FOR BHF USE

LL1

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0041210

Facility Name: Elmwood Nursing & Rehab Ctr

Address: 152 Wilma Drive (Number) Maryville (City) 62062 (Zip Code)

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			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/14 to 12/31/14 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.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	404	6	1,882	2,292	8
9	SNF/PED					9
10	ICF	16,368	3,229	2,352	21,949	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,772	3,235	4,234	24,241	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.86%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 1,765

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	168,627	15,712	10,052	194,391		194,391		194,391			1
2	Food Purchase		131,656		131,656		131,656	(176)	131,480			2
3	Housekeeping	103,822	27,618		131,440		131,440		131,440			3
4	Laundry	65,808	15,234		81,042		81,042		81,042			4
5	Heat and Other Utilities			103,248	103,248		103,248		103,248			5
6	Maintenance	61,821	25,099	70,402	157,322		157,322	(10,439)	146,883			6
7	Other (specify):*											7
8	**TOTAL General Services**	400,078	215,319	183,702	799,099		799,099	(10,615)	788,484			8
	B. Health Care and Programs											
9	Medical Director			14,000	14,000		14,000		14,000			9
10	Nursing and Medical Records	833,429	8,498	7,600	849,527		849,527	3,274	852,801			10
10a	Therapy			27,031	27,031		27,031		27,031			10a
11	Activities	40,044	843	4,066	44,953		44,953		44,953			11
12	Social Services	25,683			25,683		25,683		25,683			12
13	CNA Training											13
14	Program Transportation			4,225	4,225		4,225		4,225			14
15	Other (specify):*							544	544			15
16	**TOTAL Health Care and Programs**	899,156	9,341	56,922	965,419		965,419	3,818	969,237			16
	C. General Administration											
17	Administrative	132,886			132,886		132,886	4,703	137,589			17
18	Directors Fees											18
19	Professional Services			125,640	125,640		125,640	(54,274)	71,366			19
20	Dues, Fees, Subscriptions & Promotions			15,275	15,275		15,275	(4,774)	10,501			20
21	Clerical & General Office Expenses	114,502	5,656	145,758	265,916		265,916	(48,048)	217,868			21
22	Employee Benefits & Payroll Taxes			443,650	443,650		443,650		443,650			22
23	Inservice Training & Education											23
24	Travel and Seminar			319	319		319	90	409			24
25	Other Admin. Staff Transportation			211	211		211	1,566	1,777			25
26	Insurance-Prop.Liab.Malpractice			117,756	117,756		117,756	199	117,955			26
27	Other (specify):*							8,874	8,874			27
28	**TOTAL General Administration**	247,388	5,656	848,609	1,101,653		1,101,653	(91,664)	1,009,989			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,546,622	230,316	1,089,233	2,866,171		2,866,171	(98,461)	2,767,710			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 Ctr #0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			47,821	47,821		47,821	123,765	171,586			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,812	1,812		1,812	160,706	162,518			32
33	Real Estate Taxes			66,000	66,000		66,000		66,000			33
34	Rent-Facility & Grounds			257,157	257,157		257,157	(244,435)	12,722			34
35	Rent-Equipment & Vehicles			9,962	9,962		9,962	1,023	10,985			35
36	Other (specify):*											36
37	**TOTAL Ownership**			382,752	382,752		382,752	41,059	423,811			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,990	229,317	382,307		382,307	29,126	411,433			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,254	193,254		193,254		193,254			42
43	Other (specify):*	70,528		144,000	214,528		214,528	(214,528)	0			43
44	**TOTAL Special Cost Centers**	70,528	152,990	566,571	790,089		790,089	(185,402)	604,687			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,617,150	383,306	2,038,556	4,039,012		4,039,012	(242,804)	3,796,208			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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(13,941)	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	80,151	30		9
10	Interest and Other Investment Income	(182)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(176)	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	(7,629)	21		18
19	Entertainment	(100)	21		19
20	Contributions	(3,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(54,478)	21		24
25	Fund Raising, Advertising and Promotional	(1,916)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(263,333)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (264,604)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	21,800		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 21,800		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (242,804)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS **Page 5A**

Elmwood Nursing & Rehab Ctr

ID# **0041210**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (1,385)	21	1
2	Medical Records	(168)	10	2
3	Marketing Salaries	(70,528)	43	3
4	Sequestration Expense	(15,587)	21	4
5	Bank Charges	(3,549)	21	5
6	Collection Fees	(1,556)	21	6
7	Late Fees	(20,131)	21	7
8	Additional R&M	2,062	06	8
9	Amortization - Bldg. Co.	(7,938)	31	9
10	Replacement Tax - Bldg. Co.	(440)	21	10
11	Bank Charges - Bldg. Co	(114)	21	11
12	Non-Allowable Expense	(144,000)	43	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(263,333)		49

Elmwood Nursing & Rehab Ctr

ID# 0041210

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(176)											(176)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(11,879)		1,440									(10,439)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(12,055)		1,440									(10,615)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(168)		3,442									3,274	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			544									544	15
16	**TOTAL Health Care and Programs**	(168)		3,986									3,818	16
	C. General Administration													
17	Administrative			4,703									4,703	17
18	Directors Fees													18
19	Professional Services			(54,274)									(54,274)	19
20	Fees, Subscriptions & Promotions	(4,916)		142									(4,774)	20
21	Clerical & General Office Expenses	(104,968)	554	56,366									(48,048)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			90									90	24
25	Other Admin. Staff Transportation			1,566									1,566	25
26	Insurance-Prop.Liab.Malpractice			199									199	26
27	Other (specify):*			8,874									8,874	27
28	**TOTAL General Administration**	(109,884)	554	17,666									(91,664)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(122,107)	554	23,092									(98,461)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	80,151	43,541	73									123,765	30
31	Amortization of Pre-Op. & Org.	(7,938)	7,938											31
32	Interest	(182)	160,484	404									160,706	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(252,302)	7,867									(244,435)	34
35	Rent-Equipment & Vehicles			1,023									1,023	35
36	Other (specify):*													36
37	**TOTAL Ownership**	72,031	(40,339)	9,367									41,059	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					29,126							29,126	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(214,528)											(214,528)	43
44	**TOTAL Special Cost Centers**	(214,528)				29,126							(185,402)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(264,604)	(39,785)	32,459		29,126							(242,804)	45

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [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.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 252,302	Maryville Health Properties, LLC	100.00%	$	$ (252,302)	1
2	V	33	Rental Income - Taxes	66,000	Maryville Health Properties, LLC	100.00%	66,000		2
3	V	31	Amort. Of Loan Costs		Maryville Health Properties, LLC	100.00%	7,938	7,938	3
4	V	21	Bank Charges		Maryville Health Properties, LLC	100.00%	114	114	4
5	V	30	Depreciation		Maryville Health Properties, LLC	100.00%	43,541	43,541	5
6	V	32	Interest Expense		Maryville Health Properties, LLC	100.00%	160,484	160,484	6
7	V	21	Replacement Tax		Maryville Health Properties, LLC	100.00%	440	440	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 318,302			$ 278,517	$ * (39,785)	14

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [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.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS & MAINTENANCE	$	HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	$ 1,440	$ 1,440	15
16	V	19	PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,023	1,023	16
17	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	142	142	17
18	V	21	CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	4,250	4,250	18
19	V	24	SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	90	90	19
20	V	25	TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,566	1,566	20
21	V	26	INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	199	199	21
22	V	30	DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	73	73	22
23	V	32	INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	404	404	23
24	V	34	OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	7,867	7,867	24
25	V	35	EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,023	1,023	25
26	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	51,383	51,383	26
27	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	8,358	8,358	27
28	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	4,703	4,703	28
29	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	428	428	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	733	733	32
33	V	27	EMPLOYEE BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	88	88	33
34	V								34
35	V	10	NURSING		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	3,442	3,442	35
36	V	15	HEALTH CARE EMPLOYEE BENEFITS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	544	544	36
37	V								37
38	V	19	BOOKEEPING SERVICES	55,297				(55,297)	38
39	Total			$ 55,297			$ 87,756	$ * 32,459	39

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [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.

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [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.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	THERAPY	$ 227,624	TOWN AND COUNTRY REHAB., LLC	100.00%	$ 256,750	$ 29,126	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			$ 227,624			$ 256,750	$ * 29,126	39

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Suissa	Owner	Administrative	42.31%	See Attached	3.53	5.88%	Alloc. Salary	$ 4,703	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	$ 4,703		13

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X]

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	ILL, CT & MO. PAT. DAYS	412,241	7	$ 24,495	$	24,233	$ 1,440	1
2	19	PROFESSIONAL FEES	ILL, CT & MO. PAT. DAYS	412,241	7	17,409		24,233	1,023	2
3	20	DUES, SUBSCRIPTIONS	ILL, CT & MO. PAT. DAYS	412,241	7	2,409		24,233	142	3
4	21	CLERICAL & GENERAL	ILL, CT & MO. PAT. DAYS	412,241	7	72,304		24,233	4,250	4
5	24	SEMINAR	ILL, CT & MO. PAT. DAYS	412,241	7	1,539		24,233	90	5
6	25	TRAVEL	ILL, CT & MO. PAT. DAYS	412,241	7	26,636		24,233	1,566	6
7	26	INSURANCE	ILL, CT & MO. PAT. DAYS	412,241	7	3,391		24,233	199	7
8	30	DEPRECIATION	ILL, CT & MO. PAT. DAYS	412,241	7	1,238		24,233	73	8
9	32	INTEREST	ILL, CT & MO. PAT. DAYS	412,241	7	6,874		24,233	404	9
10	34	OFFICE SPACE	ILL, CT & MO. PAT. DAYS	412,241	7	133,828		24,233	7,867	10
11	35	EQUIPMENT RENTAL	ILL, CT & MO. PAT. DAYS	412,241	7	17,411		24,233	1,023	11
12	21	CLERICAL SALARIES	ILL, CT & MO. PAT. DAYS	412,241	7	874,111	874,111	24,233	51,383	12
13	27	EMP. BEN. GEN. & ADMIN.	ILL, CT & MO. PAT. DAYS	412,241	7	142,179		24,233	8,358	13
14	17	ADMIN. SALARY - M. SUISSA	ILL, CT & MO. PAT. DAYS	412,241	7	80,000	80,000	24,233	4,703	14
15	27	EMP. BEN.-M. SUISSA	ILL, CT & MO. PAT. DAYS	412,241	7	7,278		24,233	428	15
16										16
17										17
18	21	CLERICAL SALARIES	IL PAT.DAYS	113,793	2	3,440	3,440	24,233	733	18
19	27	EMPLOYEE BEN. GEN. & ADM	IL PAT.DAYS	113,793	2	412		24,233	88	19
20										20
21	10	NURSING	IL & MO PAT.DAYS	350,914	6	49,850	49,850	24,233	3,442	21
22	15	HEALTH CARE EMPLOYEE BI	IL & MO PAT.DAYS	350,914	6	7,882		24,233	544	22
23										23
24										24
25	TOTALS					$ 1,472,686	$ 1,007,401		$ 87,756	25

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [ ]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	Office Space	DIRECT			$	$		$ 4,000	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 4,000	25

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	THERAPY	DIRECT			$	$		$ 256,750	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					$	$		$ 256,750	25

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Mortgage	$21,025.14	10/01/09	$ 2,779,795	$ 2,384,862			$ 160,485	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Onmicare		X	Note Payable	$739.47	7/20/14	17,747	12,723	6/20/2016	5.5000	355	6
7	Select Rehabilitation		X	Note Payable				30,000				7
8	See Supplemental Schedule										1,456	8
9	TOTAL Facility Related				$21,764.61		$ 2,797,542	$ 2,427,586			$ 162,296	9
	B. Non-Facility Related*											
10	Interest Income		X								(182)	10
11	Alloc. from Healthcare Acct		X								404	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 222	14
15	TOTALS (line 9+line14)						$ 2,797,542	$ 2,427,586			$ 162,518	15

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	CGS Administrators		X				$	$			$ 1,456	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										1,456	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 64,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 66,304	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,804	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 64,196	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 66,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	62,461	8
	2010	63,570	9
	2011	63,651	10
	2012	63,923	11
	2013	66,304	12

2014 Accrual + $66,304 x 0.96 = $64,196

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Nursing & Rehab Ctr COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0041210

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-2-21-14-00-000-009	Long Term Care Facility	$ 66,303.64	$ 66,303.64
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,303.64	$ 66,303.64

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Nursing & Rehab Ctr COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0041210

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	Facility		1955	$ 184,895	1
2					2
3	TOTALS			$ 184,895	3

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	104		1995	1972	$ 1,698,088	$ 43,541	35	$ 48,517	$ 4,976	$ 928,976	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	43,296		20	2,165	2,165	42,136	9
10	Various			1997	46,441		20	2,322	2,322	41,541	10
11	Various			1998	46,036		20	2,302	2,302	38,083	11
12	Various			1999	14,188		20	709	709	10,870	12
13	Various			2000	41,832		20	2,092	2,092	30,643	13
14	Various			2001	4,916		20	246	246	3,237	14
15	Various			2002	8,317		20	150	150	7,223	15
16	Various			2003	30,929		20	270	270	29,939	16
17	Various			2004	35,139		20	513	513	34,765	17
18	Various			2005	20,712		20	1,099	1,099	19,221	18
19	Various			2006	87,017		20	2,208	2,208	53,008	19
20	Various			2007	103,010		20	5,151	5,151	40,346	20
21	Various			2008	334,237		20	33,424	33,424	205,689	21
22	Various			2009	78,715		20	7,872	7,872	45,780	22
23	Various			2010	5,555		20	1,111	1,111	4,991	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			47,821			(47,821)		69
70	TOTAL (lines 4 thru 69)		$ 2,598,427	$ 91,362		$ 110,150	$ 18,788	$ 1,536,448	70

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 2,598,427	$ 91,362		$ 110,150	$ 18,788	$ 1,536,448	1
2	Windows	2011	8,066		20	807	807	3,159	2
3	Roof Replacement	2011	13,850		20	1,385	1,385	5,078	3
4	11 Windows (Back Of Building)	2011	3,818		20	382	382	1,368	4
5	Addition To Roof Replacement	2011	5,040		20	504	504	1,890	5
6	18 Windows	2011	5,810		20	581	581	1,937	6
7	Seal Parking Lot	2011	2,800		20	187	187	654	7
8	Water Main Leak Repair	2011	2,992		20	299	299	1,047	8
9	Water Main Leak Repair	2011	5,346		20	535	535	1,871	9
10	Water Main Leak Repair	2011	4,943		20	494	494	1,689	10
11	Shower Mixing Valve	2011	4,785		20	479	479	1,555	11
12	Water Main Leak Repair	2011	2,627		20	263	263	832	12
13	Boiler Repair	2011	2,770		20	277	277	877	13
14	New Heat Pump	2012	21,934		20	2,193	2,193	5,666	14
15	Electrical Panels & Wiring	2012	35,000		20	3,500	3,500	10,208	15
16	Replace Water Main	2012	7,743		20	774	774	2,258	16
17	Roof	2012	22,500		20	2,250	2,250	6,000	17
18	New Heat Pumps	2012	16,761		20	1,676	1,676	4,470	18
19	32 Windows, Insulation & Screens	2012	9,540		20	954	954	2,306	19
20	Privacy Curtains	2012	6,354		20	1,271	1,271	2,859	20
21	Replace 8 Feet Of Water Main	2012	3,452		20	345	345	748	21
22	Replace Flooring In Hallway Areas	2012	3,100		20	310	310	672	22
23	Install Tile In Front Of Entrance	2012	7,584		20	758	758	1,706	23
24	Repair Water Main Leak, Boiler Pipe-Basement, Tunnel	2012	13,177		20	659	659	1,977	24
25	Repair Water Main Breaks In Tunner	2012	2,985		20	149	149	361	25
26	Electric Panels	2013	3,080		20	308	308	616	26
27	New Water Lines For Recirculation	2013	4,270		20	427	427	854	27
28	Drapes For Common Areas	2013	4,165		20	416	416	798	28
29	Replaced Main Sewer Line To Building	2013	6,990		20	699	699	1,282	29
30	Electrical Work On Generator, Back Up Panels	2013	4,000		20	571	571	1,000	30
31	10 Heating/Cooling Systems	2013	28,473		20	2,373	2,373	3,757	31
32	Sprinkler System	2013	108,096		20	10,810	10,810	20,718	32
33	Flooring For Main Entrance And Dining.	2013	16,100		20	1,610	1,610	2,683	33
34	TOTAL (lines 1 thru 33)		$ 2,986,578	$ 91,362		$ 148,396	$ 57,034	$ 1,629,344	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 2,986,578	$ 91,362		$ 148,396	$ 57,034	$ 1,629,344	1
2	Rewired Electrical Panels	2013	6,000		20	600	600	900	2
3	Replaced Water And Gas Lines In Tunnel	2013	7,665		20	767	767	894	3
4	Repair 5 Water Line Leaks	2013	2,555		20	128	128	202	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)		$ 3,002,798	$ 91,362		$ 149,890	$ 58,528	$ 1,631,340	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 3,002,798	$ 91,362		$ 149,890	$ 58,528	$ 1,631,340	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
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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)		$ 3,002,798	$ 91,362		$ 149,890	$ 58,528	$ 1,631,340	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 3,002,798	$ 91,362		$ 149,890	$ 58,528	$ 1,631,340	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)		$ 3,002,798	$ 91,362		$ 149,890	$ 58,528	$ 1,631,340	34

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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
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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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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
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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 Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 246,235	$ 73	$ 21,073	$ 21,000	10	$ 183,831	71
72	Current Year Purchases	4,674		623	623	10	623	72
73	Fully Depreciated Assets	319,884				10	319,745	73
74								74
75	TOTALS	$ 570,793	$ 73	$ 21,696	$ 21,623		$ 504,199	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)	$ 3,758,486	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 91,435	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 171,586	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 80,151	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,135,539	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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				855			5
6	Alloc. from Healthcare Accounting Serv.				11,867			6
7	TOTAL				$ 12,722 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 10,985 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 89,568	$		$ 89,568	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			76,610			76,610	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			61,446			61,446	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 prescrpts				81,312		81,312	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					1,693	71,678		73,371	13
14	TOTAL			$		$ 229,317	$ 152,990		$ 382,307	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.

STATE OF ILLINOIS

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 53,547	$ 55,554	1
2	Cash-Patient Deposits	27,632	27,632	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	890,272	890,272	3
4	Supply Inventory (priced at)	4,963	4,963	4
5	Short-Term Investments			5
6	Prepaid Insurance	11,314	11,314	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	18,135	18,135	8
9	Other(specify):	60	60	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,005,923	$ 1,007,930	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	1,047,673	1,047,673	15
16	Equipment, at Historical Cost	553,631	761,631	16
17	Accumulated Depreciation (book methods)	(757,928)	(1,802,273)	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):		900,578	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 843,376	$ 2,790,592	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,849,299	$ 3,798,522	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,361,148	$ 3,361,147	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,836	24,836	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,806	185,806	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,403	9,403	31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,196	64,196	32
33	Accrued Interest Payable		13,864	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	183,437	162,412	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,828,826	$ 3,821,664	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	42,723	42,723	39
40	Mortgage Payable		2,384,863	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			204,332	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 42,723	$ 2,631,918	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,871,549	$ 6,453,582	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,022,250)	$ (2,655,060)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,849,299	$ 3,798,522	48

***(See instructions.)**

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,140,511)	1
2	Restatements (describe):		2
3	**Depreciation**	(13,431)	3
4	**Other**	13	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,153,929)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	131,679	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)**	$ 131,679	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)**	$ (2,022,250)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,622,325	1
2	Discounts and Allowances for all Levels	(244,861)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,377,464	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	716,782	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 716,782	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	62,363	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,453	19
20	Radiology and X-Ray	2,894	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 74,710	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	182	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 182	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,553	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,553	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,170,691	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	799,099	31
32	Health Care	965,419	32
33	General Administration	1,101,653	33
	B. Capital Expense		
34	Ownership	382,752	34
	C. Ancillary Expense		
35	Special Cost Centers	596,835	35
36	Provider Participation Fee	193,254	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,039,012	40
41	**Income before Income Taxes (line 30 minus line 40)****	131,679	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 131,679	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,412,382	44
45	Private Pay - Net Inpatient Revenue	449,530	45
46	Medicare - Net Inpatient Revenue	326,982	46
47	Other-(specify) Hospice	194,470	47
48	Other-(specify) Insurance	(5,900)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,377,464	49

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

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

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,911	2,080	$ 72,056	$ 34.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,189	4,546	81,145	17.85	3
4	Licensed Practical Nurses	12,278	13,784	229,506	16.65	4
5	CNAs & Orderlies	39,700	43,006	450,722	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,841	3,965	40,044	10.10	10
11	Social Service Workers	1,643	1,963	25,683	13.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,711	18,038	168,627	9.35	15
16	Dishwashers					16
17	Maintenance Workers	3,971	4,328	61,821	14.28	17
18	Housekeepers	9,309	9,906	103,822	10.48	18
19	Laundry	6,975	7,543	65,808	8.72	19
20	Administrator	2,158	2,200	132,886	60.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,508	6,117	114,502	18.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,929	2,120	70,528	33.27	33
34	TOTAL (lines 1 - 33)	109,123	119,596	$ 1,617,150 *	$ 13.52	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	216	$ 10,052	01-03	35
36	Medical Director	Monthly	14,000	09-03	36
37	Medical Records Consultant	15	981	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	102	6,619	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant		27,031	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	4,066	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	381	$ 62,749		49

C. CONTRACT NURSES

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherri Dixon-Rudd	Administrator	0	$ 132,886
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 132,886

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 24,750
Healthcare Accounting Services	Accounting/Bookkeeping	55,297
National Data Corp	Data Processing	2,708
Paycom Processing Fees	Payroll	7,235
Personnel Planners	Unemployment Cons.	2,663
eHealth Data Solutions	Computer Services	5,023
Rehab Management System	Rehab Billing Review	28,035
Lawrence Schwartz	Legal	(70)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 125,640

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,313
Unemployment Compensation Insurance	63,761
FICA Taxes	118,117
Employee Health Insurance	150,246
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	1,100
Disablility/Dental/Life Ins	3,046
Employee Benefit Plan	66
TOTAL (agree to Schedule V, line 22, col.8)	$ 443,650

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,155
Health Care Worker Background Check	
(Indicate # of checks performed 233)	2,175
Patient Background Checks	
Dues & Suncriptions	2,162
Licenses & Fees	3,867
Allocated from Healthcare Accounting	142
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,501

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	319
Allocated from Healthcare Accounting	90
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 409

**See instructions.

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Elmwood Nursing & Rehab Ctr # 0041210 Report Period Beginning: 01/01/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,394** 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. $ **193,254**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.