

		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: 0032029

Facility Name: Hickory Nursing Pavilion

Address: 9246 S Roberts Road Hickory Hills 60457
Number City Zip Code

County: Cook

Telephone Number: (708) 598-4040 Fax # (708) 598-3796

HFS ID Number:

Date of Initial License for Current Owners: 3/1/1987

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) _____ * _____ (Date) _____
* Subject to the attached Accountants Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number

Hickory Nursing Pavilion

#

0032029

Report Period Beginning:

01/01/16

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					
N/A					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,444	1
2		Skilled Pediatric (SNF/PED)			2
3	40	Intermediate (ICF)	40	14,640	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,291	342	591	9,224	8
9	SNF/PED					9
10	ICF	12,560			12,560	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,851	342	591	21,784	14

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

80.43%

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 ☒

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 03/01/1987

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 03/01/1987 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 28 and days of care provided 591

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/16 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	152,403	23,259	5,868	181,530		181,530		181,530			1
2	Food Purchase		114,237		114,237	(7,708)	106,529	(18)	106,511			2
3	Housekeeping	112,771	31,863		144,634		144,634		144,634			3
4	Laundry	15,108	11,836		26,944		26,944		26,944			4
5	Heat and Other Utilities			69,017	69,017		69,017	(6,096)	62,921			5
6	Maintenance	48,918	16,964	54,430	120,312		120,312	4,353	124,665			6
7	Other (specify):*							283	283			7
8	TOTAL General Services	329,200	198,159	129,315	656,674	(7,708)	648,966	(1,478)	647,488			8
	B. Health Care and Programs											
9	Medical Director			13,500	13,500		13,500		13,500			9
10	Nursing and Medical Records	932,207	48,364	4,642	985,213		985,213		985,213			10
10a	Therapy	26,723		2,441	29,164		29,164		29,164			10a
11	Activities	64,061	1,641	678	66,380		66,380		66,380			11
12	Social Services	78,856		739	79,595		79,595		79,595			12
13	CNA Training											13
14	Program Transportation			6,164	6,164		6,164		6,164			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,101,847	50,005	28,164	1,180,016		1,180,016		1,180,016			16
	C. General Administration											
17	Administrative	81,377		209,500	290,877		290,877	(139,036)	151,841			17
18	Directors Fees											18
19	Professional Services			33,529	33,529	(253)	33,276	2,090	35,366			19
20	Dues, Fees, Subscriptions & Promotions			22,549	22,549		22,549	(7,478)	15,071			20
21	Clerical & General Office Expenses	35,140	24,023	40,106	99,269		99,269	36,830	136,099			21
22	Employee Benefits & Payroll Taxes			256,077	256,077	7,708	263,785		263,785			22
23	Inservice Training & Education											23
24	Travel and Seminar			906	906		906	108	1,014			24
25	Other Admin. Staff Transportation			4,063	4,063		4,063	2,172	6,235			25
26	Insurance-Prop.Liab.Malpractice			74,060	74,060		74,060	1,363	75,423			26
27	Other (specify):*							27,404	27,404			27
28	TOTAL General Administration	116,517	24,023	640,790	781,330	7,455	788,785	(76,547)	712,238			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,547,564	272,187	798,269	2,618,020	(253)	2,617,767	(78,026)	2,539,741			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			27,342	27,342		27,342	33,478	60,820			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56	56		56	239	295			32
33	Real Estate Taxes			159,308	159,308	253	159,561	2,626	162,187			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles							2,864	2,864			35
36	Other (specify):*											36
37	TOTAL Ownership			366,706	366,706	253	366,959	(140,793)	226,166			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		26,156	74,763	100,919		100,919		100,919			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,085	169,085		169,085		169,085			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		26,156	243,848	270,004		270,004		270,004			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,547,564	298,343	1,408,823	3,254,730	(0)	3,254,730	(218,819)	3,035,911			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

*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				4
5	Telephone, TV & Radio in Resident Rooms	(6,904)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,935)	30		9
10	Interest and Other Investment Income	(651)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(18)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,032)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,638)	21		24
25	Fund Raising, Advertising and Promotional	(491)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,493)	20		28
29	Other-Attach Schedule	(11,228)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,390)		\$	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)	(185,429)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (185,429)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (218,819)		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

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	MCA Sequester Reduction	\$ (4,321)	21	1
2	Building Co - Accounting Fees	(1,325)	19	2
3	Building Co - Replacement Tax	(2,132)	21	3
4	Building Co - Annual Report	(250)	20	4
5	PAC Dues	(3,462)	20	5
6	Additional R&M	889	06	6
7	Non-Allowable Legal	(626)	19	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	(11,228)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(18)											(18)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,904)		808									(6,096)	5
6	Maintenance	889		809	2,655								4,353	6
7	Other (specify):*				283								283	7
8	TOTAL General Services	(6,033)		1,617	2,938								(1,478)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(193,858)	54,822								(139,036)	17
18	Directors Fees													18
19	Professional Services	(1,951)	1,325	2,401		315							2,090	19
20	Fees, Subscriptions & Promotions	(7,728)	250										(7,478)	20
21	Clerical & General Office Expenses	(11,091)	8,486	39,435									36,830	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			108									108	24
25	Other Admin. Staff Transportation			2,172									2,172	25
26	Insurance-Prop.Liab.Malpractice			1,114		249							1,363	26
27	Other (specify):*			23,821	3,583								27,404	27
28	TOTAL General Administration	(20,771)	10,061	(124,807)	58,405	564							(76,547)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(26,804)	10,061	(123,190)	61,343	564							(78,026)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(5,935)	35,397	2,789		1,227							33,478	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(651)	(5)	16		879							239	32
33	Real Estate Taxes					2,626							2,626	33
34	Rent-Facility & Grounds		(180,000)	7,392		(7,392)							(180,000)	34
35	Rent-Equipment & Vehicles			2,864									2,864	35
36	Other (specify):*													36
37	TOTAL Ownership	(6,586)	(144,608)	13,061		(2,660)							(140,793)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(33,390)	(134,547)	(110,129)	61,343	(2,096)							(218,819)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 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	34	Rent Income	\$ 180,000	Hickory Health Care Associates	100.00%	\$	\$ (180,000)	1
2	V	32	Interest Income	5	Hickory Health Care Associates	100.00%		(5)	2
3	V	19	Accounting Fees		Hickory Health Care Associates	100.00%	1,325	1,325	3
4	V	30	Depreciation		Hickory Health Care Associates	100.00%	35,397	35,397	4
5	V	20	Annual Report		Hickory Health Care Associates	100.00%	250	250	5
6	V	21	ILL. RT		Hickory Health Care Associates	100.00%	2,132	2,132	6
7	V	21	Miscellaneous		Hickory Health Care Associates	100.00%	6,354	6,354	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 180,005			\$ 45,458	\$ * (134,547)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

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	UTILITIES	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 808	\$ 808	15
16	V	6	REPAIRS AND MAINT.				809	809	16
17	V	17	ADMIN. SALARY				15,642	15,642	17
18	V	19	PROFESSIONAL FEES				2,401	2,401	18
19	V	21	CLERICAL & GENERAL				39,435	39,435	19
20	V	24	SEMINARS				108	108	20
21	V	25	ADMIN. STAFF TRAVEL				2,172	2,172	21
22	V	26	INSURANCE				1,114	1,114	22
23	V	27	EMPLOYEE BENEFITS				23,821	23,821	23
24	V	30	DEPRECIATION				2,789	2,789	24
25	V	32	INTEREST EXPENSE				16	16	25
26	V	34	BUILDING RENT				7,392	7,392	26
27	V	35	EQUIP. RENTAL-AUTO				2,864	2,864	27
28	V								28
29	V	17	MANAGEMENT FEES	209,500				(209,500)	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			\$ 209,500			\$ 99,371	\$ * (110,129)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

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	1	DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$	\$	15
16	V	1	DIET. COMP - D. WENGROW						16
17	V	6	MAINT. COMP.				2,655	2,655	17
18	V	7	EMP. BEN. - S. WEBSTER						18
19	V	7	EMP. BEN. - D. WENGROW						19
20	V	7	EMP. BEN. - MAINT. NON-OWNER				283	283	20
21	V	17	ADMIN. COMP - H. WENGROW				41,105	41,105	21
22	V	17	ADMIN. COMP - J. WEBSTER				13,717	13,717	22
23	V	27	EMP. BEN. - H. WENGROW				2,723	2,723	23
24	V	27	EMP. BEN. - J. WEBSTER				860	860	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 61,343	\$ * 61,343	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

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			\$		100.00%	\$		15
16	V	19	PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		165	165	16
17	V	26	INSURANCE		DOUBLE YOU REALTY, LLC		249	249	17
18	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC		1,227	1,227	18
19	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		879	879	19
20	V	19	RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		150	150	20
21	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		2,626	2,626	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	7,392	DOUBLE YOU REALTY, LLC			(7,392)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 7,392			\$ 5,296	\$ * (2,096)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

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	ABRAHAM J. STERN	1.351%	ABBINGTON REHAB & NURSING CENTER, LTD.	ROSELLE	HICKORY HEALTH CARE ASSO	LINCOLNWOOD	BUILDING CO	1
2	DEBORAH WENGROW	12.838%	ARBOUR HEALTH CARE CENTER, LTD.	CHICAGO	DOUBLE YOU REALTY	LINCOLNWOOD	BUILDING COMPANY	2
3	FRANCES MAUER	2.027%	ATRIUM HEALTH CARE CENTER, LTD., THE	CHICAGO	STAYCARE MANAGEMENT	LINCOLNWOOD	MANAGEMENT, BOOKKEE	3
4	HOWARD L. WENGROW	14.189%	RIDGEVIEW REHAB & NURSING CENTER, LLC	CHICAGO				4
5	JEFFREY J. WEBSTER	14.189%	ZIKAINIM, INC. D/B/A ALL AMERICAN NURSING HOME	CHICAGO				5
6	MARSHALL A. MAUER	2.027%						6
7	MAURICE I. AARON	5.406%						7
8	MIRIAM LATINIK	5.406%						8
9	RALPH BROOKS	1.351%						9
10	BASHIR KAGDA	1.351%						10
11	SANDY BOKOR	1.351%						11
12	SARA WEBSTER	12.838%						12
13	SUSAN L. STERN	25.676%						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

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 Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/16 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	Jeffrey Webster	Owner	Administrative	14.19%	See Attached	5	7.14%	Alloc. Salary	\$ 13,717	17-07	1
2	Howard Wengrow	Owner	Administrative	14.19%	See Attached	15	23.08%	Alloc. Salary	41,105	17-07	2
3	Ephraim Braunstein	Relative	Clerical		See Attached	4.01	10.03%	Alloc. Salary	7,799	21-07	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	\$ 62,621		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

Ending: 12/31/16

Ending: 12/31/16

((847) 679-2122

Ending: 12/31/16

((847) 679-2122

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/16 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 DOUBLE YOU REALTY, LLC
Street Address 3737 W. ARTHUR AVENUE
City / State / Zip Code LINCOLNWOOD, IL 60712
Phone Number (847) 679-2121
Fax Number (847) 679-2122

	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						\$	\$		\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	217,497	6	1,650		21,784	165	2
3	26	INSURANCE	PATIENT DAYS	217,497	6	2,487		21,784	249	3
4	30	DEPRECIATION	PATIENT DAYS	217,497	6	12,254		21,784	1,227	4
5	32	INTEREST EXPENSE	PATIENT DAYS	217,497	6	8,771		21,784	879	5
6	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	217,497	6	1,500		21,784	150	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	217,497	6	26,220		21,784	2,626	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					\$ 52,882	\$		\$ 5,296	25

Ending: 12/31/16

Name of Related Organization

Fax Number

()

()

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

Ending: 12/31/16

Ending: 12/31/16

Ending: 12/31/16

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	MB Financial		X				\$					\$	56	1
2	Allocated from Double You Realty		X										879	2
3														3
4														4
5					-									5
	Working Capital													
6	Allocated from Staycare Management		X										16	6
7														7
8					-									8
9	TOTAL Facility Related						\$		\$			\$	951	9
	B. Non-Facility Related*													
10	Interest Income		X										(651)	10
11	Interest Income - Bldg. Co		X										(5)	11
12														12
13					-									13
14	TOTAL Non-Facility Related						\$		\$			\$	(656)	14
15	TOTALS (line 9+line14)						\$		\$			\$	295	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.)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hickory Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>23-02-420-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>67,667.36</u>	\$ <u>67,667.36</u>
2. <u>23-02-420-016-0000</u>	<u>Long Term Care Property</u>	\$ <u>67,635.50</u>	\$ <u>67,635.50</u>
3. <u>23-01-302-021-0000</u>	<u>Long Term Care Property</u>	\$ <u>10,810.13</u>	\$ <u>10,810.13</u>
4. <u>23-02-420-015-0000</u>	<u>Long Term Care Property</u>	\$ <u>8,028.51</u>	\$ <u>8,028.51</u>
5. <u>23-02-420-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>3,059.24</u>	\$ <u>3,059.24</u>
6. <u>10-35-329-014-0000</u>	<u>Home Office</u>	\$ <u>26,219.28</u>	\$ <u>2,626.06</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>183,420.02</u></u>	\$ <u><u>159,826.80</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Hickory Nursing Pavilion

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0032029

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

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 Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 provide copies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

16,200

B. General Construction Type:

Exterior

Brick

Frame

Brick

Number 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).

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	Facility	16,200	1990	\$ 74,000	1
2	Allocated from Double You Realty			5,008	2
3	TOTALS	16,200		\$ 79,008	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	74		1990	1961	\$ 1,115,000	\$ 35,397	35	\$	(35,397)	1,115,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1987	22,801		20				19,708	9
10	Various		1988	50,319		20				44,178	10
11	Various		1989	7,409		20				6,346	11
12	Various		1990	38,661		20				35,350	12
13	Various		1991	6,422		20				5,916	13
14	Various		1993	30,582		20				29,642	14
15	Various		1994	13,592		20				13,542	15
16	Various		1995	102,781		20				102,757	16
17	Various		1996	139,610		20		2,105	2,105	139,355	17
18	Various		1997	54,749		20		2,629	2,629	53,272	18
19	Various		1998	53,522		20		2,676	2,676	49,977	19
20	Various		1999	18,879		20		944	944	16,463	20
21	Various		2000	2,520		20		126	126	2,016	21
22	Various		2001	7,081		20		354	354	5,346	22
23	Various		2002	23,923		20				23,923	23
24	Various		2003	67,353		20		3,178	3,178	45,949	24
25	Various		2004	2,732		20		137	137	1,699	25
26	Various		2005	5,239		20				5,239	26
27	Various		2006	9,298		20		582	582	6,640	27
28	Various		2007	12,000		20		1,200	1,200	11,783	28
29	Various		2008	24,350		20		2,435	2,435	19,886	29
30	Various		2009	33,827		20		3,383	3,383	26,323	30
31	Various		2010	62,992		20		6,149	6,149	41,105	31
32	Various		2011	76,314		20		7,307	7,307	38,686	32
33	Various		2012	3,080		20		154	154	616	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	52,690	3,831		1,425	(2,406)	18,723	68
69	Financial Statement Depreciation		27,342			(27,342)		69
70	TOTAL (lines 4 thru 69)	\$ 2,037,725	\$ 66,570		\$ 34,784	\$ (31,786)	\$ 1,879,438	70

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

Facility Name & ID Number Hickory Nursing Pavilion

0032029

Report Period Beginning:

01/01/16

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,037,725	\$ 66,570		\$ 34,784	\$ (31,786)	\$ 1,879,438	1
2	Automatic Sprinkler System	2013	68,419		20	6,842	6,842	27,938	2
3	Turbo Air Conditioner Parts And Labor	2013	4,311		20	111	111	373	3
4	Fence	2014	9,976		20	665	665	1,829	4
5	Fire System Upgrades	2014	2,804		20	280	280	794	5
6	Patch & Paint Rms 103,105,106,108,115,117,119,122,127,129,123,1	2014	4,500		20	225	225	619	6
7	Hic Pumps For Boilers	2014	3,469		20	173	173	506	7
8	Public Bathroom Plumbing Fixtures, Tile & Flooring, Drywall	2014	17,951		20	898	898	2,319	8
9	Tuckpointing & Brickwork	2014	37,500		20	1,875	1,875	4,063	9
10	Security Cameras	2015	5,055		20	253	253	400	10
11	Boiler	2015	10,450		20	523	523	827	11
12	Remove Rear Entry Cove Base/Carpet, Install New Carpet, Walk	2015	2,961		20	148	148	271	12
13	Replace Leaky Pipes/Concrete & Rodding Shower Room Drain	2016	3,900		20	358	358	358	13
14	Parapet Wall Repair	2016	16,500		20	1,100	1,100	1,100	14
15	Water Heater	2016	12,310		20	718	718	718	15
16	Rodded Out Main Sewer From North/South End Of Building	2016	6,325		20	264	264	264	16
17	Removal/Replacement Of Facility Exterior Subsoil/Concrete	2016	4,783		20	159	159	159	17
18	Plumbing Improvement- Catch Basin	2016	13,500		20	161	161	161	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,262,439	\$ 66,570		\$ 49,535	\$ (17,035)	\$ 1,922,137	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,262,439	\$ 66,570		\$ 49,535	\$ (17,035)	\$ 1,922,137	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,262,439	\$ 66,570		\$ 49,535	\$ (17,035)	\$ 1,922,137	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,262,439	\$ 66,570		\$ 49,535	\$ (17,035)	\$ 1,922,137	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,262,439	\$ 66,570		\$ 49,535	\$ (17,035)	\$ 1,922,137	34

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

Facility Name & ID Number Hickory Nursing Pavilion

0032029

Report Period Beginning:

01/01/16

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 12D, Carried Forward		\$ 2,262,439	\$ 66,570		\$ 49,535	\$ (17,035)	\$ 1,922,137	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,262,439	\$ 66,570		\$ 49,535	\$ (17,035)	\$ 1,922,137	34

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

Facility Name & ID Number Hickory Nursing Pavilion

0032029

Report Period Beginning:

01/01/16

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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion

0032029

Report Period Beginning:

01/01/16

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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You Realty	2003	47,869	1,227	35	1,227		17,133	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare Management	2003	2,217		20	111	111	1,503	9
10	Allocated from Staycare Management	2016	2,604	2,604	20	87	(2,517)	87	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 52,690	\$ 3,831		\$ 1,425	\$ (2,406)	\$ 18,723	34

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

Facility Name & ID Number Hickory Nursing Pavilion

0032029

Report Period Beginning:

01/01/16

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 12H, Carried Forward		\$ 52,690	\$ 3,831		\$ 1,425	\$ (2,406)	\$ 18,723	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 52,690	\$ 3,831		\$ 1,425	\$ (2,406)	\$ 18,723	34

**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	\$120,570	\$	\$10,165	\$10,165	10	\$84,470	71
72	Current Year Purchases	18,099		707	707	10	707	72
73	Fully Depreciated Assets	311,101				10	311,101	73
74								74
75	TOTALS	\$449,770	\$	\$10,872	\$10,872		\$396,277	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		Allocated from Staycare Manager	2012	\$3,390	\$185	\$413	\$228	5	\$2,202	76
77										77
78										78
79										79
80	TOTALS			\$3,390	\$185	\$413	\$228		\$2,202	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$2,794,607	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$66,755	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$60,820	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(5,935)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,320,616	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐ YES

☐ NO
- If NO, see instructions.

		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								5
6								6
7	TOTAL				\$			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	Allocated from Staycare Management		\$	\$ 2,864	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 2,864	21

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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

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)	\$			

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

12345678										
	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 - 03	hrs	\$		\$ 34,534	\$		\$ 34,534	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,498			3,498	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			36,731			36,731	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				26,156		26,156	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$ 74,763	\$ 26,156		\$ 100,919	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 208,299	\$ 251,526	1
2	Cash-Patient Deposits	57,561	57,561	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	886,169	886,169	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,799	103,799	6
7	Other Prepaid Expenses	493	493	7
8	Accounts Receivable (owners or related parties)		14,039	8
9	Other(specify): <u>See Attached Schedule</u>	11	11	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,256,332	\$ 1,313,598	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,000	13
14	Buildings, at Historical Cost		1,115,000	14
15	Leasehold Improvements, at Historical Cost	830,024	830,024	15
16	Equipment, at Historical Cost	338,610	449,610	16
17	Accumulated Depreciation (book methods)	(819,071)	(1,854,826)	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)	\$ 349,563	\$ 613,808	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,605,895	\$ 1,927,406	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 121,112	\$ 121,113	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	57,561	57,561	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,797	90,797	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,936	3,936	31
32	Accrued Real Estate Taxes(Sch.IX-B)	161,917	161,917	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	63,820	63,820	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 499,143	\$ 499,144	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	211,678		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 211,678	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 710,821	\$ 499,144	46
47	TOTAL EQUITY(page 18, line 24)	\$ 895,074	\$ 1,428,262	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,605,895	\$ 1,927,406	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,037,830	1
2	Restatements (describe):		2
3	Bad Debt	(119,395)	3
4	Rounding	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 918,432	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	124,642	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	(148,000)	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)	\$ (23,358)	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)	\$ 895,074	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hickory Nursing Pavilion

0032029

Report Period Beginning: 01/01/16

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	\$ 3,319,551	1
2	Discounts and Allowances for all Levels	(127,806)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,191,745	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	158,360	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 158,360	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	27,042	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	739	19
20	Radiology and X-Ray		20
21	Other Medical Services	527	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 28,308	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	651	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 651	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	308	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 308	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,379,372	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	656,674	31
32	Health Care	1,180,016	32
33	General Administration	781,330	33
	B. Capital Expense		
34	Ownership	366,706	34
	C. Ancillary Expense		
35	Special Cost Centers	100,919	35
36	Provider Participation Fee	169,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,254,730	40
41	Income before Income Taxes (line 30 minus line 40)**	124,642	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 124,642	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,980,239	44
45	Private Pay - Net Inpatient Revenue	51,300	45
46	Medicare - Net Inpatient Revenue	160,206	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,191,745	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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	1,856	1,968	\$ 89,860	\$ 45.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,939	4,496	126,402	28.11	3
4	Licensed Practical Nurses	10,099	10,771	280,986	26.09	4
5	CNAs & Orderlies	25,061	30,566	327,452	10.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,627	1,902	26,723	14.05	8
9	Activity Director	1,924	2,182	27,097	12.42	9
10	Activity Assistants	3,143	3,559	36,964	10.39	10
11	Social Service Workers	3,555	4,098	78,856	19.24	11
12	Dietician					12
13	Food Service Supervisor	1,926	2,125	39,873	18.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,315	10,450	112,530	10.77	15
16	Dishwashers					16
17	Maintenance Workers	2,032	2,239	48,918	21.85	17
18	Housekeepers	10,828	11,458	112,771	9.84	18
19	Laundry	1,492	1,534	15,108	9.85	19
20	Administrator	1,912	2,080	81,377	39.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,092	3,205	35,140	10.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	3,073	3,645	107,508	29.49	33
34	TOTAL (lines 1 - 33)	84,874	96,278	\$ 1,547,565 *	\$ 16.07	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	Monthly	\$ 5,868	01-03	35
36	Medical Director	Monthly	13,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,642	10-03	39
40	Physical Therapy Consultant	26	1,845	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	596	10a-03	43
44	Activity Consultant	13	678	11-03	44
45	Social Service Consultant	13	739	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	60	\$ 27,868		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries					
Name	Function	% Ownership	Amount		
Joseph Javier	Administrator	0	\$ 81,377		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,377		
B. Administrative - Other					
Description			Amount		
Staycare Management - Management Fees			\$ 209,500		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 209,500		
C. Professional Services					
Vendor/Payee	Type		Amount		
Marcum LLP	Accounting		\$ 17,721		
See Attached	Legal Fees		949		
Personnel Planners	Unemployment Consulting		1,581		
Staycare Management, Ltd	Reimbursement Consulting		13,175		
Sarnoff & Baccash	RE Tax Refund		103		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 33,528		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 48,516		
Unemployment Compensation Insurance			31,101		
FICA Taxes			110,165		
Employee Health Insurance			51,320		
Employee Meals			7,708		
Illinois Municipal Retirement Fund (IMRF)*					
Employee Benefits			1,040		
Union Pension Expense			11,352		
401K			589		
Christmas Expense			1,994		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 263,784		
E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Description		Line #	Amount		
			\$		
TOTAL			\$		
F. Dues, Fees, Subscriptions and Promotions					
Description			Amount		
IDPH License Fee			\$		
Advertising: Employee Recruitment			2,060		
Health Care Worker Background Check (Indicate # of checks performed)			2,339		
Patient Background Checks					
Dues & Subscriptions			7,030		
Licenses/Permits/Fees			3,642		
Less: Public Relations Expense			()		
Non-allowable advertising			()		
Yellow page advertising			()		
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 15,071		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense			906		
Allocated from Staycare Management			108		
Entertainment Expense			()		
(agree to Sch. V, line 24, col. 8)					
TOTAL			\$ 1,014		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number Hickory Nursing Pavilion	STATE OF ILLINOIS # 0032029	Report Period Beginning: 01/01/16	Ending: 12/31/16	Page 22
--	--	---	--------------------------------	----------------

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. ICLTC: \$10,492

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,542 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. \$ 169,085
 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. \$ 7,708 Has any meal income been offset against related costs? No Indicate the amount. \$ 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 1
 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? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

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