

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	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	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	30	Intermediate (ICF)	30	10,950	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	37,960	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
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	778	298	1,703	2,779	8
9	SNF/PED					9
10	ICF	18,957	1,942	3,970	24,869	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,735	2,240	5,673	27,648	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.83%

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

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

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

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

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 10/01/1995

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/1995 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 13 and days of care provided 1,693

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	178,832	18,967	8,206	206,005		206,005		206,005		1
2	Food Purchase		134,270		134,270		134,270	(109)	134,161		2
3	Housekeeping	108,321	25,999		134,320		134,320		134,320		3
4	Laundry	81,459	16,374	512	98,345		98,345		98,345		4
5	Heat and Other Utilities			95,996	95,996		95,996		95,996		5
6	Maintenance	62,858	26,856	56,966	146,680		146,680	(8,129)	138,551		6
7	Other (specify):*										7
8	TOTAL General Services	431,470	222,466	161,680	815,616		815,616	(8,238)	807,378		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	886,839	5,517	6,779	899,135		899,135	(80)	899,055		10
10a	Therapy			1,088	1,088		1,088		1,088		10a
11	Activities	43,949	3,082	2,478	49,509		49,509		49,509		11
12	Social Services	31,039			31,039		31,039		31,039		12
13	CNA Training										13
14	Program Transportation			2,876	2,876		2,876		2,876		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	961,827	8,599	25,221	995,647		995,647	(80)	995,567		16
	C. General Administration										
17	Administrative	151,006			151,006		151,006	5,460	156,466		17
18	Directors Fees										18
19	Professional Services			193,951	193,951		193,951	(116,176)	77,775		19
20	Dues, Fees, Subscriptions & Promotions			25,063	25,063		25,063	(2,172)	22,891		20
21	Clerical & General Office Expenses	106,509	11,851	147,999	266,359		266,359	(57,685)	208,674		21
22	Employee Benefits & Payroll Taxes			437,722	437,722		437,722		437,722		22
23	Inservice Training & Education										23
24	Travel and Seminar			608	608		608	30	638		24
25	Other Admin. Staff Transportation			641	641		641	1,630	2,271		25
26	Insurance-Prop.Liab.Malpractice			111,861	111,861		111,861	361	112,222		26
27	Other (specify):*							11,056	11,056		27
28	TOTAL General Administration	257,515	11,851	917,845	1,187,211		1,187,211	(157,496)	1,029,715		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,650,812	242,916	1,104,746	2,998,474		2,998,474	(165,814)	2,832,660		29

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent. #0041210 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			37,141	37,141		37,141	133,733	170,874			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,484	2,484		2,484	154,816	157,300			32
33	Real Estate Taxes			66,000	66,000		66,000		66,000			33
34	Rent-Facility & Grounds			266,202	266,202		266,202	(242,786)	23,416			34
35	Rent-Equipment & Vehicles			17,695	17,695		17,695	(1,595)	16,100			35
36	Other (specify):*											36
37	TOTAL Ownership			389,522	389,522		389,522	44,168	433,690			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		169,211	218,818	388,029		388,029		388,029			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			214,426	214,426		214,426		214,426			42
43	Other (specify):*	80,698		144,000	224,698		224,698	(224,698)				43
44	TOTAL Special Cost Centers	80,698	169,211	577,244	827,153		827,153	(224,698)	602,455			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,731,510	412,127	2,071,512	4,215,149		4,215,149	(346,344)	3,868,805			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 Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

VI. ADJUSTMENT DETAIL

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

		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				4
5	Telephone, TV & Radio in Resident Rooms	(15,003)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	90,115	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(109)	02		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	(9,057)	21		18
19	Entertainment	(352)	21		19
20	Contributions	(2,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,032)	21		24
25	Fund Raising, Advertising and Promotional	(335)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(236)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(286,243)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (284,252)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(62,092)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (62,092)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (346,344)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Elmwood Nursing & Rehab Cent.

ID# 0041210

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salaries	\$ (80,698)	43	1
2	Misc. Income	(15,020)	21	2
3	Medical Records	(40)	10	3
4	RFMS Petty Cash Clearing Acct	(492)	21	4
5	Resident Lost Items	(40)	10	5
6	Sequestration Expense	(15,331)	21	6
7	Bank Service Charges	(2,756)	21	7
8	Collection Fees	(1,665)	21	8
9	Late Fees	(18,741)	21	9
10	Building Co. - Amortization	(10,586)	31	10
11	Building Co. - Bank Charges	(496)	21	11
12	Building Co. - Legal Fees	(975)	19	12
13	Non-Allowable Expense	(144,000)	43	13
14	Additional R&M	5,174	06	14
15	Promotions Expense	(229)	20	15
16	Non-Allowable Legal	(347)	19	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	(286,243)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Nursing & Rehab Cent.# 0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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													1
2	Food Purchase	(109)											(109)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(9,829)		1,700									(8,129)	6
7	Other (specify):*													7
8	TOTAL General Services	(9,938)		1,700									(8,238)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(80)											(80)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(80)											(80)	16
	C. General Administration													
17	Administrative			5,460									5,460	17
18	Directors Fees													18
19	Professional Services	(1,322)	975	(115,829)									(116,176)	19
20	Fees, Subscriptions & Promotions	(2,564)		392									(2,172)	20
21	Clerical & General Office Expenses	(125,179)	496	66,998									(57,685)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			30									30	24
25	Other Admin. Staff Transportation			1,630									1,630	25
26	Insurance-Prop.Liab.Malpractice			361									361	26
27	Other (specify):*			11,056									11,056	27
28	TOTAL General Administration	(129,065)	1,471	(29,902)									(157,496)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(139,083)	1,471	(28,202)									(165,814)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Nursing & Rehab Cent.# 0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	90,115	43,560	58									133,733	30
31	Amortization of Pre-Op. & Org.	(10,586)	10,586											31
32	Interest		154,240	576									154,816	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(252,302)	9,516									(242,786)	34
35	Rent-Equipment & Vehicles			(1,595)									(1,595)	35
36	Other (specify):*													36
37	TOTAL Ownership	79,529	(43,916)	8,555									44,168	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(224,698)											(224,698)	43
44	TOTAL Special Cost Centers	(224,698)											(224,698)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(284,252)	(42,445)	(19,647)									(346,344)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 252,302	Maryville Health Properties, LLC	100.00%	\$	(252,302)	1
2	V	31 Amort. Of Loan Costs		Maryville Health Properties, LLC	100.00%	10,586	10,586	2
3	V	21 Bank Charges		Maryville Health Properties, LLC	100.00%	496	496	3
4	V	30 Depreciation		Maryville Health Properties, LLC	100.00%	43,560	43,560	4
5	V	32 Interest Expense		Maryville Health Properties, LLC	100.00%	154,240	154,240	5
6	V	19 Legal Fees		Maryville Health Properties, LLC	100.00%	975	975	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 252,302			\$ 209,857	\$ * (42,445)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 REPAIRS & MAINTENANCE	\$	HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	\$ 1,700	\$	1,700	15
16	V	19 PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,802		1,802	16
17	V	20 DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	392		392	17
18	V	21 CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	4,625		4,625	18
19	V	24 SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	30		30	19
20	V	25 TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,630		1,630	20
21	V	26 INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	361		361	21
22	V	30 DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	58		58	22
23	V	32 INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	576		576	23
24	V	34 OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	9,516		9,516	24
25	V	35 AUTO RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,187		1,187	25
26	V	35 EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	(2,782)		(2,782)	26
27	V	21 CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	62,373		62,373	27
28	V	27 EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	10,503		10,503	28
29	V	17 ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	5,460		5,460	29
30	V	27 EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	553		553	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V	19 BOOKEEPING SERVICES	117,631					(117,631)	38
39	Total		\$ 117,631			\$ 97,984	\$ *	(19,647)	39

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/15

Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 Office Space	\$ 13,000	MS HEALTHCARE ACCOUNTING		\$ 13,000	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 13,000			\$ 13,000	\$ *	39

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/15

Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 THERAPY	\$ 216,897	TOWN AND COUNTRY REHAB., LLC	100.00%	\$ 216,897	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 216,897			\$ 216,897	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/15

Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1	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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Elmwood Nursing & Rehab Cent.

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Report Period Beginning:

01/01/15

Ending:

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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	Mark Suissa	Owner	Administrative	42.31%	See Attached	4.10	6.83%	Alloc. Salary	\$ 5,460	17-7	1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 5,460		13	

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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 Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization HEALTHCARE ACCOUNTING SERVICES, LI
 Street Address 1401 S. BRENTWOOD BOULEVARD
 City / State / Zip Code BRENTWOOD, MO. 63144
 Phone Number (314) 963-7570
 Fax Number (314) 963-9030

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	6	REPAIRS & MAINTENANCE	ILL, CT & MO. PAT. DAYS	405,004	7	\$ 24,913	\$ 27,643	\$ 1,700	1	
2	19	PROFESSIONAL FEES	ILL, CT & MO. PAT. DAYS	405,004	7	26,402	27,643	1,802	2	
3	20	DUES, SUBSCRIPTIONS	ILL, CT & MO. PAT. DAYS	405,004	7	5,742	27,643	392	3	
4	21	CLERICAL & GENERAL	ILL, CT & MO. PAT. DAYS	405,004	7	67,763	27,643	4,625	4	
5	24	SEMINAR	ILL, CT & MO. PAT. DAYS	405,004	7	445	27,643	30	5	
6	25	TRAVEL	ILL, CT & MO. PAT. DAYS	405,004	7	23,886	27,643	1,630	6	
7	26	INSURANCE	ILL, CT & MO. PAT. DAYS	405,004	7	5,293	27,643	361	7	
8	30	DEPRECIATION	ILL, CT & MO. PAT. DAYS	405,004	7	853	27,643	58	8	
9	32	INTEREST	ILL, CT & MO. PAT. DAYS	405,004	7	8,445	27,643	576	9	
10	34	OFFICE SPACE	ILL, CT & MO. PAT. DAYS	405,004	7	139,418	27,643	9,516	10	
11	35	AUTO RENTAL	ILL, CT & MO. PAT. DAYS	405,004	7	17,387	27,643	1,187	11	
12	35	EQUIPMENT RENTAL	ILL, CT & MO. PAT. DAYS	405,004	7	(40,754)	27,643	(2,782)	12	
13	21	CLERICAL SALARIES	ILL, CT & MO. PAT. DAYS	405,004	7	913,845	913,845	27,643	62,373	13
14	27	EMP. BEN. GEN. & ADMIN.	ILL, CT & MO. PAT. DAYS	405,004	7	153,881	27,643	10,503	14	
15	17	ADMIN. SALARY - M. SUISSA	ILL, CT & MO. PAT. DAYS	405,004	7	80,000	80,000	27,643	5,460	15
16	27	EMP. BEN.-M. SUISSA	ILL, CT & MO. PAT. DAYS	405,004	7	8,105	27,643	553	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,435,624	\$ 993,845	\$ 97,984	25	

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

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Report Period Beginning:

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Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization MS HEALTHCARE ACCOUNTING
 Street Address 3535 WEST GLENLAKE
 City / State / Zip Code CHICAGO, IL 60659
 Phone Number (917) 744-8688
 Fax Number ()

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.

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	34	Office Space	DIRECT		\$	\$		\$ 13,000	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				\$	\$		\$ 13,000	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

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Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization TOWN AND COUNTRY REHAB., LLC
 Street Address 13190 S. OUTER FORTY ROAD
 City / State / Zip Code CHESTERFIELD, MO 63017-5917
 Phone Number (314) 434-3330
 Fax Number (314) 434-9179

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	39	THERAPY	DIRECT		\$	\$		\$ 216,897	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				\$	\$		\$ 216,897	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

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Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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 Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

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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 Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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 Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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 Elmwood Nursing & Rehab Cent.

0041210 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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 Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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

Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bank Leumi		X	Mortgage	\$21,025.14	10/01/09	\$ 2,779,795	\$ 2,295,393		\$ 154,293	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	Onmicare		X	Note Payable	\$739.47	7/20/14	17,747	4,363	6/20/2016	5.5000	513	6								
7	Select Rehabilitation		X	Note Payable				20,000				7								
8	See Supplemental Schedule							4,864			2,493	8								
9	TOTAL Facility Related				\$21,764.61		\$ 2,797,542	\$ 2,324,620			\$ 157,300	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 2,797,542	\$ 2,324,620			\$ 157,300	15								

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5										5									
6										6									
7	TOTAL Long-Term									7									
Working Capital																			
8	CGS Administrators		X							1,917									
9	Twin Med		X	Note Payable			4,864												
10	Alloc. from Healthcare Acct		X							576									
11										11									
12										12									
13										13									
14	TOTAL Working Capital						4,864			2,493									
B. Non-Facility Related*																			
15										15									
16										16									
17										17									
18										18									
19										19									
20	TOTAL Non-Facility Related									20									

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2014 report.		\$	64,196	1															
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	67,341	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	3,145	3															
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	62,855	4															
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	66,000	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>63,570</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>63,651</u>	9																
	2012	<u>63,923</u>	10																
	2013	<u>66,304</u>	11																
	2014	<u>67,341</u>	12																
2015 Accrual = \$67,341 x 0.93 = \$62,627 (Rounding)																			

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,695 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

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).

None

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>1955</u>	<u>\$ 184,895</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 184,895	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	104	1995	1972	\$ 1,698,088	\$ 43,560	35	\$ 48,517	\$ 4,957	\$ 977,493	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1996	43,296		20	2,165	2,165	44,301	9
10	Various		1997	46,441		20	2,322	2,322	43,863	10
11	Various		1998	46,036		20	2,302	2,302	40,385	11
12	Various		1999	14,188		20	709	709	11,580	12
13	Various		2000	41,832		20	2,092	2,092	32,734	13
14	Various		2001	4,916		20	246	246	3,483	14
15	Various		2002	8,317		20	150	150	7,373	15
16	Various		2003	30,929		20	270	270	30,209	16
17	Various		2004	35,139		20	55	55	34,820	17
18	Various		2005	20,712		20	618	618	19,840	18
19	Various		2006	87,017		20	2,208	2,208	55,216	19
20	Various		2007	103,010		20	5,151	5,151	45,496	20
21	Various		2008	334,237		20	33,424	33,424	239,113	21
22	Various		2009	78,715		20	7,872	7,872	53,651	22
23	Various		2010	5,555		20	564	564	5,555	23
24	Various		2011	62,847		20	6,191	6,191	28,148	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	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					37,141		(37,141)	69
70		\$ 2,661,274	\$ 80,701		\$ 114,855	\$ 34,154	\$ 1,673,260	70

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.# 0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,661,274	\$ 80,701		\$ 114,855	\$ 34,154	\$ 1,673,260	1
2	New Heat Pump	2012	21,934		20	2,193	2,193	7,860	2
3	Electrical Panels & Wiring	2012	35,000		20	3,500	3,500	13,708	3
4	Replace Water Main	2012	7,743		20	774	774	3,033	4
5	Roof	2012	22,500		20	2,250	2,250	8,250	5
6	New Heat Pumps	2012	16,761		20	1,676	1,676	6,146	6
7	32 Windows, Insulation & Screens	2012	9,540		20	954	954	3,260	7
8	Privacy Curtains	2012	6,354		20	1,271	1,271	4,130	8
9	Replace 8 Feet Of Water Main	2012	3,452		20	345	345	1,093	9
10	Replace Flooring In Hallway Areas	2012	3,100		20	310	310	982	10
11	Install Tile In Front Of Entrance	2012	7,584		20	758	758	2,465	11
12	Repair Water Main Leak, Boiler Pipe-Basement, Tunnel	2012	13,177		20	659	659	2,635	12
13	Repair Water Main Breaks In Tunner	2012	2,985		20	149	149	510	13
14	Electric Panels	2013	3,080		20	308	308	924	14
15	New Water Lines For Recirculation	2013	4,270		20	427	427	1,281	15
16	Drapes For Common Areas	2013	4,165		20	416	416	1,215	16
17	Replaced Main Sewer Line To Building	2013	6,990		20	699	699	1,981	17
18	Electrical Work On Generator, Back Up Panels	2013	4,000		20	571	571	1,571	18
19	10 Heating/Cooling Systems	2013	28,473		20	2,373	2,373	6,130	19
20	Sprinkler System	2013	108,096		20	10,810	10,810	31,528	20
21	Flooring For Main Entrance And Dining.	2013	16,100		20	1,610	1,610	4,293	21
22	Rewired Electrical Panels	2013	6,000		20	600	600	1,500	22
23	Replaced Water And Gas Lines In Tunnel	2013	7,665		20	767	767	1,661	23
24	Repair 5 Water Line Leaks	2013	2,555		20	128	128	330	24
25	Shed Installation	2015	3,706		20	123	123	123	25
26	Replace Sewer Pipe, Jack Hammer Concrete Wall And Fix Water	2015	7,600		20	253	253	253	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,014,104	\$ 80,701		\$ 148,781	\$ 68,080	\$ 1,780,121	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,014,104	\$ 80,701		\$ 148,781	\$ 68,080	\$ 1,780,121	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	TOTAL (lines 1 thru 33)	\$ 3,014,104	\$ 80,701		\$ 148,781	\$ 68,080	\$ 1,780,121	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 3,014,104	\$ 80,701		\$ 148,781	\$ 68,080	\$ 1,780,121
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
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18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 3,014,104	\$ 80,701		\$ 148,781	\$ 68,080	\$ 1,780,121

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

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Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,014,104	\$ 80,701		\$ 148,781	\$ 68,080	\$ 1,780,121	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	TOTAL (lines 1 thru 33)	\$ 3,014,104	\$ 80,701		\$ 148,781	\$ 68,080	\$ 1,780,121	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 175,394	\$ 58	\$ 18,579	\$ 18,521	10	\$ 127,336	71
72	Current Year Purchases	24,579		3,455	3,455	10	3,455	72
73	Fully Depreciated Assets	396,836		59	59	10	396,836	73
74								74
75	TOTALS	\$ 596,809	\$ 58	\$ 22,093	\$ 22,035		\$ 527,627	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$			\$	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)	\$ 3,795,808	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,759	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 170,874	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 90,115	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,307,748	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/15

Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5	Storage Unit			900			5
6	Alloc. from Healthcare Accounting Serv./MS Healthcare Accounting			22,516			6
7	TOTAL			\$ 23,416			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: \$ 14,913

Description: See Attached Schedule

(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	Allocated from H.A.S		\$	\$ 1,187	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,187	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Staff		Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	84,961	\$			\$	84,961	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				77,427					77,427	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs				54,508					54,508	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39 - 02	# of prescripts						84,371			84,371	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):												12
13	Other (specify): <u>See Supplemental</u>						1,922		84,840			86,762	13
14	TOTAL			\$			218,818	\$	169,211			\$ 388,029	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 **Elmwood Nursing & Rehab Cent.**# **0041210**Report Period Beginning: **01/01/15**

Ending:

12/31/15**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/15**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 8,536	\$ 32,073	1
2	Cash-Patient Deposits	27,882	27,882	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,160,944	1,160,944	3
4	Supply Inventory (priced at)	7,771	7,771	4
5	Short-Term Investments			5
6	Prepaid Insurance	10,901	10,901	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	231,485	252,510	8
9	Other(specify):	60	60	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,447,579	\$ 1,492,141	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		184,895	13
14	Buildings, at Historical Cost		1,698,088	14
15	Leasehold Improvements, at Historical Cost	1,058,979	1,058,979	15
16	Equipment, at Historical Cost	583,385	791,385	16
17	Accumulated Depreciation (book methods)	(795,069)	(1,882,974)	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):		(10,586)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 847,295	\$ 1,839,787	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,294,874	\$ 3,331,928	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 184,138	\$ 184,139	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,836	24,836	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,037	191,037	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,683	9,683	31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,855	62,855	32
33	Accrued Interest Payable		26,297	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	651,914	651,914	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,124,463	\$ 1,150,761	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	29,227	29,227	39
40	Mortgage Payable		2,295,393	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule	2,726,122	2,029,875	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,755,349	\$ 4,354,495	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,879,812	\$ 5,505,256	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,584,938)	\$ (2,173,328)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,294,874	\$ 3,331,928	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,022,250)	1
2	Restatements (describe):		2
3	<u>Bad Debt</u>	(51,656)	3
4	<u>Prior year income</u>	2,095	4
5	<u>Rounding</u>	8	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,071,803)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	486,865	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 486,865	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,584,938)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,516,862	1
2	Discounts and Allowances for all Levels	(325,836)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,191,026	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	427,048	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 427,048	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	64,397	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,008	19
20	Radiology and X-Ray	475	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 68,880	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	15,060	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,060	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,702,014	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	815,616	31
32	Health Care	995,647	32
33	General Administration	1,187,211	33
B. Capital Expense			
34	Ownership	389,522	34
C. Ancillary Expense			
35	Special Cost Centers	612,727	35
36	Provider Participation Fee	214,426	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,215,149	40
41	Income before Income Taxes (line 30 minus line 40)**	486,865	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 486,865	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,234,122	44
45	Private Pay - Net Inpatient Revenue	344,708	45
46	Medicare - Net Inpatient Revenue	422,772	46
47	Other-(specify) Hospice	57,550	47
48	Other-(specify) Insurance	131,874	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,191,026	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 **Elmwood Nursing & Rehab Cent.**

0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,928	2,080	\$ 74,840	\$ 35.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,566	4,758	95,818	20.14	3
4	Licensed Practical Nurses	13,363	14,098	249,485	17.70	4
5	CNAs & Orderlies	45,579	47,112	466,696	9.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,810	4,172	43,949	10.53	10
11	Social Service Workers	1,988	2,151	31,039	14.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,098	18,233	178,832	9.81	15
16	Dishwashers					16
17	Maintenance Workers	3,628	3,980	62,858	15.79	17
18	Housekeepers	10,306	10,894	108,321	9.94	18
19	Laundry	8,813	9,283	81,459	8.78	19
20	Administrator	2,000	2,272	151,006	66.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,543	6,143	106,509	17.34	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,952	2,120	80,697	38.06	33
34	TOTAL (lines 1 - 33)	120,574	127,296	\$ 1,731,509 *	\$ 13.60	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	176	\$ 8,206	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	20	1,335	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	5,444	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	16	1,088	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	2,478	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	325	\$ 30,551		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/15

Ending:

12/31/15

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,995 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 214,426
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- 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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.