

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	30	Intermediate (ICF)	30	10,950	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	37,960	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	301	150	2,381	2,832	8
9	SNF/PED					9
10	ICF	15,579	3,506	3,572	22,657	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,880	3,656	5,953	25,489	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.15%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 2,191

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent. # 0041210 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	178,591	8,583	10,628	197,802		197,802		197,802		1
2	Food Purchase		125,414		125,414		125,414	(180)	125,234		2
3	Housekeeping	111,976	26,050		138,026		138,026		138,026		3
4	Laundry	95,865	12,832		108,697		108,697		108,697		4
5	Heat and Other Utilities			92,108	92,108		92,108		92,108		5
6	Maintenance	74,418	17,509	56,807	148,734		148,734	(14,439)	134,295		6
7	Other (specify):*										7
8	TOTAL General Services	460,850	190,388	159,543	810,781		810,781	(14,619)	796,162		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,174,506	8,942	38,765	1,222,213		1,222,213	(44)	1,222,169		10
10a	Therapy										10a
11	Activities	95,281	5,780	3,478	104,539		104,539		104,539		11
12	Social Services							289	289		12
13	CNA Training										13
14	Program Transportation			4,004	4,004		4,004		4,004		14
15	Other (specify):*							61	61		15
16	TOTAL Health Care and Programs	1,269,787	14,722	58,247	1,342,756		1,342,756	306	1,343,062		16
	C. General Administration										
17	Administrative	151,606		30,000	181,606		181,606	8,324	189,930		17
18	Directors Fees										18
19	Professional Services			226,629	226,629		226,629	(153,705)	72,924		19
20	Dues, Fees, Subscriptions & Promotions			33,983	33,983		33,983	(15,057)	18,926		20
21	Clerical & General Office Expenses	137,176	5,744	134,790	277,710		277,710	13,075	290,785		21
22	Employee Benefits & Payroll Taxes			315,959	315,959		315,959		315,959		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,238	2,238		2,238	148	2,386		24
25	Other Admin. Staff Transportation			2,615	2,615		2,615	2,235	4,850		25
26	Insurance-Prop.Liab.Malpractice			110,886	110,886		110,886	1,368	112,254		26
27	Other (specify):*							13,898	13,898		27
28	TOTAL General Administration	288,782	5,744	857,100	1,151,626		1,151,626	(129,714)	1,021,912		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,019,419	210,854	1,074,890	3,305,163		3,305,163	(144,027)	3,161,136		29

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

#0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			106,384	106,384		106,384	51,961	158,345			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,465	2,465		2,465	84,933	87,398			32
33	Real Estate Taxes			69,466	69,466		69,466		69,466			33
34	Rent-Facility & Grounds			260,452	260,452		260,452	(240,056)	20,396			34
35	Rent-Equipment & Vehicles			12,117	12,117		12,117	4,049	16,166			35
36	Other (specify):*											36
37	TOTAL Ownership			450,884	450,884		450,884	(99,113)	351,771			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		142,496	304,071	446,567		446,567		446,567			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,298	198,298		198,298		198,298			42
43	Other (specify):*	51,783		114,000	165,783		165,783	(165,783)				43
44	TOTAL Special Cost Centers	51,783	142,496	616,369	810,648		810,648	(165,783)	644,865			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,071,202	353,350	2,142,143	4,566,695		4,566,695	(408,923)	4,157,772			45

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

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VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(19,080)	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	8,323	30		9
10	Interest and Other Investment Income	(8,762)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(180)	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	(8,173)	21		18
19	Entertainment	(1,583)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,205)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(23)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(254,319)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (290,002)		\$	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)	(118,921)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (118,921)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (408,923)		37

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

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

(See instructions.)

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

BHF USE ONLY

48		49		50		51		52	
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Elmwood Nursing & Rehab Cent.

ID# 0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Miscellaneous Income	\$ (2,643)	21	1
2	Medical Records	(44)	10	2
3	Marketing Salaries	(51,783)	43	3
4	Sequestration Expense	(16,180)	21	4
5	Bank Charges	(5,276)	21	5
6	Collection Fees	(2,896)	21	6
7	Late Fees	(40,780)	21	7
8	Additional R & M	4,593	06	8
9	Bldg Co - Bank Service Charges	(323)	21	9
10	Non-Allowable Legal	(10,195)	19	10
11	Capitalized R & M	(5,521)	06	11
12	PAC Dues	(8,996)	20	12
13	Non-Allowable Expenses	(114,000)	43	13
14	Chamber of Commerce	(275)	20	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(254,319)		49

Elmwood Nursing & Rehab Cent.

Report Period Beginning: ID# 0041210
 Ending: 01/01/18
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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
73			24
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 Cent.# 0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	(180)											(180)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(20,008)		5,569									(14,439)	6
7	Other (specify):*													7
8	TOTAL General Services	(20,188)		5,569									(14,619)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(44)											(44)	10
10a	Therapy													10a
11	Activities													11
12	Social Services			289									289	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			61									61	15
16	TOTAL Health Care and Programs	(44)		350									306	16
	C. General Administration													
17	Administrative			8,324									8,324	17
18	Directors Fees													18
19	Professional Services	(10,195)		(143,510)									(153,705)	19
20	Fees, Subscriptions & Promotions	(15,476)		419									(15,057)	20
21	Clerical & General Office Expenses	(77,877)	323	90,629									13,075	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			148									148	24
25	Other Admin. Staff Transportation			2,235									2,235	25
26	Insurance-Prop.Liab.Malpractice			1,368									1,368	26
27	Other (specify):*			13,898									13,898	27
28	TOTAL General Administration	(103,548)	323	(26,489)									(129,714)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(123,780)	323	(20,570)									(144,027)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	8,323	43,560	78									51,961	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,762)	92,840	855									84,933	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(252,302)	12,246									(240,056)	34
35	Rent-Equipment & Vehicles			4,049									4,049	35
36	Other (specify):*													36
37	TOTAL Ownership	(439)	(115,902)	17,228									(99,113)	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):*	(165,783)											(165,783)	43
44	TOTAL Special Cost Centers	(165,783)											(165,783)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(290,002)	(115,579)	(3,342)									(408,923)	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 Rent	\$ 252,302	Maryville Health Properties, LLC		\$	\$ (252,302)	1
2	V	21 Bank Service Charges		Maryville Health Properties, LLC		323	323	2
3	V	30 Depreciation		Maryville Health Properties, LLC		43,560	43,560	3
4	V	32 Interest Expense		Maryville Health Properties, LLC		92,840	92,840	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 252,302			\$ 136,723	\$ * (115,579)	14

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.# 0041210Report Period Beginning: 01/01/18Ending: 12/31/18

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		\$ 5,569	\$ 5,569 15
16	V	19 PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC		3,490	3,490 16
17	V	20 DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC		419	419 17
18	V	21 CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC		1,180	1,180 18
19	V	24 SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC		148	148 19
20	V	25 TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC		2,235	2,235 20
21	V	26 INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC		1,368	1,368 21
22	V	30 DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC		78	78 22
23	V	32 INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC		855	855 23
24	V	34 OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC		12,246	12,246 24
25	V	35 AUTO RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC		3,045	3,045 25
26	V	35 EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC		1,004	1,004 26
27	V	21 CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC		57,944	57,944 27
28	V	27 EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC		8,031	8,031 28
29	V	17 ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC		8,324	8,324 29
30	V	27 EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC		782	782 30
31	V						
32	V	21 CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC		31,505	31,505 32
33	V	27 EMPLOYEE BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC		5,085	5,085 33
34	V						
35	V	12 SOCIAL SERVICE		HEALTHCARE ACCOUNTING SERVICES, LLC		289	289 35
36	V	15 HEALTH CARE EMPLOYEE BENEFITS		HEALTHCARE ACCOUNTING SERVICES, LLC		61	61 36
37	V						
38	V	19 BOOKEEPING SERVICES	147,000				(147,000) 38
39	Total		\$ 147,000			\$ 143,658	\$ * (3,342) 39

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

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	\$ 7,250	MS HEALTHCARE ACCOUNTING		\$ 7,250	\$	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		\$ 7,250			\$ 7,250	\$ *	39

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

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Report Period Beginning: 01/01/18

Ending: 12/31/18

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent. # 0041210 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	8.33%	Alloc Sal/Fee	\$ 38,325	17-3 / 17-7	1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 38,325		13	

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending: 12/31/18

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, LLC
 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	306,193	7	\$ 66,895	\$ 25,489	\$ 5,569	1
2	19	PROFESSIONAL FEES	ILL, & MO. PAT. DAYS	306,193	7	41,928	25,489	3,490	2
3	20	DUES, SUBSCRIPTIONS	ILL, & MO. PAT. DAYS	306,193	7	5,030	25,489	419	3
4	21	CLERICAL & GENERAL	ILL, & MO. PAT. DAYS	306,193	7	14,180	25,489	1,180	4
5	24	SEMINAR	ILL, & MO. PAT. DAYS	306,193	7	1,773	25,489	148	5
6	25	TRAVEL	ILL, & MO. PAT. DAYS	306,193	7	26,851	25,489	2,235	6
7	26	INSURANCE	ILL, & MO. PAT. DAYS	306,193	7	16,437	25,489	1,368	7
8	30	DEPRECIATION	ILL, & MO. PAT. DAYS	306,193	7	937	25,489	78	8
9	32	INTEREST	ILL, & MO. PAT. DAYS	306,193	7	10,275	25,489	855	9
10	34	OFFICE SPACE	ILL, & MO. PAT. DAYS	306,193	7	147,104	25,489	12,246	10
11	35	AUTO RENTAL	ILL, & MO. PAT. DAYS	306,193	7	36,585	25,489	3,045	11
12	35	EQUIPMENT RENTAL	ILL, & MO. PAT. DAYS	306,193	7	12,062	25,489	1,004	12
13	21	CLERICAL SALARIES	ILL, & MO. PAT. DAYS	306,193	7	696,067	696,067	57,944	13
14	27	EMP. BEN. GEN. & ADMIN.	ILL, & MO. PAT. DAYS	306,193	7	96,469	25,489	8,031	14
15	17	ADMIN. SALARY - M. SUISSA	ILL, & MO. PAT. DAYS	306,193	7	100,000	100,000	8,324	15
16	27	EMP. BEN.-M. SUISSA	ILL, & MO. PAT. DAYS	306,193	7	9,398	25,489	782	16
17									17
18	21	CLERICAL SALARIES	ILLINOIS PAT. DAYS	139,325	4	172,211	172,211	31,505	18
19	27	EMPLOYEE BEN. GEN. & ADMIN.	ILLINOIS PAT. DAYS	139,325	4	27,794	25,489	5,085	19
20									20
21	12	SOCIAL SERVICE	SPECIFIC FACIL. DAYS	306,193	7	3,474	3,474	289	21
22	15	HEALTH CARE EMPLOYEE BEN.	SPECIFIC FACIL. DAYS	306,193	7	737	25,489	61	22
23									23
24									24
25	TOTALS					\$ 1,486,207	\$ 971,752	\$ 143,658	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending: 12/31/18

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		\$	\$		\$ 7,250	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				\$	\$		\$ 7,250	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

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Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Elmwood Nursing & Rehab Cent. # 0041210 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			\$	\$ 1,836,993		\$ 92,840	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	IPFS Corporation		X	Finance Insurance Premium Various						2,465	6									
7	Select Rehabilitation		X	Note Payable		02/03/17		20,000			7									
8	See Supplemental Schedule									855	8									
9	TOTAL Facility Related						\$	\$ 1,856,993		\$ 96,160	9									
B. Non-Facility Related*																				
10	Interest Income		X							(8,762)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (8,762)	14									
15	TOTALS (line 9+line14)						\$	\$ 1,856,993		\$ 87,398	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.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Nursing & Rehab Cent. COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0041210

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>13-2-21-14-00-000-009</u>	<u>Long Term Care Facility</u>	\$ <u>68,219.04</u>	\$ <u>68,219.04</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>68,219.04</u>	\$ <u>68,219.04</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Nursing & Rehab Cent. COUNTY Madison
 FACILITY IDPH LICENSE NUMBER 0041210
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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.	_____	\$ _____	\$ _____
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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Cent.

0041210

Report Period Beginning:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>		<u>1955</u>	\$ <u>184,895</u>	1
2					2
3	TOTALS			\$ <u>184,895</u>	3

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	\$ 1,123,044	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1996		43,296		20			45,207	9
10	Various		1997		46,441		20			46,437	10
11	Various		1998		46,036		20	1,045	1,045	46,030	11
12	Various		1999		14,188		20	709	709	13,708	12
13	Various		2000		41,832		20	2,092	2,092	39,009	13
14	Various		2001		4,916		20	246	246	4,220	14
15	Various		2002		8,317		20	150	150	7,824	15
16	Various		2003		30,929		20	180	180	30,929	16
17	Various		2004		35,139		20	55	55	34,985	17
18	Various		2005		20,712		20	96	96	20,128	18
19	Various		2006		87,017		20	1,507	1,507	60,031	19
20	Various		2007		103,010		20	5,151	5,151	60,948	20
21	Various		2008		334,237		20	28,277	28,277	334,237	21
22	Various		2009		78,715		20	7,871	7,871	77,265	22
23	Various		2010		5,555		20			5,555	23
24	Various		2011		62,847		20	6,192	6,192	46,723	24
25	Various		2012		150,130		20	13,568	13,568	97,005	25
26	Various		2013		191,394		20	18,709	18,709	108,539	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

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					106,384		(106,384)	69
70		\$ 3,002,799	\$ 149,944		\$ 134,365	\$ (15,579)	\$ 2,201,824	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	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	Totals from Page 12A, Carried Forward		\$ 3,002,799	\$ 149,944		\$ 134,365	\$ (15,579)	\$ 2,201,824	1
2	Shed Installation	2015	3,706		20	185	185	679	2
3	Replace Sewer Pipe, Jack Hammer Wall & Fix Waterline Leak	2015	7,600		20	760	760	2,660	3
4	Replace Broken And Breached Cast Iron Sewer Pipes	2016	5,800		20	149	149	353	4
5	Replace 5 Main Water Lines	2016	3,675		20	94	94	200	5
6	Flat Roof Over Dining Room	2016	4,756		20	476	476	991	6
7	Main Shingle Roof	2016	9,660		20	966	966	2,013	7
8	Repaired Plumbing Leaks In Basement Tunnel	2016	2,820		20	141	141	423	8
9	Replace Water Main From Outside To Inside Tunnel	2017	6,800		20	340	340	666	9
10	Copper Piping Replacement - Maintenance Room	2017	2,965		20	148	148	241	10
11	Remove & Replace Concrete - Main Entrance	2017	6,871		20	344	344	501	11
12	Replaced Cast Iron Sewer Main & Branch In Tunnel	2017	9,400		20	470	470	646	12
13	Replaced Grease Traps In Kitchen	2017	3,700		20	185	185	254	13
14	Shed	2017	3,794		20	190	190	300	14
15	Installation Of New Air Handler, Reconnect Refrigerant Piping Fro	2018	2,757		20	138	138	138	15
16	Generator Repair, Replace Mx150 Transfer Switch Controller	2018	2,764		20	138	138	138	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)		\$ 3,079,867	\$ 149,944		\$ 139,089	\$ (10,855)	\$ 2,212,027	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	Totals from Page 12B, Carried Forward		\$ 3,079,867	\$ 149,944		\$ 139,089	\$ (10,855)	\$ 2,212,027	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)		\$ 3,079,867	\$ 149,944		\$ 139,089	\$ (10,855)	\$ 2,212,027	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	Totals from Page 12C, Carried Forward		\$ 3,079,867	\$ 149,944		\$ 139,089	\$ (10,855)	\$ 2,212,027	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)		\$ 3,079,867	\$ 149,944		\$ 139,089	\$ (10,855)	\$ 2,212,027	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	Totals from Page 12D, Carried Forward		\$ 3,079,867	\$ 149,944		\$ 139,089	\$ (10,855)	\$ 2,212,027	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)		\$ 3,079,867	\$ 149,944		\$ 139,089	\$ (10,855)	\$ 2,212,027	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	Totals from Page 12H, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	\$ 191,757	\$ 78	\$ 18,868	\$ 18,790	10	\$ 152,986	71
72	Current Year Purchases	3,877		388	388	10	388	72
73	Fully Depreciated Assets	442,827				10	442,827	73
74								74
75	TOTALS	\$ 638,461	\$ 78	\$ 19,256	\$ 19,178		\$ 596,200	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)	\$ 3,903,223	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 150,022	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 158,345	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,323	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,808,227	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				900			5
6	Alloc. from Healthcare Accounting Serv./MS Healthcare Accounting				19,496			6
7	TOTAL				\$ 20,396			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. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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: \$ 13,121 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		\$	\$ 3,045	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 3,045	21

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent. # 0041210 Report Period Beginning: 01/01/18 Ending: 12/31/18
 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		4	5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff			Outside Practitioner (other than consultant)					
			Units of Service	Cost		Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 108,773	\$		\$ 108,773	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			88,830			88,830	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39 - 03	hrs			102,252			102,252	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				76,854		76,854	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):					4,216	65,642		69,858	13	
14	TOTAL			\$		\$ 304,071	\$ 142,496		\$ 446,567	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 50,590	\$ 52,465	1
2	Cash-Patient Deposits	28,326	28,326	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	754,657	754,657	3
4	Supply Inventory (priced at)	14,825	14,825	4
5	Short-Term Investments			5
6	Prepaid Insurance	45,271	45,271	6
7	Other Prepaid Expenses	179,000	179,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	60	60	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,072,729	\$ 1,074,604	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	1,119,617	1,119,617	15
16	Equipment, at Historical Cost	638,664	846,664	16
17	Accumulated Depreciation (book methods)	(1,022,386)	(2,627,092)	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): <u>See Attached Schedule</u>	237,303	237,303	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 973,198	\$ 1,459,475	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,045,927	\$ 2,534,079	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 505,694	\$ 502,621	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,576	27,576	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,547	207,547	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,087	9,087	31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,000	69,000	32
33	Accrued Interest Payable		7,700	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	817,897	817,897	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,636,801	\$ 1,641,428	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	20,000	20,000	39
40	Mortgage Payable		1,836,993	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>	2,253,404	1,522,094	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,273,404	\$ 3,379,087	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,910,205	\$ 5,020,515	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,864,278)	\$ (2,486,436)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,045,927	\$ 2,534,079	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,678,388)	1
2	Restatements (describe):		2
3	Prior Year Maintenance	2,627	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,675,761)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(188,517)	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)	\$ (188,517)	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)	\$ (1,864,278)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

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	\$ 4,189,381	1
2	Discounts and Allowances for all Levels	(473,423)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,715,958	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	603,062	6
7	Oxygen	2,595	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 605,657	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	39,640	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,585	19
20	Radiology and X-Ray	1,889	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 45,114	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,762	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,762	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,687	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,687	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,378,178	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	810,781	31
32	Health Care	1,342,756	32
33	General Administration	1,151,626	33
B. Capital Expense			
34	Ownership	450,884	34
C. Ancillary Expense			
35	Special Cost Centers	612,350	35
36	Provider Participation Fee	198,298	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,566,695	40
41	Income before Income Taxes (line 30 minus line 40)**	(188,517)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (188,517)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,087,880	44
45	Private Pay - Net Inpatient Revenue	590,514	45
46	Medicare - Net Inpatient Revenue	529,818	46
47	Other-(specify) <u>Hospice</u>	241,746	47
48	Other-(specify) <u>Insurance</u>	266,000	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,715,958	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Cent.

0041210

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,123	2,283	\$ 99,205	\$ 43.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,633	8,207	224,806	27.39	3
4	Licensed Practical Nurses	11,919	12,817	305,635	23.85	4
5	CNAs & Orderlies	38,585	41,489	531,667	12.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,348	6,826	95,281	13.96	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,627	16,803	178,591	10.63	15
16	Dishwashers					16
17	Maintenance Workers	3,115	3,349	74,418	22.22	17
18	Housekeepers	9,785	10,522	111,976	10.64	18
19	Laundry	9,053	9,734	95,865	9.85	19
20	Administrator	2,050	2,204	151,606	68.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,814	5,176	137,176	26.50	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	876	942	13,193	14.01	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,591	1,711	51,783	30.26	33
34	TOTAL (lines 1 - 33)	113,519	122,063	\$ 2,071,202 *	\$ 16.97	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	142	\$ 6,200	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	Monthly	9,720	10-03	38
39	Pharmacist Consultant	51	3,295	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	3,478	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Dietary Contracted Services</u>	Monthly	4,428	01-03	47
48					48
49	TOTAL (lines 35 - 48)	257	\$ 40,189		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	127	5,317	10-03	51
52	Certified Nurse Assistants/Aides	793	19,365	10-03	52
53	TOTAL (lines 50 - 52)	920	\$ 24,682		53

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

Report Period Beginning:

01/01/18Ending: 12/31/18**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. HCCI \$17,992
- (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. \$ 11,980 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 198,298
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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