

		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: 0047720

Facility Name: Pine Acres Rehab & Lving Ctr

Address: 1212 South Second St DeKalb 60115
Number City Zip Code

County: DeKalb

Telephone Number: (815) 758-8151 Fax # (815) 758-6832

HFS ID Number:

Date of Initial License for Current Owners: 02/01/2006

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: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

(Signed) _____
(Date) _____
(Print Name and Title) _____
(Firm Name & Address) RSM US LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 Pine Acres Rehab & Lving Ctr

0047720 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	<u>119</u>	Skilled (SNF)	<u>119</u>	<u>43,554</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>119</u>	<u>43,554</u>	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	<u>15,580</u>	<u>10,396</u>	<u>6,807</u>	<u>32,783</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,580</u>	<u>10,396</u>	<u>6,807</u>	<u>32,783</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.27%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 ☐ Note : 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 2/1/06

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 2/1/06 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 119 and days of care provided 4,263

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: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Pine Acres Rehab & Lving Ctr # 0047720 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	370,564	14,852	13,107	398,523		398,523		398,523			1
2	Food Purchase		251,597		251,597		251,597	(2,387)	249,210			2
3	Housekeeping	107,529	31,242		138,771		138,771		138,771			3
4	Laundry	21,458	3,166	132,290	156,914		156,914		156,914			4
5	Heat and Other Utilities			107,084	107,084		107,084		107,084			5
6	Maintenance	112,993	52,646	62,968	228,607		228,607		228,607			6
7	Other (specify):*											7
8	TOTAL General Services	612,544	353,503	315,449	1,281,496		1,281,496	(2,387)	1,279,109			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	2,687,844	159,329	18,494	2,865,667		2,865,667	30,744	2,896,411			10
10a	Therapy											10a
11	Activities	97,603	6,256	6,373	110,232		110,232		110,232			11
12	Social Services	42,775		1,510	44,285		44,285		44,285			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,828,222	165,585	35,977	3,029,784		3,029,784	30,744	3,060,528			16
	C. General Administration											
17	Administrative	111,659		278,400	390,059		390,059		390,059			17
18	Directors Fees											18
19	Professional Services			124,905	124,905		124,905	(27,946)	96,959			19
20	Dues, Fees, Subscriptions & Promotions			15,825	15,825		15,825	(3,638)	12,187			20
21	Clerical & General Office Expenses	179,115	12,055	44,170	235,340		235,340	(13,840)	221,500			21
22	Employee Benefits & Payroll Taxes			625,832	625,832		625,832		625,832			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,701	2,701		2,701		2,701			24
25	Other Admin. Staff Transportation			7,291	7,291		7,291		7,291			25
26	Insurance-Prop.Liab.Malpractice			76,456	76,456		76,456	14,608	91,064			26
27	Other (specify):*											27
28	TOTAL General Administration	290,774	12,055	1,175,580	1,478,409		1,478,409	(30,816)	1,447,593			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,731,540	531,143	1,527,006	5,789,689		5,789,689	(2,459)	5,787,230			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			74,556	74,556		74,556	179,410	253,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,713	19,713		19,713	264,097	283,810			32
33	Real Estate Taxes							88,858	88,858			33
34	Rent-Facility & Grounds			528,828	528,828		528,828	(528,828)				34
35	Rent-Equipment & Vehicles			42,220	42,220		42,220		42,220			35
36	Other (specify):* Mortgage Insurance							35,010	35,010			36
37	TOTAL Ownership			665,317	665,317		665,317	38,547	703,864			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		271,597	634,732	906,329		906,329		906,329			39
40	Barber and Beauty Shops	12,138	547		12,685		12,685		12,685			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			240,384	240,384		240,384		240,384			42
43	Other (specify):* Non-Allowable Cos	126,938		98,155	225,093		225,093	(225,093)				43
44	TOTAL Special Cost Centers	139,076	272,144	973,271	1,384,491		1,384,491	(225,093)	1,159,398			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,870,616	803,287	3,165,594	7,839,497		7,839,497	(189,005)	7,650,492			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,387)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,149)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,018)	30		9
10	Interest and Other Investment Income	(33)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(1,430)	43		18
19	Entertainment	(61)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,177)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(67,533)	43		24
25	Fund Raising, Advertising and Promotional				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	(161,648)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (250,436)		\$	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)	61,431		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 61,431		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (189,005)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (12,848)	43	1
2	Wages-Marketing	(70,637)	43	2
3	Marketing	(4,134)	43	3
4	Admissions Director	(56,301)	43	4
5	Offset Telephone Income	(3,930)	21	5
6	Non-Allowable PAC Contributions	(3,888)	20	6
7	Offset Misc. Income	(9,910)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(161,648)		49

Facility Name & ID Number Pine Acres Rehab & Lving Ctr # 0047720 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
Steve Jeremias	33	Community Nursing & Rehabilitation Center, LLC	Naperville	Pine Acres Realty,	DeKalb	Real Estate
Mark Weldler	33	The Springs at Crystal Lake, LLC	Crystal Lake	LLC		
Chaim Rajchenbach	11					
The Family Rajchenbach Trust	11			Community Nursing	Naperville	Real Estate
Abraham J. Stern	4			and Rehab Realty,		
Susan L. Stern	4			LLC		
ABM Limited Partnership	4			TS Realty, LLC	Crystal Lake	Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	\$	Pine Acres Realty, LLC		\$	\$	1
2	V	20	Licenses		Pine Acres Realty, LLC		250	250	2
3	V	26	Insurance		Pine Acres Realty, LLC		49,618	49,618	3
4	V	30	Depreciation		Pine Acres Realty, LLC		181,428	181,428	4
5	V	32	Interest	530	Pine Acres Realty, LLC		264,660	264,130	5
6	V	33	Real Estate Taxes		Pine Acres Realty, LLC		88,858	88,858	6
7	V	34	Rent Expense	528,828	Pine Acres Realty, LLC		5,975	(522,853)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 529,358			\$ 590,789	\$ * 61,431	14

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

Facility Name & ID Number Pine Acres Rehab & Living Ctr # 0047720 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Jeremias	Manager	Administrative	33.00	See Sch 7A	25	50.00	Guar Payment	\$ 139,200	L17,C3	1
2	Mark Weldler	Manager	Finance	33.00	See Sch 7A	25	50.00	Guar Payment	139,200	L17,C3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 278,400		13

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

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

Facility Name & ID Number Pine Acres Rehab & Lving Ctr # 0047720 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 N/A
Street Address _____
City / State / Zip Code _____
Phone Number ()
Fax Number ()

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Heartland		X	Mortgage	41,970	5/29/14	\$ 6,512,900	\$ 6,345,447	6/1/2054	0.0415	\$ 264,660	1	
2	Housing & Health Funding		X	Bridge for HUD	6,245	06/01/14	241,995	42,889	6/1/2017	0.0500	4,056	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Lake Forest Bank & Trust Co.		X	Line of Credit	None	9/15/13	1,000,000	585,000	9/1/2017	0.0500	15,658	6	
7												7	
8												8	
9	TOTAL Facility Related				\$48,215.00		\$ 7,754,895	\$ 6,973,336			\$ 284,373	9	
	B. Non-Facility Related*												
10												10	
11												11	
12							Interest Income				(563)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (563)	14	
15	TOTALS (line 9+line14)						\$ 7,754,895	\$ 6,973,336			\$ 283,810	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 35,010 Line # 36

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	91,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2015		\$	90,258	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(1,442)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	90,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Alloc. Fr. Mgmt Co.				
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	88,858	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011	85,925	8		
		2012	88,004	9		
		2013	89,890	10		
		2014	89,843	11		
		2015	90,258	12		
FY15 RE Taxes x 1.0046% = 90,258 x 1.0046% = 90,258						
Use 90,300						

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pine Acres Rehab & Living Center, LLC COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0047720

CONTACT PERSON REGARDING THIS REPORT Mark Weldler

TELEPHONE (815) 758-8151 FAX #: (815) 758-6832

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 08-27-279-003	Nursing Home	\$ 86,027.68	\$ 86,027.68
2. 08-27-279-023	Nursing Home	\$ 4,230.34	\$ 4,230.34
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 90,258.02	\$ 90,258.02

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: 37,295

B. General Construction Type: Exterior Brick Frame 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: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use	126,760	2006	\$ 196,341	1
2					2
3	TOTALS	126,760		\$ 196,341	3

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	119		2006	1968	\$ 1,736,051	\$	40	\$ 43,401	\$ 43,401	\$ 473,795	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2 Ton Rooftop System			2007	4,562	456	10	456		4,332	9
10	Replace Heat Cable			2008	2,626	263	10	263		2,235	10
11	Replace Fan Motors			2008	3,441	344	10	344		2,924	11
12	Replace Unit Heater			2008	3,938	394	10	394		3,349	12
13	Replace Doors			2008	2,696	270	10	270		2,295	13
14	Move Electrical Box			2008	6,932	693	10	693		5,890	14
15	Sidewalk			2009	6,312	316	10	631	315	4,733	15
16	Retrofit Mechanical Room with Sprinklers			2009	2,800	140	10	280	140	2,100	16
17	Security Alarm for Front Doors			2009	4,644	232	10	464	232	3,480	17
18	Telephone System			2009	37,765	1,888	10	3,777	1,889	28,327	18
19	Telephone System Addition			2009	13,143	657	10	1,314	657	9,855	19
20	Fence			2009	5,708	285	10	571	286	4,282	20
21	Renovation & New Construction			2009	2,443,769		40	61,094	61,094	458,205	21
22	Architect Fees			2009	122,501		40	3,063	3,063	22,972	22
23	Demolition of Old House			2009	41,210		40	1,030	1,030	7,725	23
24	Carpet, Flooring & Wallcovering			2009	175,473		40	4,387	4,387	32,902	24
25	Construction Period Interest			2009	108,345		40	2,709	2,709	20,317	25
26	North Dining Room & Corridor Remodel			2009	101,743		40	2,544	2,544	19,080	26
27	Architect Fees			2009	102,207		40	2,555	2,555	19,163	27
28	Draw #11 Construction & Architect Fees			2009	13,159		40	329	329	2,468	28
29	Draw #12			2009	154,568		40	3,864	3,864	28,980	29
30	Doors & Hardware			2009	13,257		40	331	331	2,483	30
31	Panic Hardware			2009	3,730		40	93	93	698	31
32	Old House			2009	173,313		40	4,333	4,333	32,497	32
33	Ice Cube Machine (Expensed for Medicaid purposes)			2009		92			(92)		33
34	Telephone System Addition			2010	6,277	157	40	157		1,020	34
35	Satellite TV Installation			2010	8,250	825	10	825		5,363	35
36	A/C Unit Replacement (North Dining Room)			2010	10,000	1,000	10	1,000		6,500	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pine Acres Rehab & Lving Ctr

0047720

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	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	
37	Piping and Wiring (outside lights)	2010	\$ 2,896	\$ 72	40	\$ 72	\$	\$ 468	37
38									38
39	Water Heater	2011	7,442	496	15	496		2,729	39
40	Rooftop A/C replacement	2011	5,721	286	20	286		1,573	40
41	Replace 19 window cranks	2011	3,419	488	7	488		2,686	41
42									42
43	Set Up Wireless Access	2012	4,919	492	10	492		2,214	43
44	Kitchen HVAC Unit	2012	6,507	651	10	651		2,928	44
45									45
46	Hot water heater-Monarch wing	2013	7,270	727	10	727		2,545	46
47	North Wing Renovation								47
48	- Sprinkler System	2013	32,800		27.5	1,193	1,193	4,175	48
49	- Permits and architect fees	2013	32,244		27.5	1,173	1,173	4,104	49
50	- Remove North wing A/C unit and relocate the new AC unit	2013	58,088		27.5	2,112	2,112	7,393	50
51	and corrections due to initial installation								51
52	- Nurse call system	2013	18,243		27.5	663	663	2,322	52
53	- Update phone wiring and speakers	2013	8,243		10	824	824	2,885	53
54	- Bathrooms, carpentry, plumbing, electrical, paint	2013	273,666		27.5	9,951	9,951	34,830	54
55									55
56	Pave & sealcoat parking lots	2013	7,500	750	10	750		2,625	56
57	Mixing Valve	2013	6,200	620	10	620		2,170	57
58	New Vanity in resident room 146	2013	3,100	310	10	310		1,085	58
59									59
60	10 Ton Rooftop A/C	2014	4,017	402	10	402		1,005	60
61									61
62	Roof repair, Remove ductwork and reinstall	2015	14,696	1,470	10	1,470		2,204	62
63	Replace Compressor for Wak-in Freezer	2015	5,313	531	10	531		797	63
64	Service and Replace Transfer Switch in Electrical Room	2015	7,945	795	10	795		1,192	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,818,649	\$ 16,102		\$ 165,178	\$ 149,077	\$ 1,289,897	70

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

Facility Name & ID Number Pine Acres Rehab & Lving Ctr

0047720

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	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		\$ 5,818,649	\$ 16,102		\$ 165,178	\$ 149,077	\$ 1,289,897	1
2									2
3	Install New Flooring - West & East Corridors	2016	15,980	200	40	200		200	3
4	Divide EM power system, add new 200am feed, relocate 4 circuits	2016	2,655	133	10	133		133	4
5	Replace 62 sprinkler heads through Southwest Wing	2016	3,659	183	10	183		183	5
6	Roof Renovations (RE)	2016	91,900		40	1,149	1,149	1,149	6
7									7
8	To adjust to financial statement depreciation			13,423			(13,423)		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)		\$ 5,932,843	\$ 30,041		\$ 166,843	\$ 136,803	\$ 1,291,562	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	\$983,308	\$43,927	\$86,535	\$42,608	5-10	\$778,013	71
72	Current Year Purchases	5,882	588	588	-	5	588	72
73	Fully Depreciated Assets				-			73
74					-			74
75	TOTALS	\$989,190	\$44,515	\$87,123	\$42,608		\$778,601	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	N/A			\$	\$	\$	-		\$	76
77							-			77
78							-			78
79							-			79
80	TOTALS			\$-	\$-	\$-	-		\$-	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)	\$7,118,374	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$74,556	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$253,966	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$179,411	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,070,163	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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?
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:				\$ N/A			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 . N/A
N/A
9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: \$ 42,220 Description: See Sch. 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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

Facility Name:

Pine Acres Rehab & Lving Ctr

IDPH License ID Number:

0047720

Fiscal Year End:

12/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing & Medical Equipment	13,284
Office Equipment	4,687
Copy Machine	11,891
Maintenance Equipment	12,358
Total - Line 16	42,220

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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		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	\$	3,034	\$ 218,427	\$ 387	3,034	\$ 218,814	1
2	Licensed Speech and Language Development Therapist	39(2),(3)	hrs		827	59,532		827	59,532	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3)	hrs		4,955	356,773	1,521	4,955	358,294	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				254,232		254,232	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					15,457		15,457	12
13	Other (specify): _____									13
14	TOTAL			\$	8,816	\$ 634,732	\$ 271,597	8,816	\$ 906,329	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 39,183	\$ 76,173	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,608)	1,792,562	1,792,562	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,189	72,034	6
7	Other Prepaid Expenses	578,512	578,512	7
8	Accounts Receivable (owners or related parties)	360,202	334,727	8
9	Other(specify): See Sch 17A	39,660	114,178	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,869,308	\$ 2,968,186	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		196,341	13
14	Buildings, at Historical Cost		1,736,051	14
15	Leasehold Improvements, at Historical Cost	311,555	4,196,792	15
16	Equipment, at Historical Cost	292,370	989,190	16
17	Accumulated Depreciation (book methods)	(423,225)	(2,070,163)	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 (spe See Sch 17A		494,505	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 180,700	\$ 5,542,716	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,050,008	\$ 8,510,902	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 605,382	\$ 940,108	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,547	169,547	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,556	7,556	31
32	Accrued Real Estate Taxes(Sch.IX-B)		90,300	32
33	Accrued Interest Payable	2,698	24,643	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	953,221	953,221	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,738,404	\$ 2,185,375	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	627,889	6,973,336	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 627,889	\$ 6,973,336	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,366,293	\$ 9,158,711	46
47	TOTAL EQUITY (page 18, line 24)	\$ 683,715	\$ (647,809)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,050,008	\$ 8,510,902	48

*(See instructions.)

Facility Name: Pine Acres Rehab & Lving Ctr
IDPH License ID Number: 0047720
Fiscal Year End: 12/31/2016

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

Description	Operating	After
		Consolidation
2998 Rent Receivable	-	5,727
14500 RE Escrow - MIP	-	18,941
14600 RE Escrow - RE Taxes	-	37,103
14700 RE Escrow - Insurance	-	12,747
20810 Due To/from AdminAstar	39,660	39,660
Total - Line 9	39,660	114,178

XV. Balance Sheet

Line 22 Long-Term Assets Other (specify):

Description	Operating	After
		Consolidation
14400 RE Escrow Replacement	-	441,736
16030 Construction In Progress	-	-
16440 Mortgage Costs	-	56,412
16448 Accum Amort - Org Fees	-	(3,643)
Total - Line 23	-	494,505

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After
		Consolidation
20300 Accrued Management Fees	223,800	223,800
20435 Accrued Assessment Fee #2	29,731	29,731
20570 Insurance Payable	84,534	84,534
20800 Due To State	208,205	208,205
20815 Resident Credit Balances	44,064	44,064
20820 Due To/From Primary Insurance	27,374	27,374
20830 Due To/from BC-BS	12,694	12,694
20840 Due To/from Hospice	4,632	4,632
20905 Due To/from The Springs	307,292	307,292
20920 Due To/From CNRC	11,118	11,118
21510 Resident Refunds	(223)	(223)
30300 Contributions	-	-
Total - Line 36	953,221	953,221

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 932,458	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(306,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 626,458	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	57,264	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) Rounding	(7)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 57,257	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)	\$ 683,715	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pine Acres Rehab & Lving Ctr

0047720

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,607,524	1
2	Discounts and Allowances for all Levels	(221,068)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,386,456	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,170,367	6
7	Oxygen	9,282	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,179,649	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	300	12
13	Barber and Beauty Care	9,210	13
14	Non-Patient Meals	2,387	14
15	Telephone, Television and Radio	3,930	15
16	Rental of Facility Space		16
17	Sale of Drugs	196,527	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,987	19
20	Radiology and X-Ray	6,373	20
21	Other Medical Services	84,506	21
22	Laundry	8,537	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 324,757	23
	D. Non-Operating Revenue		
24	Contributions	1,529	24
25	Interest and Other Investment Income***	33	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,562	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	4,337	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,337	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,896,761	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,281,496	31
32	Health Care	3,029,784	32
33	General Administration	1,478,409	33
	B. Capital Expense		
34	Ownership	665,317	34
	C. Ancillary Expense		
35	Special Cost Centers	1,144,107	35
36	Provider Participation Fee	240,384	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,839,497	40
41	Income before Income Taxes (line 30 minus line 40)**	57,264	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 57,264	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,473,324	44
45	Private Pay - Net Inpatient Revenue	2,146,019	45
46	Medicare - Net Inpatient Revenue	1,231,496	46
47	Other-(specify) <u>Managed Care</u>	256,056	47
48	Other-(specify) <u>Hospice</u>	279,561	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,386,456	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.

^ - This entity is a cash basis taxpayer

Facility Name: Pine Acres Rehab & Lving Ctr
IDPH License ID Number: 0047720
Fiscal Year End: 12/31/2016

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description		Amount
40350	Equipment Rental	150
40899	Prior Year Adjustment	-
41350	Equipment Rental	-
41899	Prior Year Adjustment	(3,781)
42899	Prior Year Adjustment	(725)
43899	Prior Year Adjustment	-
45350	Equipment Rental	20
45899	Prior Year Adjustment	-
50899	Prior Year Adjustment	-
58899	Prior Year Adjustment	(1,645)
591010	Rental Income	-
59660	Vending Machine Income	408
59911	Misc. Income	9,910
Total - Line 28		4,337

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	1,782	1,966	\$ 85,917	\$ 43.70	1
2	Assistant Director of Nursing	1,801	2,080	80,623	38.76	2
3	Registered Nurses	19,730	20,693	639,571	30.91	3
4	Licensed Practical Nurses	16,179	17,328	485,189	28.00	4
5	CNAs & Orderlies	88,009	92,810	1,191,408	12.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,839	2,080	31,740	15.26	9
10	Activity Assistants	6,821	7,127	65,863	9.24	10
11	Social Service Workers	2,138	2,320	42,775	18.43	11
12	Dietician					12
13	Food Service Supervisor	2,539	2,655	49,440	18.62	13
14	Head Cook	5,638	6,143	84,514	13.76	14
15	Cook Helpers/Assistants	22,846	24,356	236,610	9.71	15
16	Dishwashers					16
17	Maintenance Workers	3,963	4,082	112,993	27.68	17
18	Housekeepers	12,480	13,034	107,529	8.25	18
19	Laundry	1,926	2,091	21,458	10.26	19
20	Administrator	1,850	2,080	111,659	53.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,464	10,141	179,115	17.66	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	1,599	1,916	29,057	15.16	31
32	Other Health C; See Sch 20A	5,806	6,601	176,079	26.67	32
33	Other(specify) See Sch 20A	4,368	4,788	139,076	29.05	33
34	TOTAL (lines 1 - 33)	210,777	224,291	\$ 3,870,616 *	\$ 17.26	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 13,107	1(3)	35
36	Medical Director	Monthly	9,600	9(3)	36
37	Medical Records Consultant	25	1,025	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	3,078	11(3)	44
45	Social Service Consultant	22	1,510	12(3)	45
46	Other(specify)				46
47	PPS Review	Monthly	9,600	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	93	\$ 37,920		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	90	\$ 4,062	10(3)	50
51	Licensed Practical Nurses	95	3,807	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	185	\$ 7,868		53

Facility Name: Pine Acres Rehab & Lving Ctr
IDPH License ID Number: 0047720
Fiscal Year End: 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS Coordinator	1,920	2,088	61,021	\$ 29.22
Restorative Supervisor	1,920	2,108	75,078	\$ 35.62
Restorative Aides	1,966	2,405	39,980	\$ 16.62
Total - Line 32 Other Health Care (specify):	5,806	6,601	176,079	\$ 26.67

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Beauty Shop	588	588	12,138	\$ 20.64
Admissions Director	1,872	2,080	56,301	\$ 27.07
Marketing Director	1,908	2,120	70,637	\$ 33.32
Total - Line 33 Other (specify):	4,368	4,788	139,076	\$ 29.05

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Pine Acres Rehab & Lving Ctr

0047720

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dalena Kemna-Kahn	Administrator	0	\$ 111,659
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 111,659

B. Administrative - Other

Description	Amount
Mark Weldler, Admin - Guar. Pmts.	\$ 139,200
Steve Jeremias, CFO - Guar. Pmts.	139,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 278,400

C. Professional Services

Vendor/Payee	Type	Amount
Meyers & Flowers LLC	Legal	\$ 2,787
Vanek, Larson & Kolb LLC	Legal	780
Meyer Magence	Legal	1,125
Much Shelist Attorneys at Law	Legal	4,772
Legal Accrual	Legal	210
RSM US LLP	Accounting	48,723
Paylocity	Payroll Fees	12,962
MDI / Matrix	Professional Services	30,744
Personnel Planners, Inc.	Professional Services	945
Ability Network Inc	Computer Services	3,852
American Express (Internet Radio)	Computer Services	170
Other Vendors	Computer Services	17,835
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 124,905

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 147,545
Unemployment Compensation Insurance	
FICA Taxes	355,229
Employee Health Insurance	94,807
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,635
Other Employee Benefits	16,499
Uniform Expense	6,117
TOTAL (agree to Schedule V, line 22, col.8)	\$ 625,832

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

Description	Line #	Amount
N/A		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 10)	140
Patient Background Checks 176	1,700
Miscellaneous Licenses & Fees	1,300
Miscellaneous Dues & Subscriptions	904
IL Council on LTC	11,781
Allocated from RE Entity	250
Less : Lobbying Expense	(3,888)
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,187

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	2,701
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,701

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Pine Acres Rehab & Lving Ctr
IDPH License ID Number: 0047720
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Total Fr. Pg. 21 Sect C		107,070
Information Controls, Inc.	Computer Services	1,026
CDW	Computer Services	7,261
Pine Acres Trust Account	Computer Services	150
Singer Networks LLC	Computer Services	8,702
Vivian McCain	Computer Services	696
Total (agree to Schedule V, line 19, column 3)		124,905
Allocated from RE Entity Professional Services		5,975
Reclass MDI Achieve, Inc		(30,744)
Less: Non-Allowable Legal Fees		(3,177)
Total (agree to Schedule V, line 19, column 8)		96,959

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?

Yes

If YES, give association name and amount.

IL Council on Long Term Care \$11,781

(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?

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

53,372

Line

10(2)

(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.

\$

240,384

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.

\$

N/A

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$

2,387

(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?

0

d. Have vehicle usage logs been maintained?

Adequate records have been maintained

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?

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?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees