



Facility Name & ID Number Northwoods Care Centre

# 0051813 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	<u>113</u>	Skilled (SNF)	<u>113</u>	<u>41,245</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>113</u>	TOTALS	<u>113</u>	<u>41,245</u>	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	<u>18,490</u>	<u>8,462</u>	<u>8,843</u>	<u>35,795</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,490</u>	<u>8,462</u>	<u>8,843</u>	<u>35,795</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.79%

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

N/A (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

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 12/31/2011 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 113 and days of care provided 4,604

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	236,724	20,615	8,980	266,319		266,319	266,319		1	
2	Food Purchase		186,607		186,607		186,607	186,607		2	
3	Housekeeping	151,916	33,635		185,551		185,551	185,551		3	
4	Laundry	76,733	2,150	2,875	81,758		81,758	81,758		4	
5	Heat and Other Utilities			104,173	104,173		104,173	329	104,502	5	
6	Maintenance	47,644	1,121	75,150	123,915		123,915	3,549	127,464	6	
7	Other (specify):*							287	287	7	
8	<b>TOTAL General Services</b>	513,017	244,128	191,178	948,323		948,323	4,165	952,488	8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			25,900	25,900		25,900	25,900		9	
10	Nursing and Medical Records	1,977,811	108,255	23,270	2,109,336		2,109,336	38,711	2,148,047	10	
10a	Therapy									10a	
11	Activities	188,519		11,846	200,365		200,365	200,365		11	
12	Social Services	50,523		19,816	70,339		70,339	70,339		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):* <b>Mgmt. Co. Benefits</b>							7,710	7,710	15	
16	<b>TOTAL Health Care and Programs</b>	2,216,853	108,255	80,832	2,405,940		2,405,940	46,421	2,452,361	16	
	<b>C. General Administration</b>										
17	Administrative	145,071		378,964	524,035		524,035	(378,910)	145,125	17	
18	Directors Fees									18	
19	Professional Services			201,791	201,791		201,791	4,748	206,539	19	
20	Dues, Fees, Subscriptions & Promotions			36,274	36,274		36,274	(11,270)	25,004	20	
21	Clerical & General Office Expenses	56,144	14,129	43,129	113,402		113,402	154,381	267,783	21	
22	Employee Benefits & Payroll Taxes			596,134	596,134		596,134	596,134		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			3,642	3,642		3,642	5,903	9,545	24	
25	Other Admin. Staff Transportation			1,863	1,863		1,863	318	2,181	25	
26	Insurance-Prop.Liab.Malpractice			224,146	224,146		224,146	7,400	231,546	26	
27	Other (specify):*							28,291	28,291	27	
28	<b>TOTAL General Administration</b>	201,215	14,129	1,485,943	1,701,287		1,701,287	(189,139)	1,512,148	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,931,085	366,512	1,757,953	5,055,550		5,055,550	(138,553)	4,916,997	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

Northwoods Care Centre

#0051813

Report Period Beginning:

01/01/2015

Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			80,642	80,642	80,642	2,926	83,568				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,529	3,529	3,529	(1,664)	1,865				32
33	Real Estate Taxes			86,975	86,975	86,975	2,508	89,483				33
34	Rent-Facility & Grounds			908,736	908,736	908,736	(41,129)	867,607				34
35	Rent-Equipment & Vehicles			73,912	73,912	73,912	3,645	77,557				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,153,794	1,153,794	1,153,794	(33,714)	1,120,080				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			2,091	2,091	2,091		2,091				38
39	Ancillary Service Centers		129,531	963,049	1,092,580	1,092,580		1,092,580				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			251,197	251,197	251,197		251,197				42
43	Other (specify):* <b>Non-Allowable Co</b>			221,647	221,647	221,647	(221,647)					43
44	<b>TOTAL Special Cost Centers</b>		129,531	1,437,984	1,567,515	1,567,515	(221,647)	1,345,868				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,931,085	496,043	4,349,731	7,776,859	7,776,859	(393,914)	7,382,945				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 Northwoods Care Centre

# 0051813

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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				4
5	Telephone, TV & Radio in Resident Rooms	(21,615)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,742)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,023)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,444)	43		18
19	Entertainment				19
20	Contributions	(10,380)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(126,322)	43		24
25	Fund Raising, Advertising and Promotional	(7,921)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(85,533)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (259,980)</b>		<b>\$</b>	<b>30</b>

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)	(133,934)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (133,934)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (393,914)</b>		<b>37</b>

\*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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

Northwoods Care Centre

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Nonallowable marketing events	\$ (32,071)	43	1
2	Laboratory Costs	(8,270)	43	2
3	X-Ray Costs	(8,601)	43	3
4	Lobbying Expense Offset	(13,358)	20	4
5	Nonallowable Legal	(23,233)	19	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(85,533)	49

**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		\$	N/A		\$	\$	1
2	V							2
3	V							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	<b>Total</b>		\$			\$	\$ * 0	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	5 Utilities	\$	Symphony Financial Services, LLC	100.00%	\$ 252	\$	252	15
16	V	6 Maintenance		Symphony Financial Services, LLC	100.00%	1,809		1,809	16
17	V	10 Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	25,350		25,350	17
18	V	15 Other		Symphony Financial Services, LLC	100.00%	4,654		4,654	18
19	V	17 Administrative	318,770	Symphony Financial Services, LLC	100.00%			(318,770)	19
20	V	19 Professional Services-Other		Symphony Financial Services, LLC	100.00%	27,336		27,336	20
21	V	20 Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	584		584	21
22	V	21 Clerical & General Office Exp-Salaries		Symphony Financial Services, LLC	100.00%	120,968		120,968	22
23	V	24 Travel & Seminar		Symphony Financial Services, LLC	100.00%	5,055		5,055	23
24	V	26 Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	7,400		7,400	24
25	V	27 Other		Symphony Financial Services, LLC	100.00%	21,463		21,463	25
26	V	30 Depreciation		Symphony Financial Services, LLC	100.00%	2,335		2,335	26
27	V	34 Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(41,129)		(41,129)	27
28	V	35 Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	2,551		2,551	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		\$ 318,770			\$ 178,628	\$ *	(140,142)	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	5 Utilities	\$	Maestro Consulting Services	100.00%	\$ 77	\$	77	15
16	V	6 Maintenance Salaries		Maestro Consulting Services	100.00%	1,254		1,254	16
17	V	6 Maintenance Expenses		Maestro Consulting Services	100.00%	486		486	17
18	V	7 Employee Benefits - Maintenance		Maestro Consulting Services	100.00%	287		287	18
19	V	10 Clinical Salaries		Maestro Consulting Services	100.00%	13,361		13,361	19
20	V	15 Employee Benefits - Clinical		Maestro Consulting Services	100.00%	3,056		3,056	20
21	V	17 Administrative Salaries	60,194	Maestro Consulting Services	100.00%	54		(60,140)	21
22	V	19 Professional Fees		Maestro Consulting Services	100.00%	2,811		2,811	22
23	V	20 Dues, Fees, Subscriptions, etc.		Maestro Consulting Services	100.00%	1,504		1,504	23
24	V	21 Clerical & General Salaries		Maestro Consulting Services	100.00%	29,795		29,795	24
25	V	21 Clerical & General Expenses		Maestro Consulting Services	100.00%	3,618		3,618	25
26	V	24 Seminars And Education		Maestro Consulting Services	100.00%	848		848	26
27	V	2S Transportation		Maestro Consulting Services	100.00%	318		318	27
28	V	27 Employee Benefits - Administrative		Maestro Consulting Services	100.00%	6,828		6,828	28
29	V	30 Depreciation		Maestro Consulting Services	100.00%	591		591	29
30	V	32 Interest Expense		Maestro Consulting Services	100.00%	78		78	30
31	V	33 Real Estate Tax		Maestro Consulting Services	100.00%	342		342	31
32	V	35 Equipment Rental		Maestro Consulting Services	100.00%	783		783	32
33	V	35 Auto Lease		Maestro Consulting Services	100.00%	311		311	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 60,194			\$ 66,402	\$ *	6,208	39

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

Facility Name &amp; ID Number

Northwoods Care Centre

# 0051813

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony Decatur		Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid Aurora		Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony of Crestwood		Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony of Joliet		Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Crest Belvidere					5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony Lincoln					6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Co Decatur					7
8	Jack Hartman	3.00	Symphony Evanston Healthcare	Evanston				8
9	Joseph Hartman	3.00	Symphony of Dyer	Indiana				9
10	David J. Hartman	20.00	Symphony of Crown Point	Indiana				10
11	Jay Flatt	3.00			NuCare Services	Lincolnwood	Bookkeeping Mgmt	11
12	Gerry Jenich	10.00			7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00			Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Bronzeville Park	Chicago	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			California Gardens Corp.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Claremont Rehab. & Living	Buffalo Grove	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Claremont - Hanover Park	Hanover Park	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Claridge Imperial, LTD.	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Jackson Corp	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Monroe Pavillion	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Renaissance at 87th Street	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Renaissance at Midway	Chicago				22
23			Renaissance at South Shore	Chicago				23
24			Renaissance at Park South	Chicago	* No expense paid by h			24
25			Aria Post Acute Care	Hillside	entity, therefore no pa			25
26			Seven Oaks	Glendale, Wiscosin	** No expense of this r			26
27			Renaissance East	Mesa, Arizona	allocated to homes			27
28			Renaissance West	Mesa, Arizona				28
29			Renaissance Village IL	Mesa, Arizona				29
30			Renaissance Village AL	Mesa, Arizona				30

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	No owners receive compensation from this facility.										1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13							TOTAL	\$			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 Northwoods Care Centre

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Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Symphony Financial Services, LLC  
 Street Address 7257 N. Lincoln Ave,  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number ( 847) 933-2600  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Occupied Bed Days	372,277	11	\$ 3,116	\$ 30,057	\$ 252	1
2	6	Maintenance	Occupied Bed Days	372,277	11	22,405	30,057	1,809	2
3	10	Nursing & Med. Records Salary	Occupied Bed Days	372,277	11	313,972	313,972	25,350	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	372,277	11	57,644	30,057	4,654	4
5	19	Professional Service Legal	Occupied Bed Days	372,277	11	5,442	30,057	439	5
6	19	Professional Service Other	Occupied Bed Days	372,277	11	333,134	30,057	26,897	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	372,277	11	7,234	30,057	584	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	372,277	11	1,244,063	1,244,063	100,443	8
9	21	Clerical & Gen ofc expenses	Occupied Bed Days	372,277	11	254,217	30,057	20,525	9
10	24	Travel & Seminar	Occupied Bed Days	372,277	11	62,607	30,057	5,055	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	372,277	11	91,654	30,057	7,400	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	372,277	11	265,831	30,057	21,463	12
13	30	Depreciation	Occupied Bed Days	372,277	11	28,917	30,057	2,335	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	372,277	11	(509,407)	30,057	(41,129)	14
15	35	Rent - Equipment	Occupied Bed Days	372,277	11	14,362	30,057	1,160	15
16	35	Rent - Vehicles	Occupied Bed Days	372,277	11	17,234	30,057	1,391	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,212,425	\$ 1,558,035		\$ 178,628	25

Facility Name & ID Number Northwoods Care Centre

# 0051813 Report Period Beginning: 01/01/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Bed Days Available	307,257	28	\$ 3,424	\$ 6,893	\$ 77	1	
2	6	Maintenance Salaries	Bed Days Available	307,257	28	55,893	6,893	1,254	2	
3	6	Maintenance Expenses	Bed Days Available	307,257	28	21,648	6,893	486	3	
4	7	Employee Benefits - Maintenance	Bed Days Available	307,257	28	12,799	6,893	287	4	
5	10	Clinical Salaries	Bed Days Available	307,257	28	595,582	595,582	6,893	13,361	5
6	15	Employee Benefits - Clinical	Bed Days Available	307,257	28	136,244	6,893	3,056	6	
7	17	Administrative Salaries	Bed Days Available	307,257	28	2,420	2,420	6,893	54	7
8	19	Professional Fees	Bed Days Available	307,257	28	125,288	6,893	2,811	8	
9	20	Dues, Fees, Subscriptions, etc.	Bed Days Available	307,257	28	67,058	6,893	1,504	9	
10	21	Clerical & General Salaries	Bed Days Available	307,257	28	1,328,131	1,328,131	6,893	29,795	10
11	21	Clerical & General Expenses	Bed Days Available	307,257	28	161,289	6,893	3,618	11	
12	24	Seminars And Education	Bed Days Available	307,257	28	37,815	6,893	848	12	
13	2S	Transportation	Bed Days Available	307,257	28	14,185	6,893	318	13	
14	27	Employee Benefits - Administrati	Bed Days Available	307,257	28	304,341	6,893	6,828	14	
15	30	Depreciation	Bed Days Available	307,257	28	26,334	6,893	591	15	
16	32	Interest Expense	Bed Days Available	307,257	28	3,464	6,893	78	16	
17	33	Real Estate Tax	Bed Days Available	307,257	28	15,239	6,893	342	17	
18	35	Equipment Rental	Bed Days Available	307,257	28	34,911	6,893	783	18	
19	35	Auto Lease	Bed Days Available	307,257	28	13,885	6,893	311	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,959,950	\$ 1,982,026	\$ 66,402	25	



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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>													
1. Real Estate Tax accrual used on 2014 report.			\$ <b>85,200</b>	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.)	2014		\$ <b>83,975</b>	2											
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>(1,225)</b>	3											
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>88,200</b>	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. <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>2,166</b>	5											
		Allocated from Management Co.	<b>342</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>			\$ _____	6											
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>89,483</b>	7											
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<u>62,972</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$ _____ 13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____ 14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____ 15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		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
<b>FOR BHF USE ONLY</b>															
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>68,552</u>	9												
	2012	<u>78,717</u>	10												
	2013	<u>81,086</u>	11												
	2014	<u>83,975</u>	12												
<b>2015 Tax Accrual = \$81,086 x 1.05 = 85,140.30; Use \$88,200</b>															

**NOTES:**

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



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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 12,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2/Basement

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).

N/A

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Alloc Fr Maestro 7257</u>		<u>2004</u>	<u>\$ 598</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 598</b>	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				\$	\$		\$	\$	\$	
5										
6										
7										
8	Allocated from Maestro 7257	2004		5,386		39	138	138	1,866	
	<b>Improvement Type**</b>									
9	Concrete Sidewalk Repair		2012	3,115	156	20	156		534	
10	Valley - EGINEERING/Design throughout facility		2013	155,300	7,765	20	7,765		17,471	
11	Wi-Fi Cables for Nurses Station		2013	5,108	255	20	255		659	
12										
13	Facility Remodeling		2014	696,403	42,789	5 - 20	42,789		81,144	
14	-Demolition/carpentry/soffits throughout facility									
15	-Wall coverings, painting - 1st floor dining room, front offices,									
16	resident rooms and lower level									
17	-Plumbing - cafeteria									
18	-Interior soffit enclosure - throughout facility									
19	-Counter tops, laminate - coffee, reception areas and nurses station									
20	-Electrical work - throughout facility									
21	-Floor covering - Basement, 1st Floor Corridors/Offices/									
22	Nurses Station/Resident Rooms/Dining Room/Vestibule									
23	-Interior painting - 1st floor dining room, front offices, resident rooms									
24	and lower level									
25	-Interior electrical / alarm - throughout facility									
26	-Gazebo - outside									
27	-Tile Flooring - South & East Lobby around Elevator									
28	-Landscaping - along the building & by fire hydrant									
29	-Room signage - hallways & restrooms									
30	-Dining room window treatments									
31	-Concrete Steps - outside building									
32	-General Contractors Fee									
33	-Permits									
34										
35	Masonry repairs on North Elevation		2015	10,880	136	20	136		136	
36	- North side of building									

\*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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Allocated from Maestro Consulting Services	2003	\$ 263	\$	20	\$ 3	\$ 3	\$ 157	37
38	Allocated from Maestro Consulting Services	2004	5,335		20	52	52	3,130	38
39	Allocated from Maestro Consulting Services	2005	316		20	3	3	169	39
40	Allocated from Maestro Consulting Services	2006	429		20	4	4	197	40
41	Allocated from Maestro Consulting Services	2008	452		20	4	4	160	41
42	Allocated from Maestro Consulting Services	2009	7,278		20	71	71	2,345	42
43	Allocated from Maestro Consulting Services	2010	1,118		20	11	11	252	43
44	Allocated from Maestro Consulting Services	2011	60		20	1	1	14	44
45	Allocated from Maestro Consulting Services	2012	67		20	1	1	12	45
46	Allocated from Maestro Consulting Services	2014	841		20	8	8	61	46
47	Allocated from Maestro Consulting Services	2015	237		20			2	47
48									48
49	Allocated from Maestro 7257	2004	107		10			62	49
50	Allocated from Maestro 7257	2005	491		10	3	3	325	50
51	Allocated from Maestro 7257	2015	85		15	4	4	2	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)		\$ 893,271	\$ 51,101		\$ 51,404	\$ 303	\$ 108,698	70

\*\*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	\$ 171,549	\$ 28,522	\$ 28,522	\$		\$ 65,440	71
72	Current Year Purchases	10,839	1,019	1,019			1,019	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt. Co.	53,035		2,621	2,621		28,440	74
75	TOTALS	\$ 235,423	\$ 29,541	\$ 32,162	\$ 2,621		\$ 94,899	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	Allocated from Maestro Consulting Services			\$ 199	\$	\$ 2	\$ 2		\$ 199	76
77										77
78										78
79										79
80	TOTALS			\$ 199	\$	\$ 2	\$ 2		\$ 199	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)	\$ 1,129,491	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,642	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,568	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,926	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 203,796	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

**Facility Name:** Northwoods Care Centre  
**IDPH License ID Number:** 0051813  
**Fiscal Year End:** 12/31/2015

**Schedule 13A**

**XI. Ownership Costs**

**Line 74 - Equipment Costs - Excluding Transportation**

<b>Category of Equipment</b>	<b>Cost</b>	<b>Current Book Depreciation</b>	<b>Straight Line Depreciation</b>	<b>Adjustments</b>	<b>Component Life</b>	<b>Accumulated Depreciation</b>
Allocated from Symphony Financial Services, LLC	14,283		2,335	2,335	5-7	5,731
Allocated from Maestro Consulting Services	38,752		286	286	5-10	22,709
				-		
<b>TOTAL</b>	53,035	-	2,621	2,621		28,440

Facility Name & ID Number Northwoods Care Centre

# 0051813

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Diana Master Landlord, LLC

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1972</u>	<u>113</u>	<u>12/31/2011</u>	\$ <u>906,614</u>	<u>10</u>	<u>10</u>	3
4	Additions							4
5								5
6	<u>Allocated from Mgmt. Co.</u>				<u>(41,129)</u>			6
7	TOTAL		<u>113</u>		\$ <u>865,485</u>			7

10. Effective dates of current rental agreement:

Beginning 12/31/2011

Ending 12/31/2021

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12.	<u>/2016</u>	\$ <u>728,280</u>
-----	--------------	-------------------

13.	<u>/2017</u>	\$ <u>742,846</u>
-----	--------------	-------------------

14.	<u>/2018</u>	\$ <u>757,703</u>
-----	--------------	-------------------

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 10.

2,122

21,207

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ 77,557 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name: Northwoods Care Centre  
IDPH License ID Number: 0051813  
Fiscal Year End: 12/31/2015

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Mattresses	21,337
Compressor	42
Vac Freedom	10,824
Bipap Unit	336
Equipment Fee	2,178
Computer Lease	959
Office Equipment	8,294
Printers/Copiers	9,411
Copiers	17,824
Postage Rental	344
Overhead Sound System	350
Temp Cooler	180
Dishmachine	1,657
Propane Tank	175
Allocated from HO	3,645
<b>Total - Line 16</b>	<b><u>77,557</u></b>

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2015 Ending: 12/31/2015  
**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>It is the policy of this facility to only hire certified nurses aides.                  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>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	3 Cost	Units	5 Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	6,265	\$ 451,086	\$	6,265	\$ 451,086	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		888	63,966		888	63,966	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,992	431,399		5,992	431,399	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				128,971		128,971	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See Schedule 16A</u>	39(3)				16,598			16,598	12
13	Other (specify): <u>Oxygen</u>	39(2)					560		560	13
14	<b>TOTAL</b>			\$	13,145	\$ 963,049	\$ 129,531	13,145	\$ 1,092,580	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: Northwoods Care Centre  
IDPH License ID Number: 0051813  
Fiscal Year End: 12/31/2015

**Schedule 16A**

**XIV. Special Services (Direct Cost)**

**Line 12 Other (specify)**

<u>Description</u>	<u>Units</u>	<u>Amount</u>
INHALATION THERAPY-PRIVATE		1,206
INHALATION THERAPY - MEDICARE		6,340
INHALATION THERAPY-MEDICAID		3,721
INHALATION THERAPY - MAN. CARE		1,607
PHYSICIANS - MEDICARE		185
PHYSICIANS - MEDICAID		15
I.V. THERAPY - MEDICARE		2,358
I.V. THERAPY - MANAGED CARE		1,166
<b>Total - Line 12</b>	<b>-</b>	<b>16,598</b>

Facility Name & ID Number Northwoods Care Centre

# 0051813

Report Period Beginning: 01/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 172,468	\$ 172,468	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 222,711 )	3,249,730	3,249,730	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	275	275	6
7	Other Prepaid Expenses	115,900	115,900	7
8	Accounts Receivable (owners or related parties)	860,134	860,134	8
9	Other(specify): See Schedule 17A	91,627	91,627	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 4,490,134</b>	<b>\$ 4,490,134</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		598	13
14	Buildings, at Historical Cost		5,385	14
15	Leasehold Improvements, at Historical Cost	870,806	887,886	15
16	Equipment, at Historical Cost	180,356	235,622	16
17	Accumulated Depreciation (book methods)	(166,403)	(203,796)	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 (spec Lease Cost, Net)	12,724	12,724	22
23	Other(specify): See Schedule 17A	339,455	339,455	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 1,236,938</b>	<b>\$ 1,277,874</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 5,727,072</b>	<b>\$ 5,768,008</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,001,092	\$ 1,001,092	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,958	96,958	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,200	88,200	32
33	Accrued Interest Payable	9	9	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Schedule 17A	1,783,647	1,783,647	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 2,969,906</b>	<b>\$ 2,969,906</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	107,435	107,435	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 107,435</b>	<b>\$ 107,435</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 3,077,341</b>	<b>\$ 3,077,341</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 2,649,731</b>	<b>\$ 2,690,667</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 5,727,072</b>	<b>\$ 5,768,008</b>	<b>48</b>

\*(See instructions.)

**Facility Name:** Northwoods Care Centre  
**IDPH License ID Number:** 0051813  
**Fiscal Year End:** 12/31/2015

**Schedule 17A**

**XV. Balance Sheet**

**Line 9 Current Assets Other (specify):**

Description	Operating	After Consolidation
Patient Personal Funds	42,438	42,438
Reserve for Capex	49,189	49,189
<b>Total - Line 9</b>	<b>91,627</b>	<b>91,627</b>

**XV. Balance Sheet**

**Line 23 Long-Term Assets Other (specify):**

Description	Operating	After Consolidation
Security Deposit	152,960	152,960
Real Estate Escrow	186,495	186,495
<b>Total - Line 23</b>	<b>339,455</b>	<b>339,455</b>

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

Description	Operating	After Consolidation
Exchange Formation Leasehold	852,012	852,012
Security Deposit Payable	37,113	37,113
Operating Expenses	191,208	191,208
Management Fees - Symphony	388,786	388,786
Ins Wrks Comp - Deduct/Settlement	21,490	21,490
Accumulated Amortization Deferred	(82,088)	(82,088)
State Unemployment Tax	4,635	4,635

Federal Unemployment Tax	427	427
Sales Tax	454	454
Payroll Taxes Other	8,614	8,614
Accrued Employee Benefits	240,061	240,061
FICA & W/H Fed	465	465
Due to IDPA - Addtl IL Bed Tax	31,636	31,636
Due to TKG	23,083	23,083
Due to Medicare	12,110	12,110
Due to NuCare	15,075	15,075
Due to Symphony	18,582	18,582
Wage Assign & Garnishment	2,086	2,086
Patient Personal Funds	17,898	17,898
<b>Total - Line 36</b>	<b><u>1,783,647</u></b>	<b><u>1,783,647</u></b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,993,651	1
2	Restatements (describe):		2
3	Prior Period Adjustment	7,843	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,001,494	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	648,237	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)	\$ 648,237	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,649,731	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,889,956	1
2	Discounts and Allowances for all Levels	(1,538,006)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,351,950</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,864,253	6
7	Oxygen	731	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,864,984</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		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	140,820	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,008	19
20	Radiology and X-Ray	3,151	20
21	Other Medical Services	27,974	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 203,953</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,742	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,742</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Rentals and Other Unclassified Income</b>	2,467	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 2,467</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,425,096</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	948,323	31
32	Health Care	2,405,940	32
33	General Administration	1,701,287	33
<b>B. Capital Expense</b>			
34	Ownership	1,153,794	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,316,318	35
36	Provider Participation Fee	251,197	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,776,859</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>648,237</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 648,237</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,393,158	44
45	Private Pay - Net Inpatient Revenue	1,186,220	45
46	Medicare - Net Inpatient Revenue	1,170,890	46
47	Other-(specify) <u>Hospice</u>	314,730	47
48	Other-(specify) <u>Managed Care</u>	286,952	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 6,351,950</b>	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.

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

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

^ - Tax return prepared on cash basis

Facility Name & ID Number **Northwoods Care Centre**

# **0051813**

Report Period Beginning:

**01/01/2015**

Ending:

**12/31/2015**

**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	1,725	2,124	\$ 86,099	\$ 40.54	1
2	Assistant Director of Nursing	1,757	1,987	61,790	31.10	2
3	Registered Nurses	24,713	25,950	749,253	28.87	3
4	Licensed Practical Nurses	4,996	5,397	122,176	22.64	4
5	CNAs & Orderlies	64,832	71,368	922,651	12.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	19,922	20,948	188,519	9.00	9
10	Activity Assistants					10
11	Social Service Workers	1,843	2,105	50,523	24.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,315	20,001	236,724	11.84	15
16	Dishwashers					16
17	Maintenance Workers	1,878	2,028	47,644	23.49	17
18	Housekeepers	11,185	12,811	151,916	11.86	18
19	Laundry	6,173	6,792	76,733	11.30	19
20	Administrator	1,931	1,931	96,107	49.77	20
21	Assistant Administrator	1,580	2,121	48,964	23.09	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,343	3,840	56,144	14.62	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	1,840	2,078	35,842	17.25	31
32	Other Health Care					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,033	181,481	\$ 2,931,085 *	\$ 16.15	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	Monthly	\$ 8,980	1(3)	35
36	Medical Director	Monthly	25,900	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,659	11(3)	44
45	Social Service Consultant	Monthly	19,200	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,739		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	1,059	15,881	10(3)	52
53	TOTAL (lines 50 - 52)	1,059	\$ 15,881		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	
Jennifer Cook	Administrator	0	\$ 96,107	Workers' Compensation Insurance	\$ 105,535	IDPH License Fee	\$ 3,980	
Rebecca Schnor	Administrator	0	48,964	Unemployment Compensation Insurance	22,452	Advertising: Employee Recruitment	1,992	
				FICA Taxes	219,155	Health Care Worker Background Check		
				Employee Health Insurance	231,465	(Indicate # of checks performed <u>103</u> )	1,239	
				Employee Meals		Patient Background Checks <u>105</u>	1,260	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	3,006	
				Employee Retirement	9,555	Illinois Council on Long Term Care	20,177	
				Employee Benefits - Other	7,042	Miscellaneous Dues & Subscriptions	4,620	
				Employees' Physical Exams	930	Lobbying Expense Offset	(13,358)	
						Allocated from Mgmt. Co.	2,088	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 145,071			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 596,134	
Description				Amount				
Management Fees (Eliminated in Col. 7)				\$ 378,964				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 378,964				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Sch 21C	See Sch 21C		\$ 201,791	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	3,642
							Allocated from Mgmt. Co.	5,903
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			TOTAL	
							\$ 9,545	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Facility Name:** Northwoods Care Centre  
**IDPH License ID Number:** 0051813  
**Fiscal Year End:** 12/31/2015

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<b>Vendor</b>	<b>Type</b>	<b>Amount</b>
ABILITY NETWORK , INC.	SECURE EXCHANGE MANAGED SERV	1,516
ACHIEVE ACCREDITATION	ACCREDITATION ASSISTANCE	13,728
Allen A Lefkovitz	LEGAL FEES-COMPLIANCE	2,166
COMCAST	CABLE	2,510
CREATIVE TECHNOLOGY	IT SUPPORT	8,349
E-HEALTH DATA SOLUTIONS	CAREWATCH/RISKWATCH SERVICE	5,112
EVAULT	PROTECTONE- 36 MO-SERVERONE	1,584
GRANT POWELL	BUILDING MAINTENANCE CONSULTING	3,654
HDSI	MICRO-FICHE SFTWR MAINTENANCE	1,065
HEALTH DATA SYSTEMS	MICRO-FICHE SOFTWARE MAINTENANCE	3,840
HIPP LAW OFFICE	CONTINGENT FEES	21,426
HK PAYROLL	WOTC PROGRAM	1,813
IIT/SOURCETECH	OPERATOR MONTHLY SUPPORT FEE	1,379
MAESTRO CONSULTING FEES	WAGE ALLOCATIONS: MARKETING, CLINICAL, ETC.	50,000
MUCH SHELIST	STATUTORY REGISTERED AGENT	457
NUCARE SERVICES CORP	MICROSOFT OFFICE 365	362
PERSONNEL PLANNERS	QTRLY UNEMPLOYMENT CLAIMS	843
PINNACLE QUALITY INSIGHT	CUSTOMER SATISFACTION PROGRAM	(116)
POINT B COMMUNICATIONS	YEARLY WEB HOSTING	240
RSM US LLP	ACCOUNTING	25,347
STONE, MCGUIRE & SIEGEL	LEGAL FEES-COMPLIANCE	17,563
SYMPHONY FINANCIAL SERVICES	CONSULTING	6,602
TELEMEDICINE SOLUTIONS	WOUNDCARE MGT SYSTEM IMPLEMEN	11,691
WESCOM SOLUTIONS INC.	CLINICAL/BOOKKEEPING/DATA PROC	16,129
WILLIAM COOK	LIFE SAFETY CONSULTATION	4,531
<b>Total (agree to Schedule V, line 19, column 3)</b>		<b>201,791</b>

Allocated from Management Company Legal Fees	439
Allocated from Management Company Professional Services	29,708
Less: Non-Allowable Legal Fees	(23,233)
Less: Legal Fees Reclass to Real Estate Taxes	(2,167)
<b>Total (agree to Schedule V, line 19, column 8)</b>	<u><u>206,539</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												N/A
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Northwoods Care Centre

# 0051813

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council LTC - \$20,177
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. 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. \$ 251,197  
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. \$ 0 Has any meal income been offset against related costs? No 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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
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? No  
**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? Yes  
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.