

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0051656</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Southview Manor Nursing Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>3311 South Michigan</u> <u>Chicago</u> <u>60616</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(312) 326-9101</u> Fax # <u>(312) 326-6187</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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Date of Initial License for Current Owners: <u>41087</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr

0051656 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	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>74</u>	Skilled (SNF)	<u>74</u>	<u>27,084</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>126</u>	Intermediate (ICF)	<u>126</u>	<u>46,116</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>200</u>	TOTALS	<u>200</u>	<u>73,200</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,893</u>			<u>14,893</u>	8
9	SNF/PED					9
10	ICF	<u>49,504</u>		<u>512</u>	<u>50,016</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>64,397</u>		<u>512</u>	<u>64,909</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.67%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location? Date started 06/27/2012

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 06/27/2012 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 42 and days of care provided None

Medicare Intermediary National Government 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr # 0051656 Report Period Beginning: 1/1/16 Ending: 12/31/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	306,243	48,131	14,190	368,564		368,564		368,564			1
2	Food Purchase		365,246		365,246		365,246	(10,104)	355,142			2
3	Housekeeping	356,987	86,223		443,210		443,210		443,210			3
4	Laundry	69,379	20,871		90,250		90,250		90,250			4
5	Heat and Other Utilities			230,108	230,108		230,108		230,108			5
6	Maintenance	276,047	2,489	61,677	340,213		340,213		340,213			6
7	Other (specify):* Waste Removal			107,528	107,528		107,528		107,528			7
8	TOTAL General Services	1,008,656	522,960	413,503	1,945,119		1,945,119	(10,104)	1,935,015			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,553,244	68,316	40,820	2,662,380		2,662,380	831	2,663,211			10
10a	Therapy	60,847			60,847		60,847		60,847			10a
11	Activities	165,956		11,082	177,038		177,038		177,038			11
12	Social Services	369,297		3,933	373,230		373,230		373,230			12
13	CNA Training											13
14	Program Transportation			1,595	1,595		1,595		1,595			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,149,344	68,316	87,430	3,305,090		3,305,090	831	3,305,921			16
	C. General Administration											
17	Administrative	141,744		410,267	552,011		552,011		552,011			17
18	Directors Fees											18
19	Professional Services			110,198	110,198		110,198	(9,990)	100,208			19
20	Dues, Fees, Subscriptions & Promotions			30,857	30,857		30,857	(6,913)	23,944			20
21	Clerical & General Office Expenses	179,550	19,242	65,243	264,035		264,035		264,035			21
22	Employee Benefits & Payroll Taxes			651,952	651,952		651,952		651,952			22
23	Inservice Training & Education											23
24	Travel and Seminar			350	350		350		350			24
25	Other Admin. Staff Transportation			1,707	1,707		1,707		1,707			25
26	Insurance-Prop.Liab.Malpractice			146,568	146,568		146,568	14,450	161,018			26
27	Other (specify):*											27
28	TOTAL General Administration	321,294	19,242	1,417,142	1,757,678		1,757,678	(2,453)	1,755,225			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,479,294	610,518	1,918,075	7,007,887		7,007,887	(11,726)	6,996,161			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							245,397	245,397			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			123,128	123,128		123,128	334,133	457,261			32
33	Real Estate Taxes							312,229	312,229			33
34	Rent-Facility & Grounds			1,263,834	1,263,834		1,263,834	(1,256,303)	7,531			34
35	Rent-Equipment & Vehicles			18,225	18,225		18,225		18,225			35
36	Other (specify):*											36
37	TOTAL Ownership			1,405,187	1,405,187		1,405,187	(364,544)	1,040,643			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33,258	111,499	144,757		144,757		144,757			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			503,798	503,798		503,798		503,798			42
43	Other (specify):* See Att Sch 4A	13,325		155,618	168,943		168,943	(168,943)				43
44	TOTAL Special Cost Centers	13,325	33,258	770,915	817,498		817,498	(168,943)	648,555			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,492,619	643,776	4,094,177	9,230,572		9,230,572	(545,213)	8,685,359			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(18,136)	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	245,397	30		9
10	Interest and Other Investment Income	(2,657)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(439)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,085)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,990)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(123,913)	43		24
25	Fund Raising, Advertising and Promotional	(262)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(402,154)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (320,239)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(224,974)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (224,974)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (545,213)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medical Records Income	\$ (169)	10	1
2	Vending Income	(10,104)	2	2
3	Resident Needs/Charity	(4,783)	43	3
4	PAC Dues	(6,913)	20	4
5	Building Co. - Admin Expenses	(250)	21	5
6	Building Co. - Amortization of Goodwill	(335,525)	36	6
7	Building Co. - Other Financing Costs	(31,466)	36	7
8	Building Co. - Licenses & Fees	(619)	20	8
9	Additional Nursing Equipment	1,000	10	9
10	Marketing Wages	(13,325)	43	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
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31				31
32				32
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35				35
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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	(402,154)		49

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	20	Licenses & Fees	\$	SV Chicago LLC	100.00%	\$ 619	\$ 619	1
2	V	21	Bank Charges		SV Chicago LLC	100.00%	250	250	2
3	V	26	Property Insurance		SV Chicago LLC	100.00%	14,450	14,450	3
4	V	32	Interest		SV Chicago LLC	100.00%	336,790	336,790	4
5	V	33	Real Estate Taxes		SV Chicago LLC	100.00%	312,229	312,229	5
6	V	34	Rent	1,256,303	SV Chicago LLC	100.00%		(1,256,303)	6
7	V	36	Amortization Exp-Goodwill		SV Chicago LLC	100.00%	335,525	335,525	7
8	V	36	Finance Costs		SV Chicago LLC	100.00%	31,466	31,466	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,256,303			\$ 1,031,329	\$ * (224,974)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	<u>Jimmy Nassour</u>	<u>50</u>	<u>Bourbonnais Terrace NH</u>	<u>Bourbonnais</u>	<u>SV Chicago LLC</u>	<u>Chicago</u>	<u>Lessor</u>	1
2	<u>Carl Meyer</u>	<u>50</u>	<u>Community Care Center</u>	<u>Chicago</u>				2
3			<u>Crestwood Terrace Nursing Ctr</u>	<u>Crestwood</u>				3
4			<u>Frankfort Terrace Nursing Center</u>	<u>Frankfort</u>				4
5			<u>Joliet Terrace Nursing Center</u>	<u>Joliet</u>				5
6			<u>Kankakee Terrace Nursing Center</u>	<u>Bourbonnais</u>				6
7			<u>Sycamore Healthcare Center</u>	<u>Quincy</u>				7
8			<u>Terrace Nursing Home, The</u>	<u>Waukegan</u>				8
9			<u>West Chicago Terrace NH</u>	<u>West Chicago</u>				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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr # 0051656 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr # 0051656 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Mortgage		X	Mortgage Payable			\$	12,853,339			\$	335,820	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MidCap		X	Line of Credit				1,795,456				101,489	6
7													7
8													8
9	TOTAL Facility Related						\$	14,648,795			\$	437,309	9
	B. Non-Facility Related*												
10								Amortization Expense				22,609	10
11								Interest Income Offset				(2,657)	11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	19,952	14
15	TOTALS (line 9+line14)						\$	14,648,795			\$	457,261	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2015 report.				\$	283,170	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		\$		2
3. Under or (over) accrual (line 2 minus line 1).				\$	(283,170)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	595,399	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.						
TOTAL REFUND		\$	For	Tax Year.	(Attach a copy of the real estate tax appeal board's decision.)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	312,229	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011	290,802	8		
		2012	271,252	9		
		2013	274,923	10		
		2014	280,461	11		
		2015	312,229	12		
Accrual based on prior year tax bill.						

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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southview Manor Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051656

CONTACT PERSON REGARDING THIS REPORT Jerry Harris

TELEPHONE (630) 501-0996 FAX #: (630) 501-0987

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 17-34-116-003-0000	Long Term Care Property	\$ 108,090.49	\$ 108,090.49
2. 17-34-116-004-0000	Long Term Care Property	\$ 61,412.47	\$ 61,412.47
3. 17-34-116-005-0000	Long Term Care Property	\$ 46,677.88	\$ 46,677.88
4. 17-34-116-006-0000	Long Term Care Property	\$ 46,677.88	\$ 46,677.88
5. 17-34-116-007-0000	Long Term Care Property	\$ 46,677.88	\$ 46,677.88
6. 17-34-116-008-0000	Long Term Care Property	\$ 2,692.07	\$ 2,692.07
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 312,228.67	\$ 312,228.67

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: 61,960

B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility			2012		\$ 550,000	1
2							2
3	TOTALS					\$ 550,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	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	200		2012	1980	\$ 4,215,182	\$	35	\$ 120,434	\$ 120,434	\$ 602,170
5										
6										
7										
8										
	Improvement Type**									
9	Single Door		2012		2,770		20	139	139	1,016
10	Cables For Clocks		2013		3,900		20	195	195	1,105
11	Parkway Elevators		2013		5,476		20	274	274	1,415
12	Installed Sprinklers		2013		5,250		20	263	263	941
13	Doors		2014		3,145		20	157	157	329
14	Remote Fire Pump Controllers Alarm		2014		3,389		20	169	169	323
15	Doors		2014		3,479		20	174	174	311
16	Rangeguard Hood Repair		2014		3,891		20	195	195	503
17	Nova Fire Protectors - Repairs		2015		5,150		20	258	258	468
18	Nova Fire Protectors - Replace 6# Osy Valve		2015		3,685		20	184	184	272
19	Leaking Boiler # 1 Repair		2015		3,007		20	150	150	300
20	Replace Parkway Elevator Gasket		2016		5,710		20	286	286	286
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr

0051656

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	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 Leasehold Improvements (Real Estate Entity):						\$	\$	37
38 Doors	2012	3,860		20	193	193	965	38
39 Doors	2012	2,575		20	129	129	709	39
40 Glass Doors	2012	2,770		20	139	139	749	40
41 Entrance Hall - corian countertops, vinyl planked flooring	2013	32,846		20	1,642	1,642	6,568	41
42 Aluminum Doors	2013	4,400		20	220	220	880	42
43 Two Single Doors with tempered glasses	2013	3,022		20	151	151	604	43
44 HVAC Unit	2013	5,560		20	278	278	1,112	44
45 Kitchen Hood	2013	3,490		20	175	175	700	45
46 Water Heater	2014	6,381		20	319	319	957	46
47 Awnings	2015	4,800		20	240	240	480	47
48 Two B&G Bronze Pumps 1/6 HP	2015	4,274		20	214	214	428	48
49 Remove Non-Compliant Generator Circuits and Relabel	2016	2,580		20	129	129	129	49
50 Roof Repairs	2016	18,490		20	925	925	925	50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 4,359,082	\$		\$ 127,632	\$ 127,632	\$ 624,645	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,154,619	\$	\$115,462	\$115,462	10	\$567,907	71
72	Current Year Purchases	23,028		2,303	2,303	10	2,303	72
73	Fully Depreciated Assets	2,913					2,913	73
74								74
75	TOTALS	\$1,180,560	\$	\$117,765	\$117,765		\$573,123	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	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)	\$6,089,642	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$245,397	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$245,397	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,197,768	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				7,531			5
6								6
7	TOTAL				\$ 7,531			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: \$ 16,522
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2011 Ford E350 Shuttle Bu	\$ 851.50	\$ 1,703	17
18					18
19					19
20					20
21	TOTAL		\$ 851.50	\$ 1,703	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Southview Manor Nursing Ctr

IDPH License ID Number:

0051656

Fiscal Year End:

12/31/16

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Ice Machine	2,420
Postage Machine	2,280
Copier	2,608
Computer Equip	304
Dishwasher	7,410
Air Cleaner	1,500
Total - Line 16	16,522

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$		\$ 59,251	\$		\$ 59,251	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			6,724			6,724	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			45,524			45,524	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				9,642		9,642	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached Schedule 16A						23,616		23,616	13
14	TOTAL			\$		\$ 111,499	\$ 33,258		\$ 144,757	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

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	Urological Supplies	39(2)	hrs	\$		\$	59		\$	59	1
2	Oxygen Rental/Cost	39(2)	hrs				6,929			6,929	2
3	Respiratory Rental/Cost	39(2)	hrs				16,628			16,628	3
4			hrs								4
5			visits								5
6			visits								6
7			hrs								7
8			hrs								8
9			# of prescrpts								9
10			hrs								10
11			hrs								11
12											12
13											13
14	TOTAL			\$		\$	23,616		\$	23,616	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ (22,984)	\$ (22,913)	1
2	Cash-Patient Deposits	(1,293)	(1,293)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 499,572)	1,874,458	1,874,458	3
4	Supply Inventory (priced at Cost)	7,050	7,050	4
5	Short-Term Investments			5
6	Prepaid Insurance	31,833	77,158	6
7	Other Prepaid Expenses	14,595	14,595	7
8	Accounts Receivable (owners or related parties)	176,421	176,421	8
9	Other(specify): See Attached Schedule 17A	83,589	321,454	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,163,669	\$ 2,446,930	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		550,000	13
14	Buildings, at Historical Cost	26,334	4,240,368	14
15	Leasehold Improvements, at Historical Cost		118,714	15
16	Equipment, at Historical Cost	102,507	1,180,560	16
17	Accumulated Depreciation (book methods)	(17,547)	(1,197,768)	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: Goodwill)	842,415	2,855,565	22
23	Other(specify): Loan Costs		26,438	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 953,709	\$ 7,773,877	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,117,378	\$ 10,220,807	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,369,124	\$ 1,415,833	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,795,456	1,795,456	29
30	Accrued Salaries Payable	529,855	529,855	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,777	19,777	31
32	Accrued Real Estate Taxes(Sch.IX-B)		595,399	32
33	Accrued Interest Payable		466,892	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	267,853	267,853	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,982,065	\$ 5,091,065	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,853,339	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule 17A	2,872,499	811,044	43
44	Mortgage Premium		550,819	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,872,499	\$ 14,215,202	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,854,564	\$ 19,306,267	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,737,186)	\$ (9,085,460)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,117,378	\$ 10,220,807	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Southview Manor Nursing Ctr
IDPH License ID Number: 0051656
Fiscal Year End: 12/31/16

Schedule 17A

XV. Balance Sheet

Line 9 Other Assets (specify):

Description	Operating	After Consolidation
DUE FROM EKS	30,906	30,906
IMPOUND RESERVE	52,683	52,683
MORTGAGE ESCROWS		237,865
Total - Line 9	83,589	321,454

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
ACCRUED EXPENSES	51,912	51,912
ALLIED ACCRUAL	198,879	198,879
PAYROLL WITHHOLDINGS	(12,083)	(12,083)
DUE TO/FROM INSURANCE		
DUE TO PA (AUDIT ADJ)		
DUE TO/FROM ALIEN RECIPIENT	29,145	29,145
Total - Line 36	267,853	267,853

XV. Balance Sheet

Line 43 Long-Term Liabilities (specify):

Description	Operating	After Consolidation
ACCRUED RENT	654,152	13,479
DUE TO/FROM FACILITIES	802,606	797,565
DUE TO/FROM PROPERTY	1,415,741	-
Total - Line 43	2,872,499	811,044

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,965,060)	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,965,057)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(901,309)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	129,180	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (772,129)	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)	\$ (3,737,186)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr

0051656

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,079,009	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,079,009	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	237,324	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 237,324	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,657	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,657	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	169	28
28a	<u>Vending Income</u>	10,104	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,273	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,329,263	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,945,119	31
32	Health Care	3,305,090	32
33	General Administration	1,757,678	33
	B. Capital Expense		
34	Ownership	1,405,187	34
	C. Ancillary Expense		
35	Special Cost Centers	313,700	35
36	Provider Participation Fee	503,798	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,230,572	40
41	Income before Income Taxes (line 30 minus line 40)**	(901,309)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (901,309)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,985,896	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Hospice</u>	28,289	47
48	Other-(specify) <u>Veterans</u>	64,824	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,079,009	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,040	2,080	\$ 104,305	\$ 50.15	1
2	Assistant Director of Nursing	1,904	2,080	69,911	33.61	2
3	Registered Nurses	5,700	6,009	175,504	29.21	3
4	Licensed Practical Nurses	40,222	43,488	1,065,350	24.50	4
5	CNAs & Orderlies	81,828	88,660	998,069	11.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,525	1,757	60,847	34.63	8
9	Activity Director					9
10	Activity Assistants	13,466	14,684	165,956	11.30	10
11	Social Service Workers	17,512	19,026	369,297	19.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,788	24,930	306,243	12.28	15
16	Dishwashers					16
17	Maintenance Workers	21,110	22,830	276,047	12.09	17
18	Housekeepers	28,556	31,471	356,987	11.34	18
19	Laundry	4,959	5,686	69,379	12.20	19
20	Administrator	1,888	2,249	141,744	63.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,334	12,158	179,550	14.77	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	2,887	3,095	33,795	10.92	31
32	Other Health Care <u>MDS Coordinator</u>	3,482	3,809	106,310	27.91	32
33	Other(specify) <u>Marketing</u>	348	369	13,325	36.11	33
34	TOTAL (lines 1 - 33)	261,549	284,381	\$ 4,492,619 *	\$ 15.80	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	288	\$ 14,190	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	403	19,965	L10, C3	38
39	Pharmacist Consultant	Monthly	15,600	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	394	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Psychiatric Medical Director</u>	Monthly	18,000	L9,C3	47
48	<u>Administrative</u>	56	2,870	L21,C3	48
49	TOTAL (lines 35 - 48)	753	\$ 83,019		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Southview Manor Nursing Ctr

#

0051656

Report Period Beginning:

1/1/16

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Debbie Massey	Administrator	0.00%	\$ 116,740	Workers' Compensation Insurance	\$ 90,640	IDPH License Fee	\$ 1,914	
Adeyomi Adebogun	Administrator	0	25,004	Unemployment Compensation Insurance	52,978	Advertising: Employee Recruitment	4,500	
				FICA Taxes	340,088	Health Care Worker Background Check		
				Employee Health Insurance	166,649	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	153 2,448	
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on LTC	20,760	
				Other Employee Benefits	1,597	Licenses & Fees	1,235	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 141,744					
B. Administrative - Other								
Description			Amount					
TM Healthcare Management - Management Fees			\$ 410,267					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 410,267					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	
See Attached Schedule	Legal		\$ 27,036				Out-of-State Travel	
FR&R/Marcum LLP	Accounting		24,000	N/A				
First Advantage Tax Consulting	Accounting		6,294					
Howard Simon & Associates	Payroll Processing		7,385				In-State Travel	
Ability Network	Data Processing		1,309					
E-Health Data Solutions	Data Processing		2,450					
Information Controls	Data Processing		4,411					
Change Healthcare	Data Processing		786				Seminar Expense	
Point Click Care	Data Processing		33,648				350	
Prospect Resources, Inc.	Benchmarking		700					
Personnel Planners	Unemployment Consulting		2,179					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	
(For legal fee disclosure, see page 39 of instructions)			\$ 110,198				(agree to Sch. V,	
							line 24, col. 8)	
							\$ 350	

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number		Southview Manor Nursing Ctr		STATE OF ILLINOIS	#	0051656	Report Period Beginning:	1/1/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			Yes							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			Yes 20,760 IL Council on LTC							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			No N/A							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			No N/A							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			Yes 10 Years							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ 4,991 Line 10							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			Yes							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			No N/A							
(9)	Are you presently operating under a sublease agreement?			YES X NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			X N/A							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ 503,798							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			No							
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			Yes							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.			No							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?			\$ 0 No Indicate the amount. \$ N/A							
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			No No N/A 100% Ln 14 No Yes							
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.				No N/A							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			No N/A							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			Yes							
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees			Yes							

SEE ACCOUNTANTS' PREPARATION REPORT