

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0014753

Facility Name: TWIN WILLOWS NURSING CENTER, INC

Address: 1600 N. BROADWAY SALEM 62881
Number City Zip Code

County: MARION

Telephone Number: 618-548-0542 Fax # 618-548-5893

HFS ID Number:

Date of Initial License for Current Owners: 05/02/1973

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL
☐ Charitable Corp.	☐ Individual	☐ State
☐ Trust	☐ Partnership	☐ County
IRS Exemption Code	☒ Corporation	☐ Other
	☐ "Sub-S" Corp.	
	☐ Limited Liability Co.	
	☐ Trust	
	☐ Other	

In the event there are further questions about this report, please contact:
Name: Todd C. Woodruff Telephone Number: (618)292-4640
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 01/01/2016 to 12/31/2016 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)	5-23-2017
	(Type or Print Name)	TODD C. WOODRUFF
	(Title)	ADMINISTRATOR
Paid Preparer	(Signed)	
	(Print Name and Title)	
	(Firm Name & Address)	
	(Telephone)	() Fax # ()

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 TWIN WILLOWS NURSING CENTER, INC

0014753 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

29 skilled, 43 icf

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	29	29	10,614	1
2	Skilled Pediatric (SNF/PED)			2
3	43	43	15,738	3
4	Intermediate (ICF)			4
5	Intermediate/DD			5
6	Sheltered Care (SC)			6
7	ICF/DD 16 or Less			7
7	72	TOTALS	26,352	7

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Medicaid Recipient	Private Pay	Other	Total	
8	SNF		1,643	1,643	8
9	SNF/PED				9
10	ICF	9,180	3,076	12,256	10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	9,180	3,076	13,899	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.74%

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

0 (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)

n/a

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

x

NO

☐

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

Date started 01/01/1973

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

YES

☐

Date

NO

x

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

YES

x

NO

☐

If YES, enter number

of beds certified

29

and days of care provided

1,643

Medicare Intermediary J15 A/6 MAC KY

IV. ACCOUNTING BASIS

ACCRUAL

x

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

x

NO

☐

Tax Year: 12-31-2016

Fiscal Year: 12-31-2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	135,165	15,874	4,888	155,927		155,927		155,927			1
2	Food Purchase		154,791		154,791		154,791	(8,133)	146,658			2
3	Housekeeping	45,851	10,267		56,118		56,118		56,118			3
4	Laundry	28,806	11,325		40,131		40,131		40,131			4
5	Heat and Other Utilities			54,823	54,823		54,823	(3,640)	51,183			5
6	Maintenance	2,977	8,881	29,616	41,474		41,474		41,474			6
7	Other (specify):*											7
8	TOTAL General Services	212,799	201,138	89,327	503,264		503,264	(11,773)	491,491			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	703,000	77,805	4,090	784,895		784,895		784,895			10
10a	Therapy											10a
11	Activities	15,963	3,618		19,581		19,581		19,581			11
12	Social Services	11,615		2,308	13,923		13,923		13,923			12
13	CNA Training											13
14	Program Transportation		919		919		919		919			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	730,578	82,342	8,798	821,718		821,718		821,718			16
	C. General Administration											
17	Administrative	70,000			70,000		70,000		70,000			17
18	Directors Fees											18
19	Professional Services			20,565	20,565		20,565	(20,000)	565			19
20	Dues, Fees, Subscriptions & Promotions			6,587	6,587		6,587	(3,160)	3,427			20
21	Clerical & General Office Expenses	7,257	12,598	3,345	23,200		23,200		23,200			21
22	Employee Benefits & Payroll Taxes			115,544	115,544		115,544		115,544			22
23	Inservice Training & Education			455	455		455		455			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation		1,027		1,027		1,027		1,027			25
26	Insurance-Prop.Liab.Malpractice			46,708	46,708		46,708		46,708			26
27	Other (specify):*											27
28	TOTAL General Administration	77,257	13,625	193,204	284,086		284,086	(23,160)	260,926			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,020,634	297,105	291,329	1,609,068		1,609,068	(34,933)	1,574,135			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			12,754	12,754		12,754		12,754			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,698	63,698		63,698	(963)	62,735			32
33	Real Estate Taxes			49,106	49,106		49,106		49,106			33
34	Rent-Facility & Grounds			15,000	15,000		15,000		15,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			140,558	140,558		140,558	(963)	139,595			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,019	237,245	311,264		311,264		311,264			39
40	Barber and Beauty Shops		3,310		3,310		3,310		3,310			40
41	Coffee and Gift Shops		3,501		3,501		3,501		3,501			41
42	Provider Participation Fee			115,367	115,367		115,367		115,367			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		80,830	352,612	433,442		433,442		433,442			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,020,634	377,935	784,499	2,183,068		2,183,068	(35,896)	2,147,172			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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	7,955	2-7		4
5	Telephone, TV & Radio in Resident Rooms	3,640	5-7		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	963	32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	178	2-7		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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	20,000	19-7		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	3,160	20-7		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 35,896		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 35,896		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

ID#0014753

Report Period Beginning:01/01/2016

Ending:12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TWIN WILLOWS NURSING CENTER, INC# 0014753

Report Period Beginning:

01/01/2016

Ending:

12/31/2016**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

Summary B

Facility Name & ID Number	TWIN WILLOWS NURSING CENTER, INC	#	0014753	Report Period Beginning:	01/01/2016	Ending:	12/31/2016
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

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
Helen Woodruff	95	n/a		Motel Developments	Salem	Motel
Jeffrey Woodruff	5	n/a		Woodruff Management	Carbondale	HVAC Equip & Rep

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)	
1	V		Rent	\$ 15,000	Motel Developments, Inc.	100.00%	\$ 15,000	\$	1
2	V		Background Checks	310	Woodruff Management	100.00%	310		2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 15,310			\$ 15,310	\$ *	14

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

VII. RELATED PARTIES

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

	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 TWIN WILLOWS NURSING CENTER, IN # 0014753 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Todd C. Woodruff	Administrator		0.00	0	60	100.00	Wages	\$ 70,000	17-1	1
2	Todd C. Woodruff	Administrator		0.00	0	60	100.00	Interest	18,099	32-3	2
3	Jeffrey L. Woodruff	Mgmt Serv/Background Checks		5.00	0			Fees	7,140	32-3	3
4	Jeffrey L. Woodruff	Mgmt Serv/Background Checks		5.00				Interest	310	20-8	4
5	Deborah A. Woodruff	Attorney	Legal Services	0.00	0			Fees	20,000	19-8	5
6	Deborah A. Woodruff	Clerical	Clerical	0.00	0			Wages	5,055	21-1	6
7	Steven R. Beemer			0.00	0			Interest	1,099	32-3	7
8	Helen S. Woodruff	Shareholder		95.00	0			Interest	425	32-3	8
9	Aura Woodruff			0.00	0			Interest	454	32-3	9
10	Robin Michel			0.00	0			Interest	6,000	32-3	10
11	Gregg S. Woodruff			0.00	0			Interest	3,297	32-3	11
12											12
13								TOTAL	\$ 131,879		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 TWIN WILLOWS NURSING CENTER, INC # 0014753 Report Period Beginning: 01/01/2016 Ending: #####

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Jeffrey L. Woodruff	x		Working Capital			\$ 102,000	\$ 102,000		0.0700	\$ 7,140	1
2	Helen S. Woodruff	x		Working Capital				4,555		0.1053	223	2
3	Helen S. Woodruff	x		Working Capital				40,000		0.0450	231	3
4	Other Related	x		Working Capital			467,925	512,989		varies	28,920	4
5												5
	Working Capital											
6	IPFS Corporation		x	Finance Liability Insurance			7,141	3,574			919	6
7	Guardian Insurance		x	Working Capital			173,850	188,149			11,737	7
8	Trade Accounts		x	Working Capital							14,528	8
9	TOTAL Facility Related						\$ 750,916	\$ 851,267			\$ 63,698	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 750,916	\$ 851,267			\$ 63,698	15

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

* 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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TWIN WILLOWS NURSING CENTER, INC COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0014753

CONTACT PERSON REGARDING THIS REPORT Todd C. Woodruff

TELEPHONE 618-548-0542 FAX #: 618-548-5893

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 11-02-00-027	PT S.W. N.E.	\$ 49,106.00	\$ 49,106.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 49,106.00	\$ 49,106.00

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet: 16,250

B. General Construction Type: Exterior BrickFrame FireproofNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A - none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		87,000	1973	\$ 28,000	1
2					2
3	TOTALS	87,000		\$ 28,000	3

Facility Name & ID Number TWIN WILLOWS NURSING CENTER, INC

0014753

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

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	74		1973	1966	\$ 380,183	\$	33.33	\$	\$	380,183	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater		1977		1,024		10			1,024	9
10	Fire Exit Lights		1978		695		5			695	10
11	Emergency Power		1978		1,695		5			1,695	11
12	Emergency Power		1979		1,359		5			1,359	12
13	Compressor		1979		372		5			372	13
14	Battery Units		1980		570		5			570	14
15	Compressor		1980		533		3			533	15
16	Mixing Valve		1981		780		10			780	16
17	Central Valve		1982		771		10			771	17
18	Disposal		1982		745		10			745	18
19	Storage Shed		1983		600		8			600	19
20	3 Heat Pumps		1983		2,245		10			2,245	20
21	Phone System		1985		3,318		20			3,318	21
22	2 Heat Pumps		1985		1,400		8			1,400	22
23	Driveway		1988		2,767		3			2,767	23
24	Seal Coat Patch Driveway		1997		1,850		3			1,850	24
25	Door Monitoring System		1999		7,590		10			7,590	25
26	3 Central Air System		1999		12,588		5			12,588	26
27	Roof		1999		60,629		15			60,629	27
28	Asphalt Top Coat Driveway		1999		16,136		8			16,136	28
29	Outside Walkway Lights		1999		600		10			600	29
30	South Wing Sewer Line		2000		1,046		10			1,046	30
31	3 Outside Hydrant		2000		525		10			525	31
32	Asphalt Sidewalks - Wing		2005		6,270		8			6,270	32
33	Asphalt Driveway - North		2008		3,358	208	8	208		3,358	33
34	Sewer Line - North		2009		2,735	273	10	273		2,038	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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Windows	2009	\$ 5,989	\$ 154	39	\$ 154	\$	\$ 1,105	37
38	Central Air- East Wing	2010	4,297	430	10	430		2,708	38
39	Central Air- Dining Room	2011	7,401	740	10	740		5,814	39
40	Water Heater Elec Room	2011	2,500	357	7	357		2,027	40
41	2 Central Air Systems	2013	10,351	1,035	10	1,035		3,678	41
42	Building Sprinkler System	2013	88,910	3,556	25	3,556		12,081	42
43	Water Heater	2014	8,553	855	10	855		2,479	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 640,385	\$ 7,608		\$ 7,608	\$	\$ 541,579	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$49,507	\$4,462	\$4,462	\$		\$38,188	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	299,234	684	684			294,746	73
74								74
75	TOTALS	\$348,741	\$5,146	\$5,146	\$		\$332,934	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	Patient Transport	2007 Chevy Intervan	2006	\$41,318	\$	\$	\$	7	\$41,138	76
77										77
78										78
79										79
80	TOTALS			\$41,318	\$	\$	\$		\$41,138	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,058,444	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$12,754	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$12,754	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$915,651	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	Trailer - Aluma-Lite 1982	\$10,000	\$	\$10,000	86
87	Office Building	56,000		56,000	87
88		12,309		12,309	88
89		6,119		6,119	89
90	Roof Office Building	6,708	320	1,052	90
91	TOTALS	\$91,136	\$320	\$85,480	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Motel Developments, Inc

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:				\$ 15,000			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 15,000			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: *

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: \$ Description:

(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

10. Effective dates of current rental agreement:

Beginning 01/01/2016

Ending 12/31/2016

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

Fiscal Year Ending Annual Rent

12. /2017 \$

13. /2018 \$

14. /2019 \$

* 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.

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
☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$			\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		5,731	107,416		5,731	107,416	2
3	Licensed Recreational Therapist		hrs		383	15,570		383	15,570	3
4	Licensed Physical Therapist	39-3	hrs		6,021	114,259		6,021	114,259	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				70,077		70,077	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-2					2,978		2,978	12
13	Other (specify): X-Ray	39-2					964		964	13
14	TOTAL			\$	12,135	\$ 237,245	\$ 74,019	12,135	\$ 311,264	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.

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	\$ 113,515	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,575,244		3
4	Supply Inventory (priced at)	13,600		4
5	Short-Term Investments	3,935		5
6	Prepaid Insurance	24,372		6
7	Other Prepaid Expenses	11,678		7
8	Accounts Receivable (owners or related parties)	29,661		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,772,005	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,000		13
14	Buildings, at Historical Cost	439,451		14
15	Leasehold Improvements, at Historical Cost	211,615		15
16	Equipment, at Historical Cost	474,163		16
17	Accumulated Depreciation (book methods)	(1,001,023)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 156,206	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,928,211	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 904,974	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,172,055		29
30	Accrued Salaries Payable	30,399		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,685		31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,106		32
33	Accrued Interest Payable			33
34	Deferred Compensation	110,140		34
35	Federal and State Income Taxes	67,043		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,337,402	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,730		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	stock	3,500		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 18,230	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,355,632	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,572,579	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,928,211	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,472,639	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,472,639	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	125,782	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)	\$ 125,782	17
	B. Transfers (Itemize):		
18	non tax deductible	(25,842)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (25,842)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,572,579	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER, INC

0014753

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,372,807	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,372,807	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	3,229	12
13	Barber and Beauty Care	3,310	13
14	Non-Patient Meals	7,487	14
15	Telephone, Television and Radio	2,049	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	76	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,151	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	964	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 964	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Lawn Care</u>	600	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 600	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,390,522	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	491,491	31
32	Health Care	821,718	32
33	General Administration	260,926	33
	B. Capital Expense		
34	Ownership	139,595	34
	C. Ancillary Expense		
35	Special Cost Centers	318,075	35
36	Provider Participation Fee	115,367	36
	D. Other Expenses (specify):		
37	<u>schedule for page 19</u>	50,525	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,197,697	40
41	Income before Income Taxes (line 30 minus line 40)**	192,825	41
42	Income Taxes	(67,043)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 125,782	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 741,691	44
45	Private Pay - Net Inpatient Revenue	955,937	45
46	Medicare - Net Inpatient Revenue	675,179	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,372,807	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,830	2,052	\$ 59,238	\$ 28.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,078	8,451	176,950	20.94	3
4	Licensed Practical Nurses	7,710	8,077	139,738	17.30	4
5	CNAs & Orderlies	30,634	31,700	306,570	9.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,700	1,823	15,963	8.76	9
10	Activity Assistants					10
11	Social Service Workers	1,094	1,216	11,615	9.55	11
12	Dietician					12
13	Food Service Supervisor	1,889	2,009	25,917	12.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,549	7,659	64,456	8.42	15
16	Dishwashers	5,247	5,247	44,792	8.54	16
17	Maintenance Workers	209	209	2,977	14.24	17
18	Housekeepers	5,236	5,444	45,851	8.42	18
19	Laundry	3,115	3,213	28,806	8.97	19
20	Administrator	3,120	3,480	70,000	20.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	539	539	7,257	13.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,803	1,871	20,504	10.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	79,753	82,990	\$ 1,020,634 *	\$ 12.30	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	81	\$ 4,888	1-3	35
36	Medical Director	12	2,400	9-3	36
37	Medical Records Consultant	12	780	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	87	3,310	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	36	2,308	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	228	\$ 13,686		49

C. CONTRACT NURSES

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

Facility Name & ID Number		TWIN WILLOWS NURSING CENTER, INC		STATE OF ILLINOIS		# 0014753		Report Period Beginning:		01/01/2016		Page 21		Ending: 12/31/2016	
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount					
Todd C. Woodruff		Administrator	0	\$ 70,000	Workers' Compensation Insurance		\$ 29,531	IDPH License Fee		\$ 1,990					
					Unemployment Compensation Insurance		7,562	Advertising: Employee Recruitment		517					
					FICA Taxes		75,950	Health Care Worker Background Check		365					
					Employee Health Insurance			(Indicate # of checks performed 10)							
					Employee Meals			Patient Background Checks		31					
					Illinois Municipal Retirement Fund (IMRF)*			Advertising		3,160					
					Employee Recognition		2,501	Marion Co Health		75					
TOTAL (agree to Schedule V, line 17, col. 1)								Secy of State		100					
(List each licensed administrator separately.)				\$ 70,000				State Fire Marshall		70					
B. Administrative - Other															
Description				Amount				Less: Public Relations Expense		(3,160)					
				\$				Non-allowable advertising		()					
								Yellow page advertising		()					
TOTAL (agree to Schedule V, line 17, col. 3)				\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 115,544	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,427					
(Attach a copy of any management service agreement)															
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**									
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description		Amount					
Deborah A. Woodruff		Legal	\$ 20,000				\$	Out-of-State Travel		\$					
H&R Block		Tax Prep	565												
								In-State Travel							
								Seminar Expense							
								Entertainment Expense		()					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	(agree to Sch. V, line 24, col. 8)							
(For legal fee disclosure, see page 39 of instructions)				\$ 20,565				TOTAL		\$					
* Attach copy of IMRF notifications															
**See instructions.															

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?
If YES, give association name and amount.

No

(3) Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
n/a

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

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

Yes

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.
\$
Line

10,65610

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
n/a

(9) Are you presently operating under a sublease agreement?

YESNoNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO
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.
This amount is to be recorded on line 42 of Schedule V.

\$115,367

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

Yes

(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? (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.

No

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
\$
Has any meal income been offset against related costs?
Indicate the amount. \$

0
Yes7,955

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

no

b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
n/a

c. What percent of all travel expense relates to transportation of nurses and patients?

99

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?

n/a

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
n/a

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
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
Attach invoices and a summary of services for all architect and appraisal fees

n/a non care related

HFS 3745 (N-4-99)

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