

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0032862</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Danville Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1701 North Bowman</u> <u>Danville</u> <u>61832</u>																									
Number City Zip Code																									
County: <u>Vermilion</u>																									
Telephone Number: <u>(217) 443-2955</u> Fax # <u>(217) 443-0315</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin</u> <u>Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>	(Telephone) <u>(630) 361-2868</u> 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												
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Date of Initial License for Current Owners: <u>10/1/87</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ 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 _____	
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	☒ "Sub-S" Corp.																								
	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center

0032862 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	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	<u>118</u>	Skilled (SNF)	<u>118</u>	<u>43,188</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>82</u>	Intermediate (ICF)	<u>82</u>	<u>30,012</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>200</u>	TOTALS	<u>200</u>	<u>73,200</u>	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	<u>1,601</u>	<u>1,528</u>	<u>2,355</u>	<u>5,484</u>	8
9	SNF/PED					9
10	ICF	<u>35,713</u>	<u>1,266</u>		<u>36,979</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>37,314</u>	<u>2,794</u>	<u>2,355</u>	<u>42,463</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.01%

SEE ACCOUNTANTS' PREPARATION REPORT

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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location? Date started 10/1/87

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 10/1/87 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 118 and days of care provided 1,882

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Danville Care Center** # **0032862** Report Period Beginning: **1/1/16** Ending: **12/31/16**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	252,206	27,899	11,986	292,091		292,091		292,091			1
2	Food Purchase		257,090		257,090		257,090		257,090			2
3	Housekeeping	265,270	55,052		320,322		320,322		320,322			3
4	Laundry	16,720	46,589		63,309		63,309		63,309			4
5	Heat and Other Utilities			142,337	142,337		142,337	901	143,238			5
6	Maintenance	83,417	90,022	42,111	215,550		215,550	239	215,789			6
7	Other (specify):* Waste Removal			13,648	13,648		13,648		13,648			7
8	TOTAL General Services	617,613	476,652	210,082	1,304,347		1,304,347	1,140	1,305,487			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,340,697	225,337	18,535	2,584,569		2,584,569	102,337	2,686,906			10
10a	Therapy	132,730			132,730		132,730		132,730			10a
11	Activities	55,222		7,670	62,892		62,892		62,892			11
12	Social Services	250,190		41,696	291,886		291,886		291,886			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. Emp Benefits							17,477	17,477			15
16	TOTAL Health Care and Programs	2,778,839	225,337	91,901	3,096,077		3,096,077	119,814	3,215,891			16
	C. General Administration											
17	Administrative	116,773		60,000	176,773		176,773	13,045	189,818			17
18	Directors Fees											18
19	Professional Services			150,094	150,094		150,094	1,077	151,171			19
20	Dues, Fees, Subscriptions & Promotions			51,769	51,769		51,769	921	52,690			20
21	Clerical & General Office Expenses	148,647	65,829	40,183	254,659		254,659	160,262	414,921			21
22	Employee Benefits & Payroll Taxes			608,900	608,900		608,900		608,900			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,937	13,937		13,937	10,315	24,252			24
25	Other Admin. Staff Transportation			14,597	14,597		14,597	5,059	19,656			25
26	Insurance-Prop.Liab.Malpractice			175,974	175,974		175,974	991	176,965			26
27	Other (specify):* Alloc. Emp Benefits							35,426	35,426			27
28	TOTAL General Administration	265,420	65,829	1,115,454	1,446,703		1,446,703	227,096	1,673,799			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,661,872	767,818	1,417,437	5,847,127		5,847,127	348,050	6,195,177			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			192,000	192,000		192,000	104,908	296,908			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			67,489	67,489		67,489	120,837	188,326			32
33	Real Estate Taxes			52,500	52,500		52,500		52,500			33
34	Rent-Facility & Grounds			363,330	363,330		363,330	(355,621)	7,709			34
35	Rent-Equipment & Vehicles			36,893	36,893		36,893	2,025	38,918			35
36	Other (specify):*											36
37	TOTAL Ownership			712,212	712,212		712,212	(127,851)	584,361			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,343	360,252	418,595		418,595		418,595			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			324,000	324,000		324,000		324,000			42
43	Other (specify):* See Att Sch 4A	50,032		117,189	167,221		167,221	(143,300)	23,921			43
44	TOTAL Special Cost Centers	50,032	58,343	801,441	909,816		909,816	(143,300)	766,516			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,711,904	826,161	2,931,090	7,469,155		7,469,155	76,899	7,546,054			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Danville Care Center

Period Beginning 1/1/16
Period End 12/31/16

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			22,059	22,059		22,059		22,059			
	Radiology Expenses			1,862	1,862		1,862		1,862			
	Non-Allowable Expenses	50,032		91,128	141,160		141,160	(141,160)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	50,032	0	115,049	165,081	0	165,081	(141,160)	23,921			

SEE ACCOUNTANTS' COMPILATION REPORT

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	(15,370)	43		5
6	Rented Facility Space	(3,330)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	104,908	30		9
10	Interest and Other Investment Income	(3,672)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	43		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	(816)	20		17
18	Fines and Penalties	(2,140)	43		18
19	Entertainment				19
20	Contributions	(25)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,298)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,151)	43		24
25	Fund Raising, Advertising and Promotional	(22,512)	43		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 See Page 5A	(54,778)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (57,254)		\$	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)	134,153		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 134,153		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 76,899		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Wages	(50,032)	43	1
2	Marketer Car Lease	(4,746)	35	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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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	(54,778)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest	\$	Danville Care Center Property LLC	100.00%	\$ 124,509	\$ 124,509	1
2	V	34	Rent-Facility & Grounds	360,000	Danville Care Center Property LLC	100.00%		(360,000)	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			\$ 360,000			\$ 124,509	\$ * (235,491)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	\$	Certified Health Management, Inc.	100.00%	\$ 901	\$ 901	15
16	V	6	Maintenance		Certified Health Management, Inc.	100.00%	239	239	16
17	V	10	Nursing and Medical Records		Certified Health Management, Inc.	100.00%	102,337	102,337	17
18	V	15	Emp Benefit Alloc-Healthcare		Certified Health Management, Inc.	100.00%	17,477	17,477	18
19	V	17	Administrative	60,000	Certified Health Management, Inc.	100.00%	73,045	13,045	19
20	V	19	Professional Services		Certified Health Management, Inc.	100.00%	7,375	7,375	20
21	V	20	Dues, Fees, Subs & Promo		Certified Health Management, Inc.	100.00%	1,737	1,737	21
22	V	21	Clerical & Gen Office Expenses		Certified Health Management, Inc.	100.00%	160,262	160,262	22
23	V	24	Travel and Seminar		Certified Health Management, Inc.	100.00%	10,315	10,315	23
24	V	25	Other Admin Staff Transportation		Certified Health Management, Inc.	100.00%	5,059	5,059	24
25	V	26	Ins.-Prop, Liab, Malpractice		Certified Health Management, Inc.	100.00%	991	991	25
26	V	27	Emp Benefit Alloc-Gen Admin		Certified Health Management, Inc.	100.00%	35,426	35,426	26
27	V	34	Rent-Facility & Grounds		Certified Health Management, Inc.	100.00%	7,709	7,709	27
28	V	35	Rent-Equipment & Vehicle		Certified Health Management, Inc.	100.00%	6,771	6,771	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			\$ 60,000			\$ 429,644	\$ * 369,644	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	Rita L. Geller	38.044%	Glenwood Healthcare & Rehab	Glenwood	Danville Care	Skokie	Lessor	1
2	Bradley M. Alter	22.826%	Prairie View Care Center of Lewistown	Lewistown	Center Property, LLC			2
3	ESBT Jennifer T. W. Chow	19.565%	Renaissance Care Center	Canton	Certified Health	Skokie	Management	3
4	ESBT Julie Brum	19.565%	Paxton Healthcare and Rehab	Paxton	Management, Inc.			4
5			Pontiac Healthcare and Rehab	Pontiac				5
6								6
7								7
8								8
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12								12
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25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Daniel Alter	Relative	Financial	0.00	See Att Sch 7A	8.56	21.39	Alloc. Salary	\$ 10,844	L21, C7	1
2	Zev Geller	Relative	Clerical	0.00	See Att Sch 7A	8.56	21.39	Alloc. Salary	14,313	L21, C7	2
3	Bradley Alter	Owner	Administration	22.826%	See Att Sch 7A	10.71	21.42	Alloc. Salary	39,615	L17, C7	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	\$ 64,772		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Certified Health Management, Inc.
Street Address 3856 W. Oakton
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 674-4700
Fax Number (847) 674-4733

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Heat and Other Utilities	Census Days	198,295	6	\$ 4,208	\$	42,463	\$ 901	1
2	6	Maintenance	Census Days	198,295	6	1,116		42,463	239	2
3	10	Nursing and Medical Records	Census Days	198,295	6	477,896	477,896	42,463	102,337	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	198,295	6	81,613		42,463	17,477	4
5	17	Administrative	Census Days	198,295	6	341,110	341,110	42,463	73,045	5
6	19	Professional Services	Census Days	198,295	6	34,439		42,463	7,375	6
7	20	Dues, Fees, Subs & Promo	Census Days	198,295	6	8,110		42,463	1,737	7
8	21	Clerical & Gen Office Expenses	Census Days	198,295	6	748,394	627,598	42,463	160,262	8
9	24	Travel and Seminar	Census Days	198,295	6	48,168		42,463	10,315	9
10	25	Other Admin Staff Transportation	Census Days	198,295	6	23,623		42,463	5,059	10
11	26	Ins.-Prop, Liab, Malpractice	Census Days	198,295	6	4,628		42,463	991	11
12	27	Emp Benefit Alloc-Gen Admin	Census Days	198,295	6	165,432		42,463	35,426	12
13	34	Rent-Facility & Grounds	Census Days	198,295	6	36,000		42,463	7,709	13
14	35	Rent-Equipment & Vehicle	Census Days	198,295	6	31,619		42,463	6,771	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,006,356	\$ 1,446,604		\$ 429,644	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank Leumi		X	Mortgage			\$ 2,500,000	\$ 2,386,407		0.0500	\$ 124,509	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Bank Leumi		X	Line of Credit				2,630,920		0.0550	64,703	6	
7	Insurance Financing										2,786	7	
8												8	
9	TOTAL Facility Related						\$ 2,500,000	\$ 5,017,327			\$ 191,998	9	
	B. Non-Facility Related*												
10												10	
11												11	
12								Offset Interest Income			(3,672)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (3,672)	14	
15	TOTALS (line 9+line14)						\$ 2,500,000	\$ 5,017,327			\$ 188,326	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.) SEE ACCOUNTANTS' PREPARATION REPORT

** 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 Danville Care Center COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0032862

CONTACT PERSON REGARDING THIS REPORT Bruce Harris

TELEPHONE (847) 674-4700 FAX #: (847) 674-4733

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 18-33-200-016-0060	Long Term Care Property	\$ 41,681.42	\$ 41,681.42
2. 18-34-100-005-0060	Long Term Care Property	\$ 28,965.06	\$ 28,965.06
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 70,646.48	\$ 70,646.48

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:

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	200		1987	1974	\$ 2,954,225	\$		\$ 152,666	\$ 152,666	\$ 2,900,660	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1989		34,167		20			34,167	9
10	Various		1990		17,344		20			17,344	10
11	Various		1991		45,376		20			45,376	11
12	Various		1992		12,043		20			12,043	12
13	Various		1993		9,213		20			9,213	13
14	Various		1994		8,304		20			8,304	14
15	Various		1995		39,047		20			39,047	15
16	Various		1996		44,007		20	1,287	1,287	44,007	16
17	Various		1997		28,811		20	1,441	1,441	28,091	17
18	Various		1998		394,658		20	19,733	19,733	374,925	18
19	Various		1999		42,329		20	2,116	2,116	37,037	19
20	Various		2000		51,980		20	2,599	2,599	43,045	20
21	Various		2001		1,377		20	69	69	1,067	21
22	Various		2002		11,592		20	580	580	8,187	22
23	Various		2003		122,592		20	6,130	6,130	82,763	23
24	Various		2004		68,558		20	3,428	3,428	42,372	24
25	Various		2005		83,307		20	4,165	4,165	48,120	25
26	Various		2006		46,793		20	2,340	2,340	24,705	26
27	Various		2007		6,180		20	309	309	3,090	27
28	Various		2008		10,918		20	546	546	4,710	28
29	Various		2009		68,627		20	3,431	3,431	35,287	29
30	Various		2011		24,148		20	1,207	1,207	18,577	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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Rooftop A/C Units - Lennox	2012	\$ 8,421	\$	20	\$ 421	\$ 421	\$ 2,105	37
38	Light Fixtures & Corner Guards	2012	3,402		20	170	170	2,325	38
39	Millwork, Plumbing, Paint, Wallcovering, Handrails, Corner Guards	2012	281,764		20	14,088	14,088	216,019	39
40	Sprinkler System	2012	128,750		20	6,438	6,438	27,896	40
41	Replaced Failed Compressor	2012	2,773		20	139	139	567	41
42	Hot Water Boiler System Storage Tank, Temperature Gauge, And	2013	2,695		20	135	135	427	42
43	Outlets For Kiosks	2013	9,341		20	467	467	5,449	43
44	Lennox Gas/Electric Rooftop Unit	2013	17,354		20	868	868	2,820	44
45	Hot Water Storage Tank	2013	5,475		20	274	274	867	45
46	Birch Wood Doors (6) And Installation	2013	3,273		20	164	164	559	46
47	4,345 Sq Ft Of Facility Roof	2014	35,009		20	1,750	1,750	4,522	47
48	Hallway Carpets/Baroque Modular Plush/ Vinyl Mouldings/Base	2014	31,256		20	1,563	1,563	10,940	48
49	Driveway Upgrade	2014	3,055		20	153	153	408	49
50	Drywall Rooms' Ceilings & Admin Offices	2014	4,500		20	225	225	488	50
51	Parking Lot Seal Coat	2014	4,597		20	230	230	588	51
52	Roof Powerwash, Scrubbing & Application Of Coating	2014	4,615		20	231	231	519	52
53	Concrete Work	2014	3,055		20	153	153	344	53
54	Fence Project	2015	5,652		20	283	283	471	54
55	Heat/Cool Units 230V Qty.5	2015	3,230		20	162	162	593	55
56	Code Alert System-Wandering Management Solution	2015	7,441		20	372	372	1,240	56
57	South Wing Dining Room Metrofloor Tile/Vinyl Planking	2015	8,507		20	425	425	992	57
58	Painting Trim, Shutters, Roof Vents, Etc	2015	6,000		20	300	300	600	58
59	Replace Doors (4)	2016	10,177		20	509	509	509	59
60	50 Gallon Water Heater	2016	10,375		20	519	519	519	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)		\$ 4,726,313	\$		\$ 232,086	\$ 232,086	\$ 4,143,904	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	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		\$ 4,726,313	\$		\$ 232,086	\$ 232,086	\$ 4,143,904	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements (Real Estate Entity):								8
9	Parking Lot Paving	2011	108,929		20	5,446	5,446	32,676	9
10	Nurse Call Station	2015	53,648		20	2,682	2,682	5,364	10
11	South Wing Renovation-Flooring, Lighting, Plumbing, Signage								11
12	Valances, Acrovyn, Handrails, Grab Bars	2016	281,598		20	14,080	14,080	14,080	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	Allocated from Certified Health Management	1997	20,173		20			20,173	25
26	Allocated from Certified Health Management	2014	5,672		20	284	284	993	26
27									27
28									28
29									29
30	Financial Statement Depreciation			192,000			(192,000)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,196,333	\$ 192,000		\$ 254,578	\$ 62,578	\$ 4,217,190	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 317,227	\$	\$ 31,723	\$ 31,723	10	\$ 237,199	71
72	Current Year Purchases	71,929		7,193	7,193	10	7,193	72
73	Fully Depreciated Assets	930,747				10	930,747	73
74								74
75	TOTALS	\$ 1,319,903	\$	\$ 38,916	\$ 38,916		\$ 1,175,139	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		Ford Van	1994	\$ 19,594	\$	\$	\$	5	\$ 19,594	76
77		Lift/Tie Dons	2007	8,783				5	8,783	77
78		Vehicle	2000	21,907				5	21,907	78
79		2006 Ford F-350	2011	17,072		3,414	3,414	5	13,373	79
80	TOTALS			\$ 67,356	\$	\$ 3,414	\$ 3,414		\$ 63,657	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)	\$ 6,583,592	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 192,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 296,908	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 104,908	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,455,986	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	Allocated from Management Co.				7,709			5
6								6
7	TOTAL				\$ 7,709			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: \$

15,431

Description:

See Attached Schedule 14A

(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	Patient Shuttle	Ford Challenger 2014	\$ 899.00	\$ 10,788	17
18	Patient Shuttle	Ford E350 2005	592.83	5,928	18
19					19
20	Allocated from Management Co.			6,771	20
21	TOTAL		\$ 1,491.83	\$ 23,487	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Danville Care Center

IDPH License ID Number:

0032862

Fiscal Year End:

12/31/16

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Storage	1,868
Copier	12,102
Dishwasher	1,461
Total - Line 16	15,431

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

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$		\$ 157,773	\$		\$ 157,773	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			31,753			31,753	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), 39(3)	hrs			170,726	506		171,232	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				57,837		57,837	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 360,252	\$ 58,343		\$ 418,595	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ (269,684)	\$ (266,385)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	2,540,798	2,692,373	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	117,239	117,239	6
7	Other Prepaid Expenses	29,549	29,549	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Loans</u>	1,055	1,055	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,418,957	\$ 2,573,831	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		2,954,225	14
15	Leasehold Improvements, at Historical Cost	1,814,608	2,242,108	15
16	Equipment, at Historical Cost	1,039,809	1,387,259	16
17	Accumulated Depreciation (book methods)	(1,948,818)	(5,455,986)	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) <u>LTC Mgmt Stock</u>	59,871	59,871	22
23	Other(specify): <u>Loan Costs</u>		36,087	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 965,470	\$ 1,223,564	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,384,427	\$ 3,797,395	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 688,739	\$ 688,739	26
27	Officer's Accounts Payable	263,909	263,909	27
28	Accounts Payable-Patient Deposits	5,500	5,500	28
29	Short-Term Notes Payable	2,630,920	2,630,920	29
30	Accrued Salaries Payable	248,383	248,383	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,500	15,500	31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,104	51,104	32
33	Accrued Interest Payable	1,928	5,428	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to IDPA</u>	28,692	28,692	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,934,675	\$ 3,938,175	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,386,407	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Payable</u>	1,949,743	5,423,426	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,949,743	\$ 7,809,833	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,884,418	\$ 11,748,008	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,499,991)	\$ (7,950,613)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,384,427	\$ 3,797,395	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,507,093)	1
2	Restatements (describe): Bad Debt Expense		2
3	See Attached Schedule 18A	(56,596)	3
4	Rounding	8	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,563,681)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(936,310)	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)	\$ (936,310)	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)	\$ (2,499,991)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Danville Care Center

IDPH License ID Number:

0032862

Fiscal Year End:

12/31/16

Schedule 18A

XVI. Statement of Changes in Equity

Line 2 Restatements

Description	Amount
Audit Take Back	230,678
Administrator Wages	1,206
Bad Debt Expense	(291,730)
Auto Leasing	9,485
Depreciation	(6,235)
Total	(56,596)

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,237,372	1
2	Discounts and Allowances for all Levels	156,193	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,393,565	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	135,238	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 135,238	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23	19
20	Radiology and X-Ray		20
21	Other Medical Services	347	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 370	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,672	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,672	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,532,845	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,304,347	31
32	Health Care	3,096,077	32
33	General Administration	1,446,703	33
	B. Capital Expense		
34	Ownership	712,212	34
	C. Ancillary Expense		
35	Special Cost Centers	585,816	35
36	Provider Participation Fee	324,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,469,155	40
41	Income before Income Taxes (line 30 minus line 40)**	(936,310)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (936,310)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,586,811	44
45	Private Pay - Net Inpatient Revenue	597,514	45
46	Medicare - Net Inpatient Revenue	905,149	46
47	Other-(specify) <u>Managed Care</u>	124,289	47
48	Other-(specify) <u>Hospice</u>	179,802	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,393,565	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,024	2,174	\$ 67,304	\$ 30.96	1
2	Assistant Director of Nursing	1,344	1,360	45,229	33.26	2
3	Registered Nurses	23,260	24,535	818,149	33.35	3
4	Licensed Practical Nurses	14,229	15,407	431,530	28.01	4
5	CNAs & Orderlies	63,219	67,062	813,989	12.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,212	10,348	132,730	12.83	8
9	Activity Director	1,592	1,739	30,853	17.74	9
10	Activity Assistants	2,616	2,696	24,369	9.04	10
11	Social Service Workers	9,082	10,102	198,160	19.62	11
12	Dietician					12
13	Food Service Supervisor	3,727	4,039	60,944	15.09	13
14	Head Cook	10,902	11,483	110,107	9.59	14
15	Cook Helpers/Assistants	9,048	9,224	81,155	8.80	15
16	Dishwashers					16
17	Maintenance Workers	4,568	5,119	83,417	16.30	17
18	Housekeepers	24,911	26,363	265,270	10.06	18
19	Laundry	1,841	1,969	16,720	8.49	19
20	Administrator	1,620	1,783	116,773	65.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,737	9,156	148,647	16.23	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	1,865	2,077	35,728	17.20	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	9,642	10,564	230,830	21.85	33
34	TOTAL (lines 1 - 33)	203,439	217,200	\$ 3,711,904 *	\$ 17.09	34

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	285	\$ 11,986	L1,C3	35
36	Medical Director	Monthly	24,000	L9,C3	36
37	Medical Records Consultant	66	2,959	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,326	L10,C3	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	87	5,696	L12,C3	45
46	Other(specify) Psychosocial	Monthly	36,000	L11,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	438	\$ 94,967		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Danville Care Center

Period Beginning 1/1/16
Period End 12/31/16

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	3,719	4,115	128,768	31.29
Transportation	4,099	4,425	52,030	11.76
Marketing	1,824	2,024	50,032	24.72
TOTAL	9,642	10,564	230,830	

Facility Name & ID Number		Danville Care Center		STATE OF ILLINOIS	#	0032862	Report Period Beginning:	1/1/16	Ending:	12/31/16	Page 22
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?			None							
	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 Years							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$		2,871		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.			\$		324,000					
	This amount is to be recorded on line 42 of Schedule V.										
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			No		If YES, attach an explanation of the allocation.					
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			Yes							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			No		For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.					
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.			\$		None		Has any meal income been offset against related costs?		Indicate the amount. \$	
				N/A						N/A	
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			No							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			No		If YES, please indicate the amount of income earned from such a program during this reporting period.					
				N/A		\$					
	c. What percent of all travel expense relates to transportation of nurses and patients?			100% Ln 14							
	d. Have vehicle usage logs been maintained?			N/A							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			No							
	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?			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?			Yes		See page 39 of the instructions for details.					
	Attach invoices and a summary of services for all architect and appraisal fees										

SEE ACCOUNTANTS' PREPARATION REPORT