I. IDPH License ID Number: 0041210

Facility Name: Elmwood Nursing & Rehab Cent.
Address: 152 Wilma Drive Maryville 62062
County: Madison
Telephone Number: (618) 344-7750 Fax # (618) 344-3588
HFS ID Number: ____________
Date of Initial License for Current Owners: 10/1/1995
Type of Ownership: VOLUNTARY,NON-PROFIT X PROPRIETARY GOVERNMENTAL
Charitable Corp. Individual State
Trust Partnership County
IRS Exemption Code ________ "Sub-S" Corp. Other ________
Limited Liability Co. Trust
Other _______

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address: ____________

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

(Signed) ___________________________ (Date)
Officer or Administrator of Provider (Type or Print Name) ___________________________ (Title) ____________
(Signed) ___________________________ (Date)
Paid Preparer (Print Name and Title) ___________________________
(Firm Name and Address) Marcum, LLP
9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax (847) 282-6301

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

HFS 3745 (N-4-99) IL478-2471
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

<table>
<thead>
<tr>
<th>Beds at Beginning of Report Period</th>
<th>Licensure Level of Care</th>
<th>Beds at End of Report Period</th>
<th>Licensed Bed Days During Report Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>74</td>
<td>74</td>
<td>27,010</td>
</tr>
<tr>
<td>2</td>
<td>30</td>
<td>30</td>
<td>10,950</td>
</tr>
<tr>
<td>3</td>
<td>104</td>
<td>104</td>
<td>37,960</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Census-For the entire report period.

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Patient Days by Level of Care and Primary Source of Payment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicaid Recipient</td>
<td>Private Pay</td>
</tr>
<tr>
<td>8 SNF</td>
<td>301</td>
<td>150</td>
</tr>
<tr>
<td>9 SNF/PED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 ICF</td>
<td>15,579</td>
<td>3,506</td>
</tr>
<tr>
<td>11 ICF/DD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 SC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 DD 16 OR LESS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 TOTALS</td>
<td>15,880</td>
<td>3,656</td>
</tr>
</tbody>
</table>

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 X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

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 X Date 10/01/1995 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 13 and days of care provided 2,191

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

M. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

N. On what date did you start providing long term care at this location? Date started 10/01/1995

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

P. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 13 and days of care provided 2,191

IV. ACCOUNTING BASIS

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Patient Days by Level of Care and Primary Source of Payment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicaid Recipient</td>
<td>Private Pay</td>
</tr>
<tr>
<td>8 SNF</td>
<td>301</td>
<td>150</td>
</tr>
<tr>
<td>9 SNF/PED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 ICF</td>
<td>15,579</td>
<td>3,506</td>
</tr>
<tr>
<td>11 ICF/DD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 SC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 DD 16 OR LESS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 TOTALS</td>
<td>15,880</td>
<td>3,656</td>
</tr>
</tbody>
</table>

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

* All facilities other than governmental must report on the accrual basis.
### V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

<table>
<thead>
<tr>
<th>Operating Expenses</th>
<th>Costs Per General Ledger</th>
<th>Reclassified Total</th>
<th>Adjustments</th>
<th>Adjusted Total</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary/Wage</td>
<td>Supplies</td>
<td>Other</td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>A. General Services</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Dietary</td>
<td>178,591</td>
<td>8,583</td>
<td>10,628</td>
<td>197,802</td>
<td>197,802</td>
</tr>
<tr>
<td>Food Purchase</td>
<td>125,414</td>
<td>125,414</td>
<td>125,414</td>
<td>125,414</td>
<td>(180)</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>111,976</td>
<td>26,050</td>
<td>138,026</td>
<td>138,026</td>
<td>138,026</td>
</tr>
<tr>
<td>Laundry</td>
<td>95,865</td>
<td>12,832</td>
<td>108,697</td>
<td>108,697</td>
<td>108,697</td>
</tr>
<tr>
<td>Maintenance</td>
<td>74,418</td>
<td>17,509</td>
<td>56,807</td>
<td>148,734</td>
<td>(14,439)</td>
</tr>
<tr>
<td>Other (specify):</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL General Services</td>
<td>460,850</td>
<td>190,388</td>
<td>159,543</td>
<td>810,781</td>
<td>810,781</td>
</tr>
<tr>
<td>B. Health Care and Programs</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td>12,000</td>
<td>12,000</td>
<td>12,000</td>
<td>12,000</td>
<td>12,000</td>
</tr>
<tr>
<td>Nursing and Medical Records</td>
<td>1,174,506</td>
<td>8,942</td>
<td>38,765</td>
<td>1,222,213</td>
<td>1,222,213</td>
</tr>
<tr>
<td>Therapy</td>
<td>10a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities</td>
<td>95,281</td>
<td>5,780</td>
<td>3,478</td>
<td>104,539</td>
<td>104,539</td>
</tr>
<tr>
<td>Social Services</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNA Training</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Transportation</td>
<td>4,004</td>
<td>4,004</td>
<td>4,004</td>
<td>4,004</td>
<td>14</td>
</tr>
<tr>
<td>Other (specify):</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL Health Care and Programs</td>
<td>1,269,787</td>
<td>14,722</td>
<td>58,247</td>
<td>1,342,756</td>
<td>1,342,756</td>
</tr>
<tr>
<td>C. General Administration</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative</td>
<td>151,606</td>
<td>30,000</td>
<td>181,606</td>
<td>181,606</td>
<td>8,324</td>
</tr>
<tr>
<td>Directors Fees</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Services</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dues, Fees, Subscriptions &amp; Promotions</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerical &amp; General Office Expenses</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Benefits &amp; Payroll Taxes</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inservice Training &amp; Education</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel and Seminar</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Admin. Staff Transportation</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance-Prop.Liab.Malpractice</td>
<td>26</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify):</td>
<td>27</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL General Administration</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(sum of lines 8, 16 &amp; 28)</td>
<td>288,782</td>
<td>5,744</td>
<td>857,100</td>
<td>1,151,626</td>
<td>1,151,626</td>
</tr>
<tr>
<td>TOTAL Operating Expense</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(sum of lines 8, 16 &amp; 28)</td>
<td>2,019,419</td>
<td>210,854</td>
<td>1,074,890</td>
<td>3,305,163</td>
<td>3,305,163</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Capital Expense</th>
<th>Cost Per General Ledger</th>
<th>Reclassification</th>
<th>Adjustments</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. Ownership</td>
<td></td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Depreciation</td>
<td>Salary/Wage 1 106,384</td>
<td>106,384</td>
<td>51,961</td>
<td>158,345</td>
</tr>
<tr>
<td>31 Amortization of Pre-Op. &amp; Org.</td>
<td>Supplies 2 2,465</td>
<td>2,465</td>
<td>84,933</td>
<td>87,398</td>
</tr>
<tr>
<td>32 Interest</td>
<td>Other 3</td>
<td>2,465</td>
<td>84,933</td>
<td>87,398</td>
</tr>
<tr>
<td>33 Real Estate Taxes</td>
<td>Total 4 69,466</td>
<td>69,466</td>
<td>69,466</td>
<td>69,466</td>
</tr>
<tr>
<td>34 Rent-Facility &amp; Grounds</td>
<td>Reclassified 5 260,452</td>
<td>260,452</td>
<td>(240,056)</td>
<td>20,396</td>
</tr>
<tr>
<td>35 Rent-Equipment &amp; Vehicles</td>
<td>Total 6 12,117</td>
<td>12,117</td>
<td>4,049</td>
<td>16,166</td>
</tr>
<tr>
<td>36 Other (specify):*</td>
<td>Total 7 123456789</td>
<td>Total 8 450,884</td>
<td></td>
<td>351,771</td>
</tr>
<tr>
<td>37 TOTAL Ownership</td>
<td>Ancillary Expense</td>
<td>450,884</td>
<td>(99,113)</td>
<td>351,771</td>
</tr>
<tr>
<td>E. Special Cost Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 Medically Necessary Transportation</td>
<td></td>
<td></td>
<td></td>
<td>38</td>
</tr>
<tr>
<td>39 Ancillary Service Centers</td>
<td></td>
<td>142,496</td>
<td>444,567</td>
<td>444,567</td>
</tr>
<tr>
<td>40 Barber and Beauty Shops</td>
<td></td>
<td></td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>41 Coffee and Gift Shops</td>
<td></td>
<td></td>
<td></td>
<td>41</td>
</tr>
<tr>
<td>42 Provider Participation Fee</td>
<td></td>
<td>198,298</td>
<td>198,298</td>
<td>198,298</td>
</tr>
<tr>
<td>43 Other (specify):*</td>
<td></td>
<td>51,783</td>
<td>165,783</td>
<td>(165,783)</td>
</tr>
<tr>
<td>44 TOTAL Special Cost Centers</td>
<td></td>
<td>51,783</td>
<td>412,496</td>
<td>644,865</td>
</tr>
<tr>
<td>45 GRAND TOTAL COST</td>
<td>(sum of lines 29, 37 &amp; 44)</td>
<td>2,071,202</td>
<td>2,142,143</td>
<td>4,157,772</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>NON-ALLOWABLE EXPENSES</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Day Care</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>2 Other Care for Outpatients</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3 Governmental Sponsored Special Programs</td>
<td>(19,080)</td>
<td>06</td>
<td>5</td>
</tr>
<tr>
<td>4 Non-Patient Meals</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>5 Telephone, TV &amp; Radio in Resident Rooms</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>6 Rented Facility Space</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>7 Sale of Supplies to Non-Patients</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>8 Laundry for Non-Patients</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>9 Non-Straightline Depreciation</td>
<td>8,323</td>
<td>30</td>
<td>9</td>
</tr>
<tr>
<td>10 Interest and Other Investment Income</td>
<td>(8,762)</td>
<td>32</td>
<td>10</td>
</tr>
<tr>
<td>11 Discounts, Allowances, Rebates &amp; Refunds</td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>12 Non-Working Officer's or Owner's Salary</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>13 Sales Tax</td>
<td>(180)</td>
<td>02</td>
<td>13</td>
</tr>
<tr>
<td>14 Non-Care Related Interest</td>
<td></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>15 Non-Care Related Owner's Transactions</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>16 Personal Expenses (Including Transportation)</td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>17 Non-Care Related Fees</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>18 Fines and Penalties</td>
<td>(8,173)</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>19 Entertainment</td>
<td>(1,583)</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>20 Contributions</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>21 Owner or Key-Man Insurance</td>
<td></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>22 Special Legal Fees &amp; Legal Retainers</td>
<td></td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>23 Malpractice Insurance for Individuals</td>
<td></td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>24 Bad Debt</td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>25 Fund Raising, Advertising and Promotional</td>
<td>(6,205)</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>26 Income Taxes and Illinois Personal Property Replacement Tax</td>
<td>(23)</td>
<td>21</td>
<td>26</td>
</tr>
<tr>
<td>27 CNA Training for Non-Employees</td>
<td></td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>28 Yellow Page Advertising</td>
<td></td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>29 Other-Attach Schedule</td>
<td>(254,319)</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>30 SUBTOTAL (A): (Sum of lines 1-29)</td>
<td>$ (290,002)</td>
<td>$ 30</td>
<td></td>
</tr>
</tbody>
</table>

**BHF USE ONLY**

| 48 | 49 | 50 | 51 | 52 |

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 Non-Paid Workers-Attach Schedule*</td>
<td>$ 31</td>
</tr>
<tr>
<td>32 Donated Goods-Attach Schedule*</td>
<td>$ 32</td>
</tr>
<tr>
<td>33 Amortization of Organization &amp; Pre-Operating Expense</td>
<td>$ 33</td>
</tr>
<tr>
<td>34 Adjustments for Related Organization (Schedule VII)</td>
<td>$ 34</td>
</tr>
<tr>
<td>35 Other-Attach Schedule</td>
<td>$ 35</td>
</tr>
<tr>
<td>36 SUBTOTAL (B): (sum of lines 31-35)</td>
<td>$ (118,921)</td>
</tr>
<tr>
<td>37 TOTAL ADJUSTMENTS (A) and (B)</td>
<td>$ (408,923)</td>
</tr>
</tbody>
</table>

*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.)

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## Operating Expenses

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<th>PAGE 6A</th>
<th>PAGE 6B</th>
<th>PAGE 6C</th>
<th>PAGE 6D</th>
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<th>PAGE 6G</th>
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| B. Health Care and Programs | |
|-----------------------------|------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 9. Medical Director         |                        |        |        |        |        |        |        |        |        |        |        |
| 10. Nursing and Medical Records | (44)                  |        |        |        |        |        |        |        |        |        | (44)   |
| 10a. Therapy                |                        |        |        |        |        |        |        |        |        |        | 10a    |
| 11. Activities              |                        |        |        |        |        |        |        |        |        |        | 11     |
| 12. Social Services         |                        |        |        |        |        |        |        |        |        | 289    | 12     |
| 13. CNA Training            |                        |        |        |        |        |        |        |        |        |        | 13     |
| 14. Program Transportation  |                        |        |        |        |        |        |        |        |        |        | 14     |
| 15. Other (specify):        |                        |        |        |        |        |        |        |        |        | 61      | 15     |
| 16. TOTAL Health Care and Programs | (44) |        |        |        |        |        |        |        |        |        | 306    |

<p>| C. General Administration  | |
|-----------------------------|------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 17. Administrative          |                        |        |        |        |        |        |        |        |        |        | 306    |
| 18. Directors Fees          |                        |        |        |        |        |        |        |        |        |        | 17     |
| 19. Professional Services   |                        |        |        |        |        |        |        |        |        | (10,195) | (153,705) |
| 20. Fees, Subscriptions &amp; Promotions | (15,476) |        |        |        |        |        |        |        | (143,510) | (15,057) |
| 21. Clerical &amp; General Office Expenses | (77,877) |        |        |        | 323    |        |        |        | 90,629  | 21     |
| 22. Employee Benefits &amp; Payroll Taxes |        |        |        |        |        |        |        |        |        | 22     |
| 23. Inservice Training &amp; Education |        |        |        |        |        |        |        |        |        | 23     |
| 24. Travel and Seminar      |                        |        |        |        |        |        |        |        |        | 148    | 24     |
| 25. Other Admin. Staff Transportation |        |        |        |        |        |        |        |        |        | 2,235  | 25     |
| 26. Insurance-Prop.Liab.Malpractice |        |        |        |        |        |        |        |        |        | 1,368  | 26     |
| 27. Other (specify):        |                        |        |        |        |        |        |        |        |        | 13,898 | 27     |
| 28. TOTAL General Administration | (103,548) |        |        |        | 323    |        |        |        | (26,489) | 28     |
| 29. TOTAL Operating Expense (sum of lines 8,16 &amp; 28) | (123,780) |        |        |        | 323    |        |        |        | (20,570) | 29     |</p>
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<td>(408,923)</td>
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*(sum of lines 29, 37 & 44)
### VII. RELATED PARTIES

#### A. Owners

<table>
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<tr>
<th>Name</th>
<th>Ownership %</th>
<th>Name</th>
<th>City</th>
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</table>

#### B. Related Nursing Homes

<table>
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#### C. Other Related Business Entities

<table>
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</table>

#### 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.

- [X] 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.

<table>
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<tr>
<th>Schedule V</th>
<th>Line</th>
<th>Item</th>
<th>Amount</th>
<th>Name of Related Organization</th>
<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
<th>Differences of Related Organization Costs (7 minus 4)</th>
</tr>
</thead>
<tbody>
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<td>Rent</td>
<td>$252,302</td>
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<td>$43,560</td>
<td>(115,579)</td>
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* Total must agree with the amount recorded on line 34 of Schedule VI.
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. 

<table>
<thead>
<tr>
<th>Line</th>
<th>Item Description</th>
<th>Name of Related Organization</th>
<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
<th>Difference: Adjustments for Related Organization Costs (7 minus 4)</th>
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</table>

* 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.  

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</table>

* 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.

<table>
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<th>Line</th>
<th>Item</th>
<th>Amount</th>
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<th>Percent of Ownership</th>
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* 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.

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VII. RELATED PARTIES (continued)

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- [ ] YES  
- [ ] NO

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VII. RELATED PARTIES (continued)

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

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.

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<th>Line</th>
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<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
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* 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.

<table>
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<tr>
<th>Line</th>
<th>Item</th>
<th>Amount</th>
<th>Name of Related Organization</th>
<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
<th>Adjustments for Related Organization Costs (7 minus 4)</th>
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*Total must agree with the amount recorded on line 34 of Schedule VI.*
### VII. RELATED PARTIES

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

<table>
<thead>
<tr>
<th>OWNER</th>
<th>Ownership %</th>
<th>RELATED NURSING HOMES</th>
<th>OTHER RELATED BUSINESS ENTITIES</th>
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### VII. RELATED PARTIES

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

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### 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Function</th>
<th>Ownership Interest</th>
<th>Compensation Received From Other Nursing Homes*</th>
<th>Average Hours Per Work Week Devoted to this Facility and % of Total Work Week</th>
<th>Compensation Included in Costs for this Reporting Period**</th>
<th>Schedule V, Line &amp; Column</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mark Suissa</td>
<td>Owner</td>
<td>Administrative</td>
<td>42.31%</td>
<td>5 8.33%</td>
<td>Alloc Sal/Fee $ 38,325</td>
<td>17-3 / 17-7</td>
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<td>Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts</td>
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<td>12 anticipated to be considered allowable by the IL. Dept. of HFS,</td>
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<td>13 TOTAL $ 38,325</td>
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</table>

* 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 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.
VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES ☐ NO ☐

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

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

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<td>Total Units</td>
<td>Number of Subunits Being Allocated Among</td>
<td>Total Indirect Cost Being Allocated</td>
<td>Amount of Salary Cost Contained in Column 6</td>
<td>Facility Allocation Units</td>
<td>(col.8/col.4)x col.6</td>
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TOTALS

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### VIII. ALLOCATION OF INDIRECT COSTS

**A.** Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

- **YES** [x]
- **NO** [ ]

**Name of Related Organization:** HEALTHCARE ACCOUNTING SERVICES, LLC

**Address:** 1401 S. BRENTWOOD BOULEVARD

**City / State / Zip Code:** BRENTWOOD, MO. 63144

**Phone Number:** (314) 963-7570

**Fax Number:** (314) 963-9030

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

<table>
<thead>
<tr>
<th>Schedule V Line Reference</th>
<th>Item</th>
<th>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Facility Allocation (col.8/col.4)x col.6</th>
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### VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

- **YES** - X
- **NO** - □

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<th>Name of Related Organization</th>
<th>MS HEALTHCARE ACCOUNTING</th>
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<td>Street Address</td>
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</tr>
<tr>
<td>Phone Number</td>
<td>(917) 744-8688</td>
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B. Show the allocation of costs below. If necessary, please attach worksheets.

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### VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

- YES
- NO

Name of Related Organization: 

Street Address: 

City / State / Zip Code: 

Phone Number: 

Fax Number: 

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

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<th>Schedule V Line Reference</th>
<th>1 Schedule V Line Reference</th>
<th>2 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>3 Total Units</th>
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<th>5 Number of Subunits Being Allocated Among</th>
<th>6 Amount of Salary Cost Contained in Column 6</th>
<th>7 Cost Being Allocated</th>
<th>8 Facility Allocation Units (col.8/col.4)x col.6</th>
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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

Yes [ ] No [ ]

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

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

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<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Units</th>
<th>Allocation (col.8/col.4)x col.6</th>
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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

<table>
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<th>YES</th>
<th>NO</th>
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B. Show the allocation of costs below. If necessary, please attach worksheets.

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<th>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Facility Allocation Units (col.8/col.4)x col.6</th>
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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES [ ] NO [ ]

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

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

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<td>Amount of Salary Cost Contained in Column 6 Units</td>
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### VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

- YES [ ]
- NO [ ]

Name of Related Organization: ____________________________
Street Address: ____________________________
City / State / Zip Code: ____________________________
Phone Number: (______) _______ _______  _______
Fax Number: (______) _______ _______  _______

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

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</table>
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.

<table>
<thead>
<tr>
<th>Line Reference</th>
<th>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Facility Allocation Units</th>
<th>Allocation (col.8/col.4)x col.6</th>
</tr>
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<tbody>
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</table>
### VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

<table>
<thead>
<tr>
<th>Schedule V Line Reference</th>
<th>Unit of Allocation Item</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Facility Allocation (col.8/col.4)x col.6</th>
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### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

<table>
<thead>
<tr>
<th>Name of Lender</th>
<th>Related**</th>
<th>Purpose of Loan</th>
<th>Monthly Payment Required</th>
<th>Date of Note</th>
<th>Amount of Note</th>
<th>Maturity Date</th>
<th>Interest Rate (4 Digits)</th>
<th>Reporting Period Interest Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank Leumi</td>
<td>NO</td>
<td>Mortgage</td>
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<td>Mortgage</td>
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<td>Mortgage</td>
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<td>IPFS Corporation</td>
<td>NO</td>
<td>Finance Insurance Premium</td>
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<tr>
<td>Select Rehabilitation</td>
<td>NO</td>
<td>Note Payable</td>
<td>02/03/17</td>
<td>20,000</td>
<td></td>
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<tr>
<td>See Supplemental Schedule</td>
<td>NO</td>
<td>Note Payable</td>
<td>02/03/17</td>
<td>20,000</td>
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<tr>
<td>TOTAL Facility Related</td>
<td>NO</td>
<td>Note Payable</td>
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<tr>
<td>TOTAL Non-Facility Related</td>
<td>NO</td>
<td>Note Payable</td>
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<tr>
<td>TOTALS (line 9+line14)</td>
<td>NO</td>
<td>Note Payable</td>
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</table>

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

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)
### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
#### B. Real Estate Taxes

**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Real Estate Tax accrual used on 2017 report.</td>
<td>$67,753</td>
</tr>
<tr>
<td>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.)</td>
<td>$68,219</td>
</tr>
<tr>
<td>3. Under or (over) accrual (line 2 minus line 1).</td>
<td>$466</td>
</tr>
<tr>
<td>4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)</td>
<td>$69,000</td>
</tr>
<tr>
<td>5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</td>
<td>$</td>
</tr>
<tr>
<td>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.)</td>
<td>$</td>
</tr>
<tr>
<td>7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.</td>
<td>$69,466</td>
</tr>
</tbody>
</table>

**Real Estate Tax History:**

<table>
<thead>
<tr>
<th>Real Estate Tax Bill for Calendar Year:</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>FROM R. E. TAX STATEMENT FOR 2017 $</td>
</tr>
<tr>
<td>2014</td>
<td>PLUS APPEAL COST FROM LINE 5 $</td>
</tr>
<tr>
<td>2015</td>
<td>LESS REFUND FROM LINE 6 $</td>
</tr>
<tr>
<td>2016</td>
<td>AMOUNT TO USE FOR RATE CALCULATION $</td>
</tr>
</tbody>
</table>

2018 Accrual = $68,219 x 1.01 = $69,000 (rounded)

**NOTES:**

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

<table>
<thead>
<tr>
<th>(A)</th>
<th>(B)</th>
<th>(C)</th>
<th>(D) Tax Applicable to Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Index Number</td>
<td>Property Description</td>
<td>Total Tax</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>13-2-21-14-00-000-009</td>
<td>Long Term Care Facility</td>
<td>$68,219.04</td>
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</table>

TOTALS $68,219.04 $68,219.04

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.

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
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<tbody>
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<td>Tax Index Number</td>
<td>Property Description</td>
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<td>Tax Applicable to Nursing Home</td>
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<td>10.</td>
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</tr>
<tr>
<td>TOTALS</td>
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<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

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.
X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,695

B. General Construction Type: Exterior Brick Frame Wood

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Domains 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.

(Domains 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:

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

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<thead>
<tr>
<th>Beds*</th>
<th>FOR BHF USE ONLY</th>
<th>Year Acquired</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
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Improvement Type**

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</tbody>
</table>

*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
### B. Building and Improvement Costs-Including Fixed Equipment

(See instructions.) Round all numbers to nearest dollar.

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
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**Improvement type must be detailed in order for the cost report to be considered complete.
### 1. Improvement Type**

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**Improvement type must be detailed in order for the cost report to be considered complete.
## B. Building and Improvement Costs-Including Fixed Equipment

(See instructions.) Round all numbers to nearest dollar.

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<th>Improvement Type**</th>
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<th>4 Cost</th>
<th>5 Current Book Depreciation</th>
<th>6 Life in Years</th>
<th>7 Straight Line Depreciation</th>
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**Improvement type must be detailed in order for the cost report to be considered complete.
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### B. Building and Improvement Costs-Including Fixed Equipment

(See instructions.) Round all numbers to nearest dollar.

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### Building and Improvement Costs (continued)

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

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**Improvement type must be detailed in order for the cost report to be considered complete.
### B. Building and Improvement Costs-Including Fixed Equipment

(See instructions.) Round all numbers to nearest dollar.

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

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<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
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**TOTAL (lines 1 thru 33) | $ | $ | $ | $ | $ | $ | 34
### XI. OWNERSHIP COSTS (continued)

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

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<th>Improvement Type**</th>
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<th>Life in Years</th>
<th>Straight Line Depreciation</th>
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**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.

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**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.)

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#### D. Vehicle Costs. (See instructions.)*

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<tr>
<td>78</td>
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<td></td>
</tr>
<tr>
<td>80 TOTALS</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

#### E. Summary of Care-Related Assets

<table>
<thead>
<tr>
<th>Reference</th>
<th>1</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>81 Total Historical Cost</td>
<td>(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)</td>
<td>$3,903,223</td>
</tr>
<tr>
<td>82 Current Book Depreciation</td>
<td>(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)</td>
<td>$150,022</td>
</tr>
<tr>
<td>83 Straight Line Depreciation</td>
<td>(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)</td>
<td>$158,345</td>
</tr>
<tr>
<td>84 Adjustments</td>
<td>(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)</td>
<td>$8,323</td>
</tr>
<tr>
<td>85 Accumulated Depreciation</td>
<td>(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)</td>
<td>$2,808,227</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>1 Description &amp; Year Acquired</th>
<th>2 Cost</th>
<th>Accumulated Depreciation</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>86</td>
<td>$</td>
<td>$</td>
<td>86</td>
</tr>
<tr>
<td>87</td>
<td>87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>89</td>
<td>89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>91 TOTALS</td>
<td>$</td>
<td>$</td>
<td>91</td>
</tr>
</tbody>
</table>

#### G. Construction-in-Progress

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>92</td>
<td>$</td>
</tr>
<tr>
<td>93</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>$</td>
</tr>
<tr>
<td>**</td>
<td>This must agree with Schedule V line 30, column 8.</td>
</tr>
</tbody>
</table>

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.
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? YES NO

   If NO, see instructions.

<table>
<thead>
<tr>
<th>Year Constructed</th>
<th>Number of Beds</th>
<th>Original Lease Date</th>
<th>Rental Amount</th>
<th>Total Years of Lease</th>
<th>Total Years Renewal Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3 Building: $3

Additions: $900

4. Alloc. from Healthcare Accounting Serv./MS Healthcare Accounting

   Description: See Attached Schedule

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.


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

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
    /2019 $12
    /2020 $13
    /2021 $14

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

   Rental Amount for movable equipment: $13,121 Description: See Attached Schedule

C. Vehicle Rental (See instructions.)

16. Rental Amount for movable equipment: $13,121 Description: See Attached Schedule

<table>
<thead>
<tr>
<th>Use</th>
<th>Model Year and Make</th>
<th>Monthly Lease Payment</th>
<th>Rental Expense for This Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Allocated from H.A.S $</td>
<td>$3,045</td>
<td>17</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td>$3,045</td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>$3,045</td>
<td>19</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td>$3,045</td>
<td>20</td>
</tr>
<tr>
<td>21</td>
<td>TOTAL</td>
<td>$3,045</td>
<td>21</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>2. CLASSROOM PORTION:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. CLINICAL PORTION:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

### B. EXPENSES

#### ALLOCATION OF COSTS

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

(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.

### 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

<table>
<thead>
<tr>
<th></th>
<th>COMPLETED</th>
<th>DROP-OUTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From this facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. From other facilities (f)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL TRAINED

(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.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Schedule V Line &amp; Column Reference</th>
<th>Staff</th>
<th>Outside Practitioner (other than consultant)</th>
<th>Supplies (Actual or Allocated)</th>
<th>Total Units (Column 2 + 4)</th>
<th>Total Cost (Col. 3 + 5 + 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Licensed Occupational Therapist</td>
<td>39 - 03 hrs</td>
<td>$108,773</td>
<td>$108,773</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Licensed Speech and Language Development Therapist</td>
<td>39 - 03 hrs</td>
<td>$88,830</td>
<td>$88,830</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Licensed Recreational Therapist</td>
<td>hrs</td>
<td>$102,252</td>
<td>$102,252</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Licensed Physical Therapist</td>
<td>hrs</td>
<td>$102,252</td>
<td>$102,252</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Physician Care</td>
<td>visits</td>
<td>$76,854</td>
<td>$76,854</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Dental Care</td>
<td>visits</td>
<td>$4,216</td>
<td>$65,642</td>
<td>$69,858</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Work Related Program</td>
<td>hrs</td>
<td>$4,216</td>
<td>$65,642</td>
<td>$69,858</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Habilitation</td>
<td># of</td>
<td>$4,216</td>
<td>$65,642</td>
<td>$69,858</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Psychological Services</td>
<td>39 - 02 prescrpts</td>
<td>76,854</td>
<td>76,854</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Evaluation and Diagnosis/Behavior Modification)</td>
<td>hrs</td>
<td>4,216</td>
<td>65,642</td>
<td>69,858</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Academic Education</td>
<td>hrs</td>
<td>4,216</td>
<td>65,642</td>
<td>69,858</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Other (specify):</td>
<td></td>
<td>4,216</td>
<td>65,642</td>
<td>69,858</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Other (specify):</td>
<td></td>
<td>4,216</td>
<td>65,642</td>
<td>69,858</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 TOTAL</td>
<td>$304,071</td>
<td>$142,496</td>
<td>$446,567</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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
As of 12/31/18

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

### A. Current Assets

<table>
<thead>
<tr>
<th>1</th>
<th>Operating</th>
<th>2</th>
<th>After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cash on Hand and in Banks</td>
<td>$50,590</td>
<td>$52,465</td>
</tr>
<tr>
<td>2</td>
<td>Cash-Patient Deposits</td>
<td>$28,326</td>
<td>$28,326</td>
</tr>
<tr>
<td>3</td>
<td>Accounts &amp; Short-Term Notes Receivable-Patients (less allowance)</td>
<td>$754,657</td>
<td>$754,657</td>
</tr>
<tr>
<td>4</td>
<td>Supply Inventory (priced at cost)</td>
<td>$14,825</td>
<td>$14,825</td>
</tr>
<tr>
<td>5</td>
<td>Short-Term Investments</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>Prepaid Insurance</td>
<td>$45,271</td>
<td>$45,271</td>
</tr>
<tr>
<td>7</td>
<td>Other Prepaid Expenses</td>
<td>$179,000</td>
<td>$179,000</td>
</tr>
<tr>
<td>8</td>
<td>Accounts Receivable (owners or related parties)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9</td>
<td>Other (specify):</td>
<td>See Attached Schedule</td>
<td>60</td>
</tr>
<tr>
<td>10</td>
<td>TOTAL Current Assets (sum of lines 1 thru 9)</td>
<td>$1,072,729</td>
<td>$1,074,604</td>
</tr>
</tbody>
</table>

### B. Long-Term Assets

| 11 | Long-Term Notes Receivable | - | - | 11 |
| 12 | Long-Term Investments | - | - | 12 |
| 13 | Land | $184,895 | $184,895 | 13 |
| 14 | Buildings, at Historical Cost | $1,698,088 | $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): | See Attached Schedule | $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 |

### 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 | - | - | 31 |
| 32 | Accrued Real Estate Taxes (Sch.IX-B) | $69,000 | $69,000 | 32 |
| 33 | Accrued Interest Payable | - | - | 33 |
| 34 | Deferred Compensation | - | - | 34 |
| 35 | Federal and State Income Taxes | - | - | 35 |
| 36 | Other Current Liabilities (specify): | See Attached Schedule | $817,897 | 36 |
| 37 | 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 | - | - | 40 |
| 41 | Bonds Payable | - | - | 41 |
| 42 | Deferred Compensation | - | - | 42 |
| 43 | Other Long-Term Liabilities (specify): | See Attached Schedule | $2,253,404 | 43 |
| 44 | TOTAL Long-Term Liabilities (sum of lines 39 thru 44) | $2,273,404 | $3,379,087 | 45 |
| 45 | TOTAL LIABILITIES (sum of lines 26 and 38) | $3,910,205 | $5,020,515 | 46 |
| 46 | TOTAL EQUITY (page 18, line 24) | $(1,864,278) | $(2,486,436) | 47 |
| 47 | TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47) | $2,045,927 | $2,534,079 | 48 |

* (See instructions.)
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Balance at Beginning of Year, as Previously Reported</td>
<td>$(1,678,388)</td>
</tr>
<tr>
<td>2</td>
<td>Restatements (describe):</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Prior Year Maintenance</td>
<td>2,627</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Balance at Beginning of Year, as Restated (sum of lines 1-5)</td>
<td>$(1,675,761)</td>
</tr>
</tbody>
</table>

**A. Additions (deductions):**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>NET Income (Loss) (from page 19, line 43)</td>
<td>$(188,517)</td>
</tr>
<tr>
<td>8</td>
<td>Acquisitions of Pooled Companies</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Proceeds from Sale of Stock</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Stock Options Exercised</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Contributions and Grants</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Expenditures for Specific Purposes</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Dividends Paid or Other Distributions to Owners</td>
<td>( )</td>
</tr>
<tr>
<td>14</td>
<td>Donated Property, Plant, and Equipment</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>TOTAL Additions (deductions) (sum of lines 7-16)</td>
<td>$(188,517)</td>
</tr>
</tbody>
</table>

**B. Transfers (Itemize):**

<table>
<thead>
<tr>
<th></th>
<th>Transfer Item</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>TOTAL Transfers (sum of lines 18-22)</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</td>
<td>$(1,864,278)</td>
</tr>
</tbody>
</table>

* This must agree with page 17, line 47.
### XVII. INCOME STATEMENT

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

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

#### I. Revenue

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$4,189,381</td>
</tr>
<tr>
<td>$473,423</td>
</tr>
<tr>
<td>$3,715,958</td>
</tr>
<tr>
<td>$605,657</td>
</tr>
<tr>
<td>$45,114</td>
</tr>
<tr>
<td>$8,762</td>
</tr>
<tr>
<td>$2,687</td>
</tr>
<tr>
<td>$4,378,178</td>
</tr>
</tbody>
</table>

#### II. Expenses

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$810,781</td>
</tr>
<tr>
<td>$1,342,756</td>
</tr>
<tr>
<td>$1,151,626</td>
</tr>
<tr>
<td>$450,884</td>
</tr>
<tr>
<td>$612,350</td>
</tr>
<tr>
<td>$198,298</td>
</tr>
<tr>
<td>$4,566,695</td>
</tr>
<tr>
<td>$188,517</td>
</tr>
<tr>
<td>$188,517</td>
</tr>
<tr>
<td>$3,715,958</td>
</tr>
</tbody>
</table>

#### III. Net Inpatient Revenue detailed by Payer Source

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,087,880</td>
</tr>
<tr>
<td>$500,514</td>
</tr>
<tr>
<td>$529,818</td>
</tr>
<tr>
<td>$214,746</td>
</tr>
<tr>
<td>$206,000</td>
</tr>
<tr>
<td>$3,715,958</td>
</tr>
</tbody>
</table>

*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.
### XVIII. A. STAFFING AND SALARY COSTS

(please report each line separately)

(This schedule must cover the entire reporting period)

<table>
<thead>
<tr>
<th>1</th>
<th>2**</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Hrs. Actually Worked</td>
<td># of Hrs. Paid and Accrued</td>
<td>Reporting Period Total Salaries, Wages</td>
<td>Average Hourly Wage</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>2,123</td>
<td>2,283</td>
<td>$99,205</td>
</tr>
<tr>
<td>Assistant Director of Nursing</td>
<td>7,633</td>
<td>8,207</td>
<td>224,806</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>11,919</td>
<td>12,817</td>
<td>305,635</td>
</tr>
<tr>
<td>CNAs &amp; Ordineries</td>
<td>38,585</td>
<td>41,489</td>
<td>531,587</td>
</tr>
<tr>
<td>CNA Trainees</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed Therapist</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dieticians</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Service Supervisor</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Cook</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cook Helpers/Assistants</td>
<td>15,627</td>
<td>16,803</td>
<td>178,591</td>
</tr>
<tr>
<td>Dishwashers</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance Workers</td>
<td>3,115</td>
<td>3,349</td>
<td>74,418</td>
</tr>
<tr>
<td>Housekeepers</td>
<td>9,785</td>
<td>10,522</td>
<td>111,976</td>
</tr>
<tr>
<td>Laundry</td>
<td>9,053</td>
<td>9,734</td>
<td>95,865</td>
</tr>
<tr>
<td>Administrators</td>
<td>2,050</td>
<td>2,204</td>
<td>151,606</td>
</tr>
<tr>
<td>Assistant Administrators</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Administrative</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Manager</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerical</td>
<td>4,814</td>
<td>5,176</td>
<td>137,176</td>
</tr>
<tr>
<td>Vocational Instruction</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic Instruction</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified MR Prof. (QMRP)</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident Services Coordinator</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habilitation Aides (DD Homes)</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records</td>
<td>876</td>
<td>942</td>
<td>13,193</td>
</tr>
<tr>
<td>Other Health Care(specify)</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other(specify) See Attached</td>
<td>1,591</td>
<td>1,711</td>
<td>51,783</td>
</tr>
<tr>
<td>TOTAL (lines 1 - 33)</td>
<td>113,519</td>
<td>122,063</td>
<td>$2,071,202</td>
</tr>
</tbody>
</table>

* This total must agree with page 4, column 1, line 45.

** See instructions.

### B. CONSULTANT SERVICES

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hrs.</td>
<td>Total Consultant</td>
<td>Schedule V</td>
</tr>
<tr>
<td>of Hrs.</td>
<td>Cost for</td>
<td>Line &amp; Column Reference</td>
</tr>
<tr>
<td>Paid &amp; Accrued</td>
<td>Reporting Period</td>
<td></td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>2,123</td>
<td>2,283</td>
</tr>
<tr>
<td>Assistant Director of Nursing</td>
<td>7,633</td>
<td>8,207</td>
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<td>12,817</td>
</tr>
<tr>
<td>CNAs &amp; Ordineries</td>
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<td>41,489</td>
</tr>
<tr>
<td>CNA Trainees</td>
<td>6</td>
<td></td>
</tr>
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<td>7</td>
<td></td>
</tr>
<tr>
<td>Dieticians</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Food Service Supervisor</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Head Cook</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Cook Helpers/Assistants</td>
<td>15,627</td>
<td>16,803</td>
</tr>
<tr>
<td>Dishwashers</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Maintenance Workers</td>
<td>3,115</td>
<td>3,349</td>
</tr>
<tr>
<td>Housekeepers</td>
<td>9,785</td>
<td>10,522</td>
</tr>
<tr>
<td>Laundry</td>
<td>9,053</td>
<td>9,734</td>
</tr>
<tr>
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<td>2,050</td>
<td>2,204</td>
</tr>
<tr>
<td>Assistant Administrators</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Other Administrative</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Office Manager</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Clerical</td>
<td>4,814</td>
<td>5,176</td>
</tr>
<tr>
<td>Vocational Instruction</td>
<td>25</td>
<td></td>
</tr>
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<td>Academic Instruction</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Qualified MR Prof. (QMRP)</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Resident Services Coordinator</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Habilitation Aides (DD Homes)</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Medical Records</td>
<td>876</td>
<td>942</td>
</tr>
<tr>
<td>Other Health Care(specify)</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Other(specify) See Attached</td>
<td>1,591</td>
<td>1,711</td>
</tr>
<tr>
<td>TOTAL (lines 1 - 33)</td>
<td>113,519</td>
<td>122,063</td>
</tr>
</tbody>
</table>

### C. CONTRACT NURSES

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hrs.</td>
<td>Total Contract</td>
<td>Schedule V</td>
</tr>
<tr>
<td>of Hrs.</td>
<td>Wages</td>
<td>Line &amp; Column Reference</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>$</td>
<td>50</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>127</td>
<td>5,317</td>
</tr>
<tr>
<td>Certified Nurse Assistants/Aides</td>
<td>793</td>
<td>19,365</td>
</tr>
<tr>
<td>TOTAL (lines 50 - 52)</td>
<td>920</td>
<td>24,682</td>
</tr>
</tbody>
</table>
## XIX. SUPPORT SCHEDULES

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Administrative Salaries</strong></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Function</td>
</tr>
<tr>
<td>Sherri Dixon-Rudd</td>
<td>Administrator</td>
</tr>
<tr>
<td>Workers' Compensation Insurance</td>
<td></td>
</tr>
<tr>
<td>Employee Health Insurance</td>
<td></td>
</tr>
<tr>
<td>Illinois Municipal Retirement Fund (IMRF)*</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

**B. Administrative - Other**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management Fees - Mark Suissa</td>
<td>$30,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$315,959</td>
</tr>
</tbody>
</table>

**C. Professional Services**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marcum LLP Accounting Services</td>
<td>$31,113</td>
</tr>
<tr>
<td>Healthcare Accounting Services</td>
<td>$147,000</td>
</tr>
<tr>
<td>Personnel Planners</td>
<td>$1,605</td>
</tr>
<tr>
<td>Data Processing</td>
<td>$2,534</td>
</tr>
<tr>
<td>See Attached</td>
<td>$12,962</td>
</tr>
<tr>
<td>Paycom</td>
<td>$19,565</td>
</tr>
<tr>
<td>National Data Corp</td>
<td>$1,989</td>
</tr>
<tr>
<td>CSC</td>
<td>$2,151</td>
</tr>
<tr>
<td>Legat Architects</td>
<td>$5,785</td>
</tr>
<tr>
<td>TASC</td>
<td>$1,925</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$226,629</td>
</tr>
</tbody>
</table>

**F. Dues, Fees, Subscriptions and Promotions**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dues &amp; Subscriptions</td>
<td>$11,716</td>
</tr>
<tr>
<td>Licenses &amp; Fees</td>
<td>$2,890</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$18,926</td>
</tr>
</tbody>
</table>

**G. Schedule of Travel and Seminar**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-State Travel</td>
<td>$</td>
</tr>
<tr>
<td>In-State Travel</td>
<td>$</td>
</tr>
<tr>
<td>Seminar Expense</td>
<td>$2,338</td>
</tr>
<tr>
<td>Allocated from Healthcare Accounting</td>
<td>$148</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$2,338</td>
</tr>
</tbody>
</table>

*Attach copy of IMRF notifications

**See instructions.
### XX. GENERAL INFORMATION:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Are nursing employees (RN, LPN, NA) represented by a union?</td>
<td>No</td>
</tr>
<tr>
<td>(2) Are there any dues to nursing home associations included on the cost report?</td>
<td>Yes</td>
</tr>
<tr>
<td>If YES, give association name and amount.</td>
<td>HCCI $17,992</td>
</tr>
<tr>
<td>(3) Did the nursing home make political contributions or payments to a political action organization?</td>
<td>Yes</td>
</tr>
<tr>
<td>If YES, have these costs been properly adjusted out of the cost report?</td>
<td>Yes</td>
</tr>
<tr>
<td>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?</td>
<td>No</td>
</tr>
<tr>
<td>If YES, what is the capacity?</td>
<td>N/A</td>
</tr>
<tr>
<td>(5) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?</td>
<td>Yes</td>
</tr>
<tr>
<td>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.</td>
<td>$11,980 Line 10</td>
</tr>
<tr>
<td>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?</td>
<td>Yes</td>
</tr>
<tr>
<td>If NO, attach a complete explanation.</td>
<td>N/A</td>
</tr>
<tr>
<td>(8) Are you presently operating under a sale and leaseback arrangement?</td>
<td>No</td>
</tr>
<tr>
<td>If YES, give effective date of lease.</td>
<td>N/A</td>
</tr>
<tr>
<td>(9) Are you presently operating under a sublease agreement?</td>
<td>YES X NO</td>
</tr>
<tr>
<td>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?</td>
<td>YES</td>
</tr>
<tr>
<td>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.</td>
<td>N/A</td>
</tr>
<tr>
<td>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.</td>
<td>$198,298</td>
</tr>
<tr>
<td>This amount is to be recorded on line 42 of Schedule V.</td>
<td></td>
</tr>
<tr>
<td>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?</td>
<td>No</td>
</tr>
<tr>
<td>If YES, attach an explanation of the allocation.</td>
<td></td>
</tr>
<tr>
<td>(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?</td>
<td>Yes</td>
</tr>
<tr>
<td>(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?</td>
<td>No</td>
</tr>
<tr>
<td>If YES, attach a schedule which explains how all related costs were allocated to these functions.</td>
<td></td>
</tr>
<tr>
<td>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs?</td>
<td>N/A</td>
</tr>
<tr>
<td>Indicate the amount. $</td>
<td></td>
</tr>
<tr>
<td>(16) Travel and Transportation:</td>
<td></td>
</tr>
<tr>
<td>a. Are there costs included for out-of-state travel?</td>
<td>No</td>
</tr>
<tr>
<td>If YES, attach a complete explanation.</td>
<td></td>
</tr>
<tr>
<td>b. Do you have a separate contract with the Department to provide medical transportation for residents?</td>
<td>No</td>
</tr>
<tr>
<td>If YES, please indicate the amount of income earned from such a program during this reporting period. $</td>
<td>N/A</td>
</tr>
<tr>
<td>c. What percent of all travel expense relates to transportation of nurses and patients?</td>
<td>100% Ln 14</td>
</tr>
<tr>
<td>d. Have vehicle usage logs been maintained?</td>
<td>Yes</td>
</tr>
<tr>
<td>e. Are all vehicles stored at the nursing home during the night and all other times when not in use?</td>
<td>Yes</td>
</tr>
<tr>
<td>f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?</td>
<td></td>
</tr>
<tr>
<td>g. Does the facility transport residents to and from day training?</td>
<td>No</td>
</tr>
<tr>
<td>Indicate the amount of income earned from providing such transportation during this reporting period. $</td>
<td>N/A</td>
</tr>
<tr>
<td>(17) Has an audit been performed by an independent certified public accounting firm?</td>
<td>No</td>
</tr>
<tr>
<td>Firm Name:</td>
<td>N/A</td>
</tr>
<tr>
<td>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?</td>
<td>Yes</td>
</tr>
<tr>
<td>(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.</td>
<td></td>
</tr>
<tr>
<td>Attach invoices and a summary of services for all architect and appraisal fees</td>
<td></td>
</tr>
</tbody>
</table>