		12,307	88
89		6,119	285	4,461	89
90					90
91	TOTALS	\$ 84,426	\$ 285	\$ 82,768	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning:

01-01-09

Ending: 12-31-09

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Motel Developments, Inc.

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:				\$ 1,200			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ 1,200			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					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 01/01/09

Ending 12/31/09

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

Fiscal Year Ending Annual Rent

12. /2010 \$ \_\_\_\_\_

13. /2011 \$ \_\_\_\_\_

14. /2012 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</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	1 Schedule V Line & Column Reference	2 Staff		4 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	39-3	hrs	\$	6,924	\$ 134,312	\$	6,924	\$ 134,312	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		971	38,847		971	38,847	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		7,097	136,426		7,097	136,426	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				109,987		109,987	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab</u>	39-2					10,572		10,572	12
13	Other (specify): <u>X-Ray</u>	39-2					1,538		1,538	13
14	<b>TOTAL</b>			\$	14,992	\$ 309,585	\$ 122,097	14,992	\$ 431,682	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 &amp; ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning: 01-01-09

Ending:

12-31-09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-09

(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	\$ 62,370	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,354,879		3
4	Supply Inventory (priced at )	13,700		4
5	Short-Term Investments	5,135		5
6	Prepaid Insurance	9,004		6
7	Other Prepaid Expenses	995		7
8	Accounts Receivable (owners or related parties)	41,509		8
9	Other(specify): <u>Fed/State Taxes</u>	84,440		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,572,032	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,000		13
14	Buildings, at Historical Cost	439,541		14
15	Leasehold Improvements, at Historical Cost	103,801		15
16	Equipment, at Historical Cost	415,678		16
17	Accumulated Depreciation (book methods)	(839,576)		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</b> (sum of lines 11 thru 23)	\$ 151,444	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,723,476	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 219,578	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	105,051		29
30	Accrued Salaries Payable	29,509		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,484		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,546		32
33	Accrued Interest Payable	402		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</b> (sum of lines 26 thru 37)	\$ 397,570	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	14,730		39
40	Mortgage Payable			40
41	Bonds Payable	5,150		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Stock</u>	3,500		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 23,380	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 420,950	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,302,526	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,723,476	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,223,775</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>1,223,775</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>97,039</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>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>97,039</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Non Deductibles</b>	<b>(18,288)</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>(18,288)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,302,526</b>	<b>24</b> *

\* 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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,590,909	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,590,909	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		11
12	Gift and Coffee Shop	5,460	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,619	14
15	Telephone, Television and Radio	1,692	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	173	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	224	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 14,168	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	965	24
25	Interest and Other Investment Income***	15,313	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 16,278	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Lawn Care</u>	200	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 200	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,621,555	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	540,410	31
32	Health Care	915,699	32
33	General Administration	354,297	33
<b>B. Capital Expense</b>			
34	Ownership	70,350	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	438,670	35
36	Provider Participation Fee	40,515	36
<b>D. Other Expenses (specify):</b>			
37	<u>s</u>	119,627	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,479,568	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	141,987	41
42	<b>Income Taxes</b>	(44,948)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 97,039	43

\* 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 **Twin Willows Nursing Center**

# **0014753**

Report Period Beginning:

**01-01-09**

Ending:

**12-31-09**

**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	1,912	2,144	\$ 61,478	\$ 28.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,654	10,137	204,370	20.16	3
4	Licensed Practical Nurses	8,580	9,020	145,830	16.17	4
5	CNAs & Orderlies	37,877	39,185	338,387	8.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,224	1,470	13,798	9.39	9
10	Activity Assistants	2,764	3,104	25,893	8.34	10
11	Social Service Workers	1,252	1,439	13,618	9.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,961	2,029	25,951	12.79	14
15	Cook Helpers/Assistants	8,320	8,653	70,430	8.14	15
16	Dishwashers	5,516	5,893	48,179	8.18	16
17	Maintenance Workers	1,625	2,091	29,453	14.09	17
18	Housekeepers	5,707	5,842	48,488	8.30	18
19	Laundry	2,740	2,866	24,504	8.55	19
20	Administrator	2,500	2,774	60,670	21.87	20
21	Assistant Administrator					21
22	Other Administrative	386	386	5,810	15.05	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	1,920	1,958	20,908	10.68	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	93,938	98,991	\$ 1,137,767 *	\$ 11.49	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	\$ 4,519	1-3	35
36	Medical Director	12	2,400	9-3	36
37	Medical Records Consultant	28	1,000	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,800	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				44
45	Social Service Consultant	39	2,455	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	223	\$ 12,174		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

**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	\$ 60,670	Workers' Compensation Insurance	\$ 101,509	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	15,927	Advertising: Employee Recruitment	640	
				FICA Taxes	87,039	Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed <u>18</u> )	180	
				Employee Meals		Patient Background Checks <u>39</u>	390	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Cert State	100	
				Christmas Recognition	3,021	MES	26	
						IHCA	2,910	
						MHCA	75	
						Advertising	15,099	
						Less: Public Relations Expense	(9,088)	
						Non-allowable advertising	( )	
						Yellow page advertising	(6,011)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
			\$ 60,670		\$ 207,496		\$ 5,316	
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
Deborah Woodruff			\$ 5,810				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
			\$ 5,810					\$
C. Professional Services								
Vendor/Payee	Type	Amount						
Helen Woodruff	Accounting	\$ 2,164						
Deborah Woodruff	Legal Fees	3,229						
H&R Block	Tax Return	455						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
			\$ 5,848					

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Twin Willows Nursing Center

# 0014753

Report Period Beginning: 01-01-09

Ending:

12-31-09

**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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
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18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? N
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA 2910
- (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? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,888 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,135
- (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. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 90
  - 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.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, 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.