

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0041210</u></p> <p>Facility Name: <u>Elmwood Nursing & Rehab Ctr</u></p> <p>Address: <u>152 Wilma Drive</u> <u>Maryville</u> <u>62062</u> Number City Zip Code</p> <p>County: <u>Madison</u></p> <p>Telephone Number: <u>(618) 344-7750</u> Fax # <u>(618) 344-3588</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/1/1995</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____ *</td> </tr> <tr> <td>* Subject to the attached Accountants Consulting Report (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____		(Title) _____	Paid Preparer	(Signed) _____ *	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	27,084	1
2		Skilled Pediatric (SNF/PED)			2
3	30	Intermediate (ICF)	30	10,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	38,064	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	900	511	1,782	3,193	8
9	SNF/PED					9
10	ICF	17,484	2,052	5,333	24,869	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,384	2,563	7,115	28,062	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.72%

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 1,714

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	182,197	17,651	10,054	209,902		209,902		209,902		1
2	Food Purchase		116,632		116,632		116,632	(107)	116,525		2
3	Housekeeping	126,726	25,932		152,658		152,658		152,658		3
4	Laundry	86,718	8,775		95,493		95,493		95,493		4
5	Heat and Other Utilities			103,668	103,668		103,668		103,668		5
6	Maintenance	71,817	20,113	67,471	159,401		159,401	(11,231)	148,170		6
7	Other (specify):*										7
8	TOTAL General Services	467,458	189,103	181,193	837,754		837,754	(11,338)	826,416		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	921,587	8,456	8,903	938,946		938,946	(665)	938,281		10
10a	Therapy										10a
11	Activities	48,963	5,667	3,440	58,070		58,070		58,070		11
12	Social Services	27,569			27,569		27,569	10,754	38,323		12
13	CNA Training										13
14	Program Transportation			7,302	7,302		7,302		7,302		14
15	Other (specify):*							889	889		15
16	TOTAL Health Care and Programs	998,119	14,123	31,645	1,043,887		1,043,887	10,978	1,054,865		16
	C. General Administration										
17	Administrative	161,311			161,311		161,311	7,788	169,099		17
18	Directors Fees										18
19	Professional Services			329,619	329,619		329,619	(279,873)	49,746		19
20	Dues, Fees, Subscriptions & Promotions			36,891	36,891		36,891	(11,240)	25,651		20
21	Clerical & General Office Expenses	116,601	6,393	108,409	231,403		231,403	72,096	303,499		21
22	Employee Benefits & Payroll Taxes			338,960	338,960		338,960		338,960		22
23	Inservice Training & Education										23
24	Travel and Seminar			957	957		957	422	1,379		24
25	Other Admin. Staff Transportation			847	847		847	2,582	3,429		25
26	Insurance-Prop.Liab.Malpractice			109,812	109,812		109,812	1,044	110,856		26
27	Other (specify):*							17,499	17,499		27
28	TOTAL General Administration	277,912	6,393	925,495	1,209,800		1,209,800	(189,682)	1,020,118		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,743,489	209,619	1,138,333	3,091,441		3,091,441	(190,042)	2,901,399		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			53,248	53,248		53,248	117,671	170,919		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			2,405	2,405		2,405	122,717	125,122		32
33	Real Estate Taxes			75,532	75,532		75,532		75,532		33
34	Rent-Facility & Grounds			261,975	261,975		261,975	(238,156)	23,819		34
35	Rent-Equipment & Vehicles			12,016	12,016		12,016	3,027	15,043		35
36	Other (specify):*										36
37	TOTAL Ownership			405,176	405,176		405,176	5,259	410,435		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		149,619	268,041	417,660		417,660		417,660		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			215,980	215,980		215,980		215,980		42
43	Other (specify):*	88,020		144,000	232,020		232,020	(232,020)	0		43
44	TOTAL Special Cost Centers	88,020	149,619	628,021	865,660		865,660	(232,020)	633,640		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,831,509	359,238	2,171,530	4,362,277		4,362,277	(416,803)	3,945,474		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(17,216)	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	74,051	30		9
10	Interest and Other Investment Income	(172)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(107)	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	(4,248)	21		18
19	Entertainment	(1,046)	21		19
20	Contributions	(2,500)	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	(39,885)	21		24
25	Fund Raising, Advertising and Promotional	(510)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(145)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(289,366)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (281,144)		\$	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)	(135,659)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (135,659)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (416,803)		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	

Elmwood Nursing & Rehab Ctr

ID# 0041210

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medical Records	\$ (665)	10	1
2	Bank Service Charge	(2,426)	21	2
3	Sequestration Expense	(1,429)	21	3
4	Marketing Salaries	(88,020)	43	4
5	Collection Fees	(1,252)	21	5
6	Late Fees	(13,936)	21	6
7	Prior Year Expenses	(6)	21	7
8	Building Co. - Amortization	(15,502)	31	8
9	Building Co. - Bank Charges	(561)	21	9
10	Misc. Income	(4,745)	21	10
11	PAC Dues	(8,926)	20	11
12	Non-Allowable Expense	(144,000)	43	12
13	Non-Allowable Legal	(11,004)	19	13
14	Additional R&M	5,925	06	14
15	Capitalized R&M	(2,820)	06	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(289,366)		49

Elmwood Nursing & Rehab Ctr

ID# 0041210

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
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74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	(107)											(107)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(14,111)		2,880									(11,231)	6
7	Other (specify):*													7
8	TOTAL General Services	(14,218)		2,880									(11,338)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(665)											(665)	10
10a	Therapy													10a
11	Activities													11
12	Social Services			10,754									10,754	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			889									889	15
16	TOTAL Health Care and Programs	(665)		11,643									10,978	16
	C. General Administration													
17	Administrative			7,788									7,788	17
18	Directors Fees													18
19	Professional Services	(11,004)		(268,869)									(279,873)	19
20	Fees, Subscriptions & Promotions	(11,936)		696									(11,240)	20
21	Clerical & General Office Expenses	(69,678)	487	141,287									72,096	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			422									422	24
25	Other Admin. Staff Transportation			2,582									2,582	25
26	Insurance-Prop.Liab.Malpractice			1,044									1,044	26
27	Other (specify):*			17,499									17,499	27
28	TOTAL General Administration	(92,618)	487	(97,551)									(189,682)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(107,501)	487	(83,028)									(190,042)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	74,051	43,560	60									117,671	30
31	Amortization of Pre-Op. & Org.	(15,502)	15,502											31
32	Interest	(172)	122,889										122,717	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(252,300)	14,144									(238,156)	34
35	Rent-Equipment & Vehicles			3,027									3,027	35
36	Other (specify):*													36
37	TOTAL Ownership	58,377	(70,349)	17,231									5,259	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):*	(232,020)											(232,020)	43
44	TOTAL Special Cost Centers	(232,020)											(232,020)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(281,144)	(69,862)	(65,797)									(416,803)	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	\$ 252,300	Maryville Health Properties, LLC	100.00%	\$	\$ (252,300)	1
2	V	31 Amort. Of Loan Costs		Maryville Health Properties, LLC	100.00%	15,502	15,502	2
3	V	21 Bank Charges		Maryville Health Properties, LLC	100.00%	561	561	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%	122,889	122,889	5
6	V	21 Misc. Income	74	Maryville Health Properties, LLC	100.00%		(74)	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 252,374			\$ 182,512	\$ * (69,862)	14

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

Facility Name & ID Number

Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending:

12/31/16

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%	\$ 2,880	\$ 2,880
16	V	19 PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	2,790	2,790
17	V	20 DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	696	696
18	V	21 CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	7,108	7,108
19	V	24 SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	422	422
20	V	25 TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	2,582	2,582
21	V	26 INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,044	1,044
22	V	30 DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	60	60
23	V	32 INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%		
24	V	34 OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	14,144	14,144
25	V	35 AUTO RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,693	1,693
26	V	35 EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,334	1,334
27	V	21 CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	76,050	76,050
28	V	27 EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	12,504	12,504
29	V	17 ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	7,788	7,788
30	V	27 EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	703	703
31	V						
32	V	21 CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	58,129	58,129
33	V	27 EMPLOYEE BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	4,292	4,292
34	V						
35	V	12 SOCIAL SERVICE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	10,754	10,754
36	V	15 HEALTH CARE EMPLOYEE BENEFITS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	889	889
37	V						
38	V	19 BOOKEEPING SERVICES	271,659				(271,659)
39	Total		\$ 271,659			\$ 205,862	\$ * (65,797)

* 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	34 Office Space	\$ 9,000	MS HEALTHCARE ACCOUNTING	100.00%	\$ 9,000	\$	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		\$ 9,000			\$ 9,000	\$ *	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	39 THERAPY	\$ 264,896	TOWN AND COUNTRY REHAB., LLC	100.00%	\$ 264,896	\$	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		\$ 264,896			\$ 264,896	\$ *	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: 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.

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 Ctr

0041210

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Makhlouf Suissa	42.310%			MARYVILLE HEALTH PROPER	MARYVILLE	BUILDING CO.	1
2	Moshe David Aryeh	4.800%	CORI MANOR	ST. LOUIS MO.	HEALTHCARE ACCOUNTING S	ST. LOUIS MO.	BOOKEEPING/FINANCIAL	2
3	William Rothner Trust	4.800%	GRAND MANOR NURSING AND REHAB	ST. LOUIS MO.	TOWN AND COUNTRY REHAB.	CHESTERFIELD, MO	THERAPY CO.	3
4	Daniel Rothner Trust	4.800%	NORTHVIEW VILLAGE	ST. LOUIS MO.	MS HEALTHCARE ACCT.	CHICAGO, IL	ACCOUNTING	4
5	Adam Vales Turst	4.810%	SALEM VILLAGE NURSING AND REHABILITATION CENTER, L.L.C	JOLIET				5
6	Kathryn Vales Trust	4.810%						6
7	Melissa Rothner Trust	4.810%						7
8	Kimberly Richman Trust	4.810%						8
9	Rachel Rothner Trust	4.810%						9
10	Nathan & Shirley Rothner Family Trust	9.620%						10
11	Noah Wolff Family Trust	9.620%						11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	5.84	9.73%	Alloc Salary	\$ 7,788	17-7	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	\$ 7,788		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 Ctr

0041210

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 Ctr

0041210

Report Period Beginning:

01/01/16

Ending: 12/31/16

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, & MO. PAT. DAYS	288,276	6	\$ 29,583	\$ 28,062	\$ 2,880	1	
2	19	PROFESSIONAL FEES	ILL, & MO. PAT. DAYS	288,276	6	28,657	28,062	2,790	2	
3	20	DUES, SUBSCRIPTIONS	ILL, & MO. PAT. DAYS	288,276	6	7,146	28,062	696	3	
4	21	CLERICAL & GENERAL	ILL, & MO. PAT. DAYS	288,276	6	73,018	28,062	7,108	4	
5	24	SEMINAR	ILL, & MO. PAT. DAYS	288,276	6	4,333	28,062	422	5	
6	25	TRAVEL	ILL, & MO. PAT. DAYS	288,276	6	26,522	28,062	2,582	6	
7	26	INSURANCE	ILL, & MO. PAT. DAYS	288,276	6	10,722	28,062	1,044	7	
8	30	DEPRECIATION	ILL, & MO. PAT. DAYS	288,276	6	617	28,062	60	8	
9	32	INTEREST	ILL, & MO. PAT. DAYS	288,276	6		28,062		9	
10	34	OFFICE SPACE	ILL, & MO. PAT. DAYS	288,276	6	145,297	28,062	14,144	10	
11	35	AUTO RENTAL	ILL, & MO. PAT. DAYS	288,276	6	17,387	28,062	1,693	11	
12	35	EQUIPMENT RENTAL	ILL, & MO. PAT. DAYS	288,276	6	13,703	28,062	1,334	12	
13	21	CLERICAL SALARIES	ILL, & MO. PAT. DAYS	288,276	6	781,245	781,245	28,062	76,050	13
14	27	EMP. BEN. GEN. & ADMIN.	ILL, & MO. PAT. DAYS	288,276	6	128,456	28,062	12,504	14	
15	17	ADMIN. SALARY - M. SUISSA	ILL, & MO. PAT. DAYS	288,276	6	80,000	80,000	28,062	7,788	15
16	27	EMP. BEN.-M. SUISSA	ILL, & MO. PAT. DAYS	288,276	6	7,218	28,062	703	16	
17									17	
18	21	CLERICAL SALARIES	ILLINOIS PAT. DAYS	108,914	2	225,609	225,609	28,062	58,129	18
19	27	EMPLOYEE BEN. GEN. & ADM	ILLINOIS PAT. DAYS	108,914	2	16,658	28,062	4,292	19	
20									20	
21	12	SOCIAL SERVICE	SPECIFIC FACIL. DAYS	207,424	5	79,486	79,486	28,062	10,754	21
22	15	HEALTH CARE EMPLOYEE BEN	SPECIFIC FACIL. DAYS	207,424	5	6,571	28,062	889	22	
23									23	
24									24	
25	TOTALS					\$ 1,682,228	\$ 1,166,340	\$ 205,862	25	

Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 MS HEALTHCARE ACCOUNTING
 Street Address 3535 WEST GLENLAKE
 City / State / Zip Code CHICAGO, IL 60659
 Phone Number (917) 744-8688
 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	34	Office Space	DIRECT		\$	\$		\$ 9,000	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				\$	\$		\$ 9,000	25

Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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	39	THERAPY	DIRECT		\$	\$		\$ 264,896	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				\$	\$		\$ 264,896	25

Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 Ctr

0041210

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 Ctr

0041210

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 Ctr

0041210

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 Ctr

0041210

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 Ctr

0041210

Report Period Beginning:

01/01/16

Ending: 12/31/16

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

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	210,225	10/01/09	\$ 2,779,795	\$ 2,136,363		\$ 122,889	1									
2											2									
3											3									
4											4									
5				-							5									
Working Capital																				
6	Onmicare		X	Note Payable	739.47	7/20/14	16,805		6/20/2016	96	6									
7	Select Rehabilitation		X	Note Payable				20,000			7									
8	See Supplemental Schedule				-					2,309	8									
9	TOTAL Facility Related				210964.61		\$ 2,796,600	\$ 2,156,363		\$ 125,294	9									
B. Non-Facility Related*																				
10	Interest Income		X							(172)	10									
11											11									
12											12									
13				-							13									
14	TOTAL Non-Facility Related						\$	\$		\$ (172)	14									
15	TOTALS (line 9+line14)						\$ 2,796,600	\$ 2,156,363		\$ 125,122	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/16 Ending: 12/31/16

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											
										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																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8	IPFS Corporation		X	Finance Agreement	Various		\$	\$		\$ 2,267										
9	Home Depot		X	Credit Card	Various					42										
10																				
11																				
12																				
13																				
14	TOTAL Working Capital									2,309										
B. Non-Facility Related*																				
15							\$	\$		\$										
16																				
17																				
18																				
19																				
20	TOTAL Non-Facility Related																			

* 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 2015 report.		\$	62,855	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.)		\$	68,487	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,632	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	138,387	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.		\$	144,019	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	<u>63,651</u>	8	
	2012	<u>63,923</u>	9	
	2013	<u>66,304</u>	10	
	2014	<u>67,341</u>	11	
	2015	<u>68,487</u>	12	
2016 Accrual = \$68,487 x 1.02 = \$69,900 (rounded) + 2015 tax \$68,487 = \$138,387				
The variance between line 7 and page 4 line 33 is the result of the late payment of the 2015 tax bill. The bill was paid in early 2017				
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Nursing & Rehab Ctr COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0041210

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-2-21-14-00-000-009</u>	<u>Long Term Care Facility</u>	\$ <u>68,487.40</u>	\$ <u>68,487.40</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>68,487.40</u></u>	\$ <u><u>68,487.40</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Nursing & Rehab Ctr COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0041210

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending:

12/31/16

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:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 1955, \$184,895. Row 2: (blank), (blank), (blank). Row 3: TOTALS, \$184,895.

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	\$ 1,026,010
5									
6									
7									
8									
	Improvement Type**								
9	Various		1996	43,296		20	906	906	45,206
10	Various		1997	46,441		20	2,321	2,321	46,184
11	Various		1998	46,036		20	2,302	2,302	42,687
12	Various		1999	14,188		20	709	709	12,289
13	Various		2000	41,832		20	2,092	2,092	34,826
14	Various		2001	4,916		20	246	246	3,729
15	Various		2002	8,317		20	150	150	7,523
16	Various		2003	30,929		20	270	270	30,479
17	Various		2004	35,139		20	55	55	34,875
18	Various		2005	20,712		20	96	96	19,936
19	Various		2006	87,017		20	1,800	1,800	57,016
20	Various		2007	103,010		20	5,151	5,151	50,647
21	Various		2008	334,237		20	33,424	33,424	272,537
22	Various		2009	78,715		20	7,872	7,872	61,523
23	Various		2010	5,555		20			5,555
24	Various		2011	62,847		20	6,191	6,191	34,340
25	Various		2012	150,130		20	14,840	14,840	68,911
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending:

12/31/16

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					53,248		(53,248)	69
70		\$ 2,811,404	\$ 96,808		\$ 126,941	\$ 30,133	\$ 1,854,272	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,811,404	\$ 96,808		\$ 126,941	\$ 30,133	\$ 1,854,272	1
2	Electric Panels	2013	3,080		20	308	308	1,232	2
3	New Water Lines For Recirculation	2013	4,270		20	427	427	1,708	3
4	Drapes For Common Areas	2013	4,165		20	416	416	1,631	4
5	Replaced Main Sewer Line To Building	2013	6,990		20	699	699	2,680	5
6	Electrical Work On Generator, Back Up Panels	2013	4,000		20	571	571	2,143	6
7	10 Heating/Cooling Systems	2013	28,473		20	2,373	2,373	8,502	7
8	Sprinkler System	2013	108,096		20	10,810	10,810	42,338	8
9	Flooring For Main Entrance And Dining.	2013	16,100		20	1,610	1,610	5,903	9
10	Rewired Electrical Panels	2013	6,000		20	600	600	2,100	10
11	Replaced Water And Gas Lines In Tunnel	2013	7,665		20	767	767	2,427	11
12	Repair 5 Water Line Leaks	2013	2,555		20	128	128	458	12
13	Shed Installation	2015	3,706		20	247	247	371	13
14	Replace Sewer Pipe, Jack Hammer Wall & Fix Waterline Leak	2015	7,600		20	760	760	1,140	14
15	Replace Broken And Breached Cast Iron Sewer Pipes	2016	5,800		20	193	193	193	15
16	Replace 5 Main Water Lines	2016	3,675		20	122	122	122	16
17	Flat Roof Over Dining Room	2016	4,756		20	40	40	40	17
18	Main Shingle Roof	2016	9,660		20	81	81	81	18
19	Repaired Plumbing Leaks In Basement Tunnel	2016	2,820		20	141	141	141	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)		\$ 3,040,815	\$ 96,808		\$ 147,233	\$ 50,425	\$ 1,927,481	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 3,040,815	\$ 96,808		\$ 147,233	\$ 50,425	\$ 1,927,481	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		\$ 3,040,815	\$ 96,808		\$ 147,233	\$ 50,425	\$ 1,927,481	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		\$ 3,040,815	\$ 96,808		\$ 147,233	\$ 50,425	\$ 1,927,481	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)	\$ 3,040,815	\$ 96,808		\$ 147,233	\$ 50,425	\$ 1,927,481	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 3,040,815	\$ 96,808		\$ 147,233	\$ 50,425	\$ 1,927,481	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		\$ 3,040,815	\$ 96,808		\$ 147,233	\$ 50,425	\$ 1,927,481	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 Building Company		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

**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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
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	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.

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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
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	\$ 200,255	\$ 60	\$ 22,641	\$ 22,581	10	\$ 153,481	71
72	Current Year Purchases	7,791		1,039	1,039	10	1,039	72
73	Fully Depreciated Assets	400,970		6	6	10	400,970	73
74								74
75	TOTALS	\$ 609,017	\$ 60	\$ 23,686	\$ 23,626		\$ 555,491	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)	\$ 3,834,727	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,868	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 170,919	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 74,051	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,482,972	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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				675			5
6	Alloc. from Healthcare Accounting Serv./MS Healthcare Accounting				23,144			6
7	TOTAL				\$ 23,819			7

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. _____ /2017 \$ _____

13. _____ /2018 \$ _____

14. _____ /2019 \$ _____

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: \$ 13,350 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		\$	1,693	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 1,693	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.

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			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 92,051	\$		\$ 92,051	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			75,366			75,366	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			97,478			97,478	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				73,631		73,631	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>					3,146	75,988		79,134	13
14	TOTAL			\$		\$ 268,041	\$ 149,619		\$ 417,660	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 Ctr**

0041210

Report Period Beginning: **01/01/16**

Ending:

12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/16**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 51,555	\$ 54,053	1
2	Cash-Patient Deposits	41,944	41,944	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,325,685	1,325,685	3
4	Supply Inventory (priced at)	14,825	14,825	4
5	Short-Term Investments			5
6	Prepaid Insurance	11,484	11,484	6
7	Other Prepaid Expenses	17,952	17,952	7
8	Accounts Receivable (owners or related parties)	175,093	194,143	8
9	Other(specify): <u>See Attached Schedule</u>	60	60	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,638,598	\$ 1,660,146	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	1,087,635	1,087,635	15
16	Equipment, at Historical Cost	592,336	800,336	16
17	Accumulated Depreciation (book methods)	(848,317)	(2,347,714)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 831,654	\$ 1,423,240	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,470,252	\$ 3,083,386	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 132,413	\$ 132,413	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,194	41,194	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	199,939	199,939	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,611	10,611	31
32	Accrued Real Estate Taxes(Sch.IX-B)	138,387	138,387	32
33	Accrued Interest Payable		13,864	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	749,527	749,527	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,272,071	\$ 1,285,935	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	20,000	20,000	39
40	Mortgage Payable		2,136,363	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	2,636,985	1,940,738	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,656,985	\$ 4,097,101	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,929,056	\$ 5,383,036	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,458,804)	\$ (2,299,650)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,470,252	\$ 3,083,386	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,584,938)	1
2	Restatements (describe):		2
3	Bad Debt	(40,000)	3
4	Rounding	11	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,624,927)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	166,123	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)	\$ 166,123	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)	\$ (1,458,804)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elmwood Nursing & Rehab Ctr

0041210

Report Period Beginning: 01/01/16

Ending: 12/31/16

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	\$ 4,515,151	1
2	Discounts and Allowances for all Levels	(540,643)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,974,508	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	490,821	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 490,821	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	53,984	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,087	19
20	Radiology and X-Ray	418	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 57,489	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	172	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 172	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	5,410	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,410	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,528,400	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	837,754	31
32	Health Care	1,043,887	32
33	General Administration	1,209,800	33
B. Capital Expense			
34	Ownership	405,176	34
C. Ancillary Expense			
35	Special Cost Centers	649,680	35
36	Provider Participation Fee	215,980	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,362,277	40
41	Income before Income Taxes (line 30 minus line 40)**	166,123	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 166,123	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,606,552	44
45	Private Pay - Net Inpatient Revenue	411,600	45
46	Medicare - Net Inpatient Revenue	208,699	46
47	Other-(specify) <u>Hospice</u>	56,407	47
48	Other-(specify) <u>Insurance</u>	691,250	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,974,508	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 Ctr

0041210

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	1,972	2,052	\$ 66,018	\$ 32.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,339	3,431	68,628	20.00	3
4	Licensed Practical Nurses	15,588	16,261	329,064	20.24	4
5	CNAs & Orderlies	40,906	42,739	457,877	10.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,796	3,996	48,963	12.25	10
11	Social Service Workers	1,905	1,969	27,569	14.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,530	17,207	182,197	10.59	15
16	Dishwashers					16
17	Maintenance Workers	4,746	4,903	71,817	14.65	17
18	Housekeepers	12,570	12,991	126,726	9.75	18
19	Laundry	9,389	9,885	86,718	8.77	19
20	Administrator	2,131	2,211	161,311	72.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,983	6,221	116,601	18.74	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)	2,067	2,147	88,020	41.00	33
34	TOTAL (lines 1 - 33)	118,922	126,013	\$ 1,831,509 *	\$ 14.53	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	209	\$ 10,054	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	16	1,068	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	73	4,740	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	3,440	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	346	\$ 31,302		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	78	3,095	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	78	\$ 3,095		53

Facility Name & ID Number Elmwood Nursing & Rehab Ctr# 0041210Report Period Beginning: 01/01/16Ending: 12/31/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$27,048
- (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? 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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,190 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 No 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. \$ 215,980
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% in 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. Yes
Attach invoices and a summary of services for all architect and appraisal fees