

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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: 0046367

Facility Name: Hawthorne Inn of Danville

Address: 3222 Independence Dr Danville 61832

NumberCityZip Code

County: Vermilion

Telephone Number: (217) 431-1600 Fax # (217) 431-3782

HFS ID Number:

Date of Initial License for Current Owners: 07/01/2003

Type of Ownership:

☒

VOLUNTARY, NON-PROFIT

☒

Charitable Corp.

☐

Trust

IRS Exemption Code 501 (c) 3

☐

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: Brian BurgerTelephone Number: (309) 343-1550Email 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 4/1/2024 to 3/31/2025 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)

(Type or Print Name) Brian Burger

(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Hawthorne Inn of Danville

0046367

Report Period Beginning: 4/1/2024

Ending: 3/31/2025

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	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	60	Sheltered Care (SC)	60	21,900	5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	4,196	5,312	1,683		9,579	3,573	2,523	26,866	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC					11,799			11,799	12
13	DD 16 OR LESS									13
14	TOTALS	4,196	5,312	1,683		21,378	3,573	2,523	38,665	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

75.67%

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

0 (Do not include bed reserve 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 07/01/03

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

YES ☒ Date 07/01/03 NO ☐

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

YES ☒ NO ☐ If YES, enter certified beds.

number of certified beds 80

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: 3/31/25 Fiscal Year: 3/31/25

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number

Hawthorne Inn of Danville

#0046367

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	444,762	42,523	18,737	506,022		506,022		506,022			1
2	Food Purchase		452,602		452,602		452,602		452,602			2
3	Housekeeping	255,597	45,058		300,655		300,655		300,655			3
4	Laundry	72,565	23,551	59	96,175		96,175		96,175			4
5	Heat and Other Utilities			199,979	199,979		199,979		199,979			5
6	Maintenance	198,260	74,078	168,083	440,421		440,421		440,421			6
7	Other (specify):*											7
8	TOTAL General Services	971,184	637,812	386,858	1,995,854		1,995,854		1,995,854			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	4,182,557	250,804	11,950	4,445,311		4,445,311		4,445,311			10
10a	Therapy											10a
11	Activities	116,251	6,848		123,099		123,099		123,099			11
12	Social Services	74,612			74,612		74,612		74,612			12
13	CNA Training			1,514	1,514		1,514		1,514			13
14	Program Transportation			12,848	12,848		12,848		12,848			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,373,420	257,652	44,312	4,675,384		4,675,384		4,675,384			16
	C. General Administration											
17	Administrative	127,573			127,573		127,573		127,573			17
18	Directors Fees							2,365	2,365			18
19	Professional Services			356,412	356,412		356,412	(1,675)	354,737			19
20	Dues, Fees, Subscriptions & Promotions			39,273	39,273		39,273	(3,996)	35,277			20
21	Clerical & General Office Expenses	193,434	27,368	87,555	308,357		308,357	517	308,874			21
22	Employee Benefits & Payroll Taxes			758,234	758,234		758,234		758,234			22
23	Inservice Training & Education			2,220	2,220		2,220		2,220			23
24	Travel and Seminar			1,492	1,492		1,492		1,492			24
25	Other Admin. Staff Transportation			1,501	1,501		1,501		1,501			25
26	Insurance-Prop.Liab.Malpractice			236,338	236,338		236,338	32,362	268,700			26
27	Other (specify):*											27
28	TOTAL General Administration	321,007	27,368	1,483,025	1,831,400		1,831,400	29,573	1,860,973			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,665,611	922,832	1,914,195	8,502,638		8,502,638	29,573	8,532,211			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			101,338	101,338		101,338	537,559	638,897			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							215,090	215,090			32
33	Real Estate Taxes			100	100		100	135,000	135,100			33
34	Rent-Facility & Grounds			938,400	938,400		938,400	(938,400)				34
35	Rent-Equipment & Vehicles			32,012	32,012		32,012		32,012			35
36	Other (specify):* Mortgage Ins							51,319	51,319			36
37	TOTAL Ownership			1,071,850	1,071,850		1,071,850	568	1,072,418			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,062	2,062		2,062		2,062			38
39	Ancillary Service Centers		266,060	792,233	1,058,293		1,058,293	(3,264)	1,055,029			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,318	4,318		4,318	(3,375)	943			41
42	Provider Participation Fee			371,521	371,521		371,521		371,521			42
43	Other (specify):* Disallowed Costs	55,780		189,266	245,046		245,046	(245,046)				43
44	TOTAL Special Cost Centers	55,780	266,060	1,359,400	1,681,240		1,681,240	(251,685)	1,429,555			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,721,391	1,188,892	4,345,445	11,255,728		11,255,728	(221,544)	11,034,184			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				4
5	Telephone, TV & Radio in Resident Rooms	(13,503)	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	(4,613)	30		9
10	Interest and Other Investment Income	(1,183)	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	(48)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,999)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(127,785)	43		24
25	Fund Raising, Advertising and Promotional	(30,737)	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	(83,640)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (264,508)		\$	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)	42,964		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 42,964		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (221,544)		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	Political Action Committee Payments	\$ (3,980)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Offset Marketing Salary	(55,780)	43	3
4	Offset Medicare Pt. A Lab	(12,565)	43	4
5	Offset Medicare Pt. A X-Ray	(4,676)	43	5
6	Offset Vending Machine revenue	(3,375)	41	6
7	Offset Miscellaneous Income-Pharmacy	(3,264)	39	7
8				8
9				9
10				10
11				11
12				12
13				13
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(83,640)		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
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	Frances House, Inc. (FH)		Danville Independence	Danville	Real Estate Entity
		Residential Alternatives of Illinois, Inc. (FH is sole mem		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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	18	Director Fees	\$	Residential Alternatives of Illinois, Inc.	100.00%	\$ 2,365	\$ 2,365	1
2	V	19	Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	1,324	1,324	2
3	V	20	Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	32	32	3
4	V	21	Clerical & General Office		Residential Alternatives of Illinois, Inc.	100.00%	517	517	4
5	V	26	Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	1,472	1,472	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 5,710	\$ * 5,710	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance		Danville Independence, LLC	100.00%	\$ 30,890	\$ 30,890	15
16	V	30	Depreciation Expense		Danville Independence, LLC	100.00%	542,172	542,172	16
17	V	32	Interest	114	Danville Independence, LLC	100.00%	216,387	216,273	17
18	V	33	Real Estate		Danville Independence, LLC	100.00%	135,000	135,000	18
19	V	34	Facility Rent	938,400	Danville Independence, LLC	100.00%		(938,400)	19
20	V	36	MIP Insurance		Danville Independence, LLC	100.00%	51,319	51,319	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 938,514			\$ 975,768	\$ * 37,254	39

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Residential Alternatives of Illinois	100%	Manor Court of Princeton	Princeton				1
2	Residential Alternatives of Illinois	100%	Manor Court of Clinton-Sold in 2025	Clinton				2
3	Residential Alternatives of Illinois	100%	Manor Court of Freeport	Freeport				3
4	Residential Alternatives of Illinois	100%	Manor Court of Peru	Peru				4
5	Residential Alternatives of Illinois	100%	Manor Court of Peoria	Peoria				5
6	Residential Alternatives of Illinois	100%	Manor Court of Rochelle	Rochelle				6
7	Residential Alternatives of Illinois	100%			Hawthorne Inn of Freeport	Freeport, IL	Supportive Living Facility	7
8	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peoria	Peoria, IL	Assisted Living Facility	8
9	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peru	Peru, IL	Assisted Living Facility	9
10	Residential Alternatives of Illinois	100%			Liberty Estates of Geneseo	Geneseo, IL	Asst'd & Ind Living	10
11	Residential Alternatives of Illinois	100%			Liberty Estates of Streator	Streator, IL	Asst'd & Ind Living	11
12	Residential Alternatives of Illinois	100%			Liberty Estates of Danville	Danville, IL	Independent Living	12
13	Residential Alternatives of Illinois	100%			Liberty Estates of Freeport	Freeport, IL	Independent Living	13
14	Residential Alternatives of Illinois	100%			Liberty Estates of Peoria	Peoria, IL	Independent Living	14
15	Residential Alternatives of Illinois	100%			Liberty Estates of Peru	Peru, IL	Independent Living	15
16	Residential Alternatives of Illinois	100%	Windmill Manor	Coralville IA				16
17	Residential Alternatives of Illinois	100%			Hawthorne Inn of Rochelle	Rochelle, IL	Assisted Living Facility	17
18	Frances House, Inc.	100%	Casa Willis	Sterling, IL	Woodburn	Sterling, IL	CILA	18
19	Frances House, Inc.	100%	Freeport Terrace	Freeport, IL				19
20	Frances House, Inc.	100%	Gordon Jones Terrace	Lanark, IL				20
21	Frances House, Inc.	100%	Hallam Terrace	Rockford, IL				21
22	Frances House, Inc.	100%	Hammett House	Sterling, IL				22
23	Frances House, Inc.	100%	Kanthak House	Ottawa, IL				23
24	Frances House, Inc.	100%	Olson Terrace	Rockford, IL				24
25	Frances House, Inc.	100%	Ridge Terrace	Freeport, IL				25
26	Frances House, Inc.	100%	Cantebury Place	Rockford, IL				26
27	Frances House, Inc.	100%	Glenwood Villa	Rockford, IL				27
28	Frances House, Inc.	100%	Rockton Court	Rockford, IL				28
29	Frances House, Inc.	100%	Rose House	Moline, IL				29
30								30

Facility Name & ID Number

Hawthorne Inn of Danville

0046367

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Frances House, Inc.	100%	Seborg Terrace	Rockford, IL				1
2	Frances House, Inc.	100%	Smith Square	Moline, IL				2
3	Frances House, Inc.	100%	Stern Square	Sterling, IL				3
4	Frances House, Inc.	100%	Stouffer Terrace	Oregon, IL				4
5	Frances House, Inc.	100%	Lewis Terrace	North Chicago, IL				5
6	Frances House, Inc.	100%	Seymour Terrace	North Chicago, IL				6
7	Frances House, Inc.	100%	Waukegan Terrace	Waukegan, IL				7
8	Frances House, Inc.	100%	Pine Terrace	Waukegan, IL				8
9	Pioneer Concepts, Inc.	100%	Broadway Terrace	Chicago Heights, IL	Woodgate	Matteson	CILA	9
10	Pioneer Concepts, Inc.	100%	Carole Lane Terrace	Sauk Village, IL	Thornton	Thornton	CILA	10
11	Pioneer Concepts, Inc.	100%	Flossmoor Terrace	Flossmoor, IL				11
12	Pioneer Concepts, Inc.	100%	Ravisloe Terrace	Country Club Hills, IL				12
13	Pioneer Concepts, Inc.	100%	Spaulding Terrace	Markham, IL				13
14	Pioneer Concepts, Inc.	100%	Calumet City Terrace	Calumet City, IL				14
15	Pioneer Concepts, Inc.	100%	Dolton Terrace	Dolton, IL				15
16	Pioneer Concepts, Inc.	100%	Lynwood Terrace	Lynwood, IL				16
17	Pioneer Concepts, Inc.	100%	Holland Terrace	South Holland, IL				17
18	Pioneer Concepts, Inc.	100%	Matteson Court	Matteson, IL				18
19	Pioneer Concepts, Inc.	100%	Priarie House	Sauk Village, IL				19
20	Pioneer Concepts, Inc.	100%	Torrence Place	Sauk Village, IL				20
21	Pinnacle Opportunities	100%	Chambness Square	Bourbannais, IL	Gravlin Square	Bradley, IL	CILA	21
22	Pinnacle Opportunities	100%	Collins Square	Bradley, IL				22
23	Pinnacle Opportunities	100%	Dearborn Court	Kankakee, IL				23
24	Pinnacle Opportunities	100%	River Court	Kankakee, IL				24
25	Pinnacle Opportunities	100%	Station Court	Kankakee, IL				25
26	Pinnacle Opportunities	100%	Eagle Court	Kankakee, IL				26
27	Pinnacle Opportunities	100%	Kankakee Court	Kankakee, IL				27
28	Pinnacle Opportunities	100%	Roy Court	Bourbannais, IL				28
29	Pinnacle Opportunities	100%	Hunt Terrace	Kankakee, IL				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	Ben McMahan	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	\$ 473	L18, C7	1
2	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	473	L18, C7	2
3	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	473	L18, C7	3
4	Marilyn Holt	Board Member	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	473	L18, C7	4
5	Wayne Stone	Board Member	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	473	L18, C7	5
6											6
7											7
8											8
9	No board members provide services or have business entities that provide services to the facility.										9
10											10
11											11
12											12
13								TOTAL	\$ 2,365		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

Ending: 3/31/2025

(309) 343-2857

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	Cambridge Realty Capital		X	Facility Purchase (Refinance)	\$56,176.00	02/01/13	\$ 12,627,000	\$ 9,260,911	09/01/43	3.5000	\$ 216,387	1	
2	Ltd. Of Illinois - SNF			Including trade premium on								2	
3				note of \$214,099 as of 3/31/25								3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$56,176.00		\$ 12,627,000	\$ 9,260,911			\$ 216,387	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income Offset		(1,297)		11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,297)	14	
15	TOTALS (line 9+line14)						\$ 12,627,000	\$ 9,260,911			\$ 215,090	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 51,319 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.) 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.)

B. Real Estate Taxes

17	AMOUNT TO USE FOR RATE CALCULATION \$	17
----	---------------------------------------	----

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hawthorne Inn of Danville COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0046367

CONTACT PERSON REGARDING THIS REPORT Brian Burger

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 18-21-304-042	Fieldstone Est Sec 2, PT E2 SW4	\$ 135,243.84	\$ 135,243.84
2.	21 20 11, Lts 21 & 22 Ex E18'	\$	\$
3.	Lt 23 & All Lts 26 & 28	\$	\$
4.		\$	\$
5. 18-21-303-023	Outlot A - Detention Area	\$ 101.20	\$ 101.20
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 135,345.04	\$ 135,345.04

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,122 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (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? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (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. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	194,800	2008	\$ 886,000	1
2	Facility	18,480	2011	73,333	2
3	TOTALS	213,280		\$ 959,333	3

Facility Name & ID Number Hawthorne Inn of Danville

#

0046367

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

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	140		2008	1999	\$ 12,503,803	\$	25	\$ 500,158	\$ 500,158	\$ 8,335,924
5				2010	914,486		25	36,580	36,580	530,402
6										
7										
8										
	Improvement Type**									
9	Backflow Installment, exterior sign			2000	4,732		15			4,732
10	Carpet, door lock system, concrete			2001	13,544		5 to 15			13,544
11	Curtain Tracking			2003	4,979		5			4,979
12	Light/surge protection			2004	28,000		11			28,000
13	Electric Sign,Asphalt,Condenser fan,Asphalt,Floor tile,Lighting-parking l			2005	66,071		5 to 10			66,071
14	Stage area-entry way,sign,kitchen remodel,countertops,circle head			2006	41,830		10 to 15			41,830
15	Nurse call system,cabinet/countertop rep,wall rep, paint, roof, landscaping			2008	360,639		5 to 15			360,639
16	Sidewalks replacement and repairs			2009	4,071	68	15	68		4,071
17	Compressor for Furnace			2010	2,997	200	15	200		2,914
18	Sign			2010	2,930		10			2,930
19	AC Units			2011	2,997		5			2,997
20	Furnace/AC for Kitchen			2011	6,275		10			6,275
21	Carpet-corridor/LR/Vestibule Replacements			2011	22,825		5			22,825
22	Vinyl - Activity Room			2011	3,444		10			3,444
23	Parking Lot -Asphalt			2011	5,147		8			5,147
24	Skilled Rooms Remodel-Chairs/Paint/Wallpaper/VCT Tile/Cubicles/Wind			2012	93,501		12			93,501
25	Water Heater			2012	4,969		10			4,969
26	Window Replacement			2013	6,516	434	15	434		5,176
27	AC Compressor			2013	5,752	383	15	383		4,474
28	New Countertops in Nurses Station			2013	27,536		10			27,536
29	New Shower Room tiles			2014	4,212	211	20	211		2,334
30	Cabinets/Counter Tops - AL Bedrooms			2014	6,045	504	12	504		5,541
31	Drapes/Wood Blinds - Dining Room & Lounge			2015	7,935		5			7,935
32	Condensor			2015	13,939		15	930	930	9,373
33	Water Damage -Paint/Drywall/Insulation/Carpet - Main level/office 1 and			2015	35,080		12	2,923	2,923	29,474
34	Resident Rooms/Office-Carpet/Paint/Chairs - AL 40 Rooms			2015	61,448		12	5,121	5,121	51,636
35	10' Ton Carrier Unit - Van Dyke Hall			2015	15,332	1,533	10	1,533		14,566
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

Facility Name & ID Number Hawthorne Inn of Danville

0046367

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

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	Concrete Parking Lot	2015	\$ 124,691	\$ 8,313	15	\$ 8,313	\$	\$ 78,972	37
38	Water Heater	2015	5,647	565	10	565		5,272	38
39	Replace Windows - rooms 318-322	2015	3,690	246	15	246		2,296	39
40	Fire Panel Update	2015	7,700	770	10	770		7,251	40
41	Replace Condenser/Coils for East Side Dining Room	2015	8,276	828	10	828		7,796	41
42	Replace Sprinkler Pipes - Van Dyke Wing	2016	4,700	470	10	470		4,308	42
43	Paint - Garden Court	2016	12,385		5			12,385	43
44	New Hot Water Heater	2017	3,148	315	10	315		2,598	44
45	New Nurse Call System	2016	102,632	10,263	10	10,263		88,092	45
46	Painting - Town Center/Dining Room/Main Entrance Doors	2017	5,646		5			5,646	46
47	New Toilets	2017	7,841	784	10	784		5,815	47
48	Condensor/Coil	2017	4,151	277	15	277		2,145	48
49	Painting Bounce Back Rooms-13/Hall/Garden View Hall	2018	9,700		5			9,700	49
50	Water Heater-Sprinkler Room	2018	6,464	646	10	646		4,579	50
51	Condensor-Mini Split System Kitchenette	2018	5,587	372	15	372		2,421	51
52	Drywall/Insulation-Dining Rooms in Assisted Care Wings	2019	4,765	476	10	476		2,898	52
53	New Concrete - Entrance/Sidewalks/Curbing	2019	3,136	209	15	209		1,202	53
54	Porch - New Columns/Rails	2019	20,578	1,715	12	1,715		9,717	54
55	New Water Heater	2019	7,394	739	10	739		4,189	55
56	New Vinyl - Bathrooms	2019	5,477	548	10	548		2,923	56
57	4 New PTAC Units	2020	2,568	514	5	514		2,397	57
58	Garden Court Unit-Replace Compressor/Fan Motor/Fuses	2020	3,464	231	15	231		1,078	58
59	Laundry Room Unit- Replace Compressor	2020	2,805	281	10	281		1,311	59
60	Therapy Room Unit - Replace Compressor	2020	2,220	148	15	148		691	60
61	Double Face Message Sign	2020	21,133	2,113	10	2,113		9,686	61
62	Replace Twinned Furnaces	2021	6,700	447	15	447		1,712	62
63	Air Conditioner-Front Office	2021	4,500	900	5	900		3,075	63
64	3 New PTAC Units	2022	2,566	513	5	513		1,240	64
65	Paint-Entrance/Hall/Bathrooms/East Reception/Offices/Conf Rm	2022	15,261	3,052	5	3,052		9,157	65
66	New Countertops-Reception Area	2022	12,452	1,245	10	1,245		3,528	66
67	New LVT Flooring - 300 Hallway & Bathroom	2022	12,000	1,200	10	1,200		3,300	67
68	New Water Heater	2022	9,556	956	10	956		2,469	68
69	New Fire Pump/Motor	2023	7,271	485	15	485		1,091	69
70	TOTAL (lines 4 thru 69)		\$ 14,727,139	\$ 42,954		\$ 588,666	\$ 545,712	\$ 9,994,179	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Hawthorne Inn of Danville

0046367

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 14,727,139	\$ 42,954		\$ 588,666	\$ 545,712	\$ 9,994,179	1
2	New Pump Backflow Valves/Adapters for Fire Sprinkler System	2023	4,212	421	10	421		877	2
3	Various Repairs and Testing to Sprinkler System	2023	10,967	731	15	731		1,218	3
4	New Furnace-120k BTU-Behind Stage-East Side Town Square	2024	3,930	262	15	262		306	4
5	New AC Unit installed Therapy Roof Top	2024	17,847	1,785	10	1,785		1,933	5
6	New Wall Light Fixtures Installed Throughout Facility	2024	9,491	949	10	949		1,186	6
7	4 New PTAC Units	2023	3,971	794	5	794		1,324	7
8	Install Carpet Squares in Resident Rooms	2024	13,965	2,793	5	2,793		3,491	8
9	Install New Modules for Tampers/Flows	2024	3,387	339	10	339		339	9
10	Install New Wet Fire Sprinkler System	2024	83,000	5,072	15	5,072		5,072	10
11	New Water Heater-Mechanical Room	2024	9,341	856	10	856		856	11
12	Install Soffits over Wet Sprinkler System	2024	72,000	4,000	15	4,000		4,000	12
13	New Water Heater-Mechanical Room	2024	4,960	413	10	413		413	13
14	New Furnace/AC Unit - Therapy Room	2024	17,464	873	15	873		873	14
15	Replace Compressor in Walk in Cooler	2024	9,013	451	15	451		451	15
16	Replace Coil for AC Unit	2025	5,281	264	5	264		264	16
17	New Water Heater-Sprinkler Rm for Main Kitchen/Laundry	2025	13,091	109	10	109		109	17
18	Install New Vision Link for Nurses Station	2025	8,871	74	10	74		74	18
19	Install New Countertops-Resident Rooms	2025	4,800	120	10	120		120	19
20	Install 4 New PTAC Units	2024	3,467	636	5	636		636	20
21	Install 9 New PTAC Units with Thermostats	2024	7,700	1,326	5	1,326		1,326	21
22	Install 3 New PTAC Units	2024	2,554	255	5	255		255	22
23									23
24									24
25									25
26									26
27	Additional Financial Statement Depreciation			5,563			(5,563)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,036,451	\$ 71,040		\$ 611,189	\$ 540,149	\$ 10,019,302	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$297,456	\$25,778	\$25,778	\$	5-15 yrs	\$205,003	71
72	Current Year Purchases	54,269	4,164	1,574	(2,590)	5-15 yrs	1,574	72
73	Fully Depreciated Assets	557,903					557,903	73
74								74
75	TOTALS	\$909,628	\$29,942	\$27,352	\$(2,590)		\$764,480	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2003 GMC Van	2005	\$29,800	\$	\$	\$	4	\$29,800	76
77	Patient Care	2013 Ford E350 Van	2013	51,355				4	51,355	77
78	Facility	2010 Chrysler Van	2024	1,900	356	356		4	356	78
79										79
80	TOTALS			\$83,055	\$356	\$356	\$		\$81,511	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$16,988,467	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$101,338	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$638,897	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$537,559	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$10,865,293	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	2017 Toyota Corolla	\$18,089	\$	\$18,089	86
87					87
88					88
89					89
90					90
91	TOTALS	\$18,089	\$	\$18,089	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	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- Facility Owned
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								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: \$ 32,012 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			\$	\$	17
18	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name:

Hawthorne Inn of Danville

IDPH License ID Number:

0046367

Fiscal Year End:

3/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	31,824
Other Equipment Rental	188
Total - Line 16	32,012

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 1,514	\$	\$ 1,514
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	\$	\$ 1,514	\$	\$ 1,514
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,514			

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$	3,104	\$ 223,482	\$	3,104	\$ 223,482	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		821	59,094		821	59,094	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		7,079	509,657		7,079	509,657	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				266,060		266,060	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	11,004	\$ 792,233	\$ 266,060	11,004	\$ 1,058,293	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	\$ 96,510	\$ 183,128	1
2	Cash-Patient Deposits	49,177	49,177	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 221,000)	1,304,323	1,389,614	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	112,647	125,837	6
7	Other Prepaid Expenses	662	662	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	10,887,840	8,403,144	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 12,451,159	\$ 10,151,562	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		959,333	13
14	Buildings, at Historical Cost	1,642,691	14,891,451	14
15	Leasehold Improvements, at Historical Cost		145,000	15
16	Equipment, at Historical Cost	677,705	992,683	16
17	Accumulated Depreciation (book methods)	(1,277,214)	(10,865,293)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Schedule 17A		1,348,545	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,043,182	\$ 7,471,719	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,494,341	\$ 17,623,281	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 346,247	\$ 459,699	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,177	49,177	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	160,327	160,327	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		169,857	32
33	Accrued Interest Payable		19,224	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 555,751	\$ 858,284	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,260,911	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	83,470	83,470	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 83,470	\$ 9,344,381	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 639,221	\$ 10,202,665	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,855,120	\$ 7,420,616	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,494,341	\$ 17,623,281	48

Facility Name:

Hawthorne Inn of Danville

IDPH License ID Number:

0046367

Fiscal Year End:

3/31/2025

Schedule 17A

XV. Balance Sheet

Line 23 Long Term Assets Other (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow		119,346
MIP Insurance Escrow		52,134
Reserve for Replacement		1,177,065
Total - Line 23	-	1,348,545

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,535,666	1
2	Restatements (describe):		2
3	Prior Period Adjustments-Rent Expense	(65,100)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,470,566	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(615,446)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (615,446)	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)	\$ 12,855,120	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hawthorne Inn of Danville

0046367

Report Period Beginning: 4/1/2024

Ending: 3/31/2025

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	\$ 10,463,650	1
2	Discounts and Allowances for all Levels	(52,246)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,411,404	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	203,676	6
7	Oxygen	8,760	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 212,436	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,375	12
13	Barber and Beauty Care	2,761	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(813)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,147	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,470	23
	D. Non-Operating Revenue		
24	Contributions	507	24
25	Interest and Other Investment Income***	1,183	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,690	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Income	1,693	28
28a	See Attached Sch 19A	4,589	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,282	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,640,282	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,995,854	31
32	Health Care	4,675,384	32
33	General Administration	1,831,400	33
	B. Capital Expense		
34	Ownership	1,071,850	34
	C. Ancillary Expense		
35	Special Cost Centers	1,309,719	35
36	Provider Participation Fee	371,521	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,255,728	40
41	Income before Income Taxes (line 30 minus line 40)**	(615,446)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (615,446)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,108,833.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,257,156.00	45
46	MMAI-Medicaid is the Primary Payer	444,749.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,107,731.00	48
49	Medicare Part A	2,207,201.00	49
50	Other-(specify) Medicare Replacement/Managed Care	1,105,448.00	50
51	Other-(specify) Hospice	201,241.00	51
52	Other-(specify) Sheltered Care	1,979,045.00	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,411,404	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Hawthorne Inn of Danville

IDPH License ID Number:

0046367

Fiscal Year End:

3/31/2025

Schedule 19A

XVII. Income Statement

Line 28a Other Income

Rental Description	Amount
Late Fees	1,280
Processing Fee	45
Miscellaneous Income	3,264
Total - Line 28a	4,589

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	1,976	2,080	\$ 104,536	\$ 50.26	1
2	Assistant Director of Nursing	1,907	2,115	62,307	29.46	2
3	Registered Nurses	22,952	27,214	1,078,090	39.62	3
4	Licensed Practical Nurses	13,538	16,560	491,793	29.70	4
5	CNAs & Orderlies	100,039	125,155	2,388,514	19.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,939	6,327	116,251	18.37	10
11	Social Service Workers	4,445	4,997	74,612	14.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,050	26,670	444,762	16.68	15
16	Dishwashers					16
17	Maintenance Workers	8,611	9,412	198,260	21.06	17
18	Housekeepers	14,533	15,595	255,597	16.39	18
19	Laundry	4,573	4,885	72,565	14.85	19
20	Administrator	1,864	2,080	127,573	61.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,928	8,539	193,434	22.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,920	2,243	57,317	25.55	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,912	2,080	55,780	26.82	33
34	TOTAL (lines 1 - 33)	217,187	255,952	\$ 5,721,391 *	\$ 22.35	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 18,737	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,568	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 45,305		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 NumberHawthorne Inn of Danville# 0046367Report Period Beginning:4/1/2024Ending:3/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Darci Dreher

Administrator

None

\$ 127,573

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 127,573

B. Administrative - Other

Description

Amount

N/A

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

LTC Support Services, LLC

Support Services

\$ 128,880

RFMS, Inc.

Administrative Services

180,180

RSM US LLP

Accounting Services

38,226

Templin Healthcare Accounting

Accounting Services

4,504

Guided Care

Managed Care Consultant

1,000

Davis & Campbell, LLC

Legal Services

289

Polsinelli

Legal Services

334

Saikley,Garrison,Colombo

Legal Services

2,924

Vermilion County

Title Search

75

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 356,412

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 74,773

Unemployment Compensation Insurance

18,775

FICA Taxes

425,594

Employee Health Insurance

221,460

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401k

8,893

Other Employee Benefits

8,739

TOTAL (agree to Schedule V, line 22, col.8)

\$ 758,234

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

\$ 1,990

Advertising: Employee Recruitment

18,365

Health Care Worker Background Check

(Indicate # of checks performed 50)

1,246

Patient Background Checks

239

Association Dues (total from pg 22, #4)

11,571

Subscriptions

2,859

Other Licenses & Fees

850

Indirect costs

32

Less: Public Relations Expense

(48)

PAC and Lobbying payments

(3,980)

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 35,277

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

1,492

Seminar Expense

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 1,492

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

IL HEALTHCARE ASSOCIATION (IHCA)

Amount

7,591

7,591

Total

(3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)

3,980

3,980

Total

(4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)

11,571

11,571

Total

(5)

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

\$

52,070

Line

10

(6)

Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

Yes

If NO, attach a complete explanation.

(7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$

371,521

This amount is to be recorded on line 42 of Schedule V.

(8)

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.

(9)

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

(10)

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.

(11)

Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V.

\$

N/A

Has any meal income been offset against
related costs?

Indicate the amount.

\$

N/A

(12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for
residents?

No

If YES, please indicate the amount of income earned from such a
program during this reporting period.

\$

N/A

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

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other
times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such
transportation during this reporting period.

\$

N/A

(13)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

RSM US LLP

(14)

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

Yes

(15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

Yes

See page 39 of the instructions for details.

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