FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0032029

Facility Name: Hickory Nursing Pavilion

Address: 9246 South Roberts Road (Number) Hickory Hills (City) 60457 (Zip Code)

County: Cook

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,410	1
2		Skilled Pediatric (SNF/PED)			2
3	40	Intermediate (ICF)	40	14,600	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,785	147	842	8,774	8
9	SNF/PED					9
10	ICF	14,201			14,201	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,986	147	842	22,975	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.06%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/1987

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 842

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	145,095	22,235	6,642	173,972		173,972		173,972			1
2	Food Purchase		114,098		114,098	(7,307)	106,791	(7)	106,783			2
3	Housekeeping	106,418	32,643		139,061		139,061		139,061			3
4	Laundry	17,422	17,273		34,695		34,695		34,695			4
5	Heat and Other Utilities			70,796	70,796		70,796	(3,526)	67,270			5
6	Maintenance	51,272	18,058	55,116	124,446		124,446	1,961	126,407			6
7	Other (specify):*							342	342			7
8	**TOTAL General Services**	320,207	204,307	132,554	657,068	(7,307)	649,761	(1,230)	648,530			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	973,518	53,331	5,230	1,032,079		1,032,079		1,032,079			10
10a	Therapy	23,288		776	24,064		24,064		24,064			10a
11	Activities	61,897	1,339	900	64,136		64,136		64,136			11
12	Social Services	93,095		1,190	94,285		94,285		94,285			12
13	CNA Training											13
14	Program Transportation			140	140		140		140			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,151,798	54,670	17,236	1,223,704		1,223,704		1,223,704			16
	C. General Administration											
17	Administrative	81,427		223,650	305,077		305,077	(154,000)	151,077			17
18	Directors Fees											18
19	Professional Services			53,545	53,545	(8,808)	44,737	2,360	47,097			19
20	Dues, Fees, Subscriptions & Promotions			19,876	19,876		19,876	(4,293)	15,583			20
21	Clerical & General Office Expenses	50,202	19,375	36,963	106,540		106,540	26,275	132,815			21
22	Employee Benefits & Payroll Taxes			266,525	266,525	7,307	273,832		273,832			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,155	1,155		1,155	97	1,252			24
25	Other Admin. Staff Transportation			3,796	3,796		3,796	2,266	6,062			25
26	Insurance-Prop.Liab.Malpractice			56,271	56,271		56,271	1,287	57,558			26
27	Other (specify):*							29,459	29,459			27
28	**TOTAL General Administration**	131,629	19,375	661,781	812,785	(1,501)	811,284	(96,548)	714,736			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,603,634	278,352	811,571	2,693,557	(8,808)	2,684,749	(97,779)	2,586,970			29

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

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

Facility Name & ID Number Hickory Nursing Pavilion #0032029 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,415	33,415		33,415	31,877	65,292			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14	14		14	(14)	0			32
33	Real Estate Taxes			173,068	173,068	8,808	181,876	2,583	184,459			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles							3,724	3,724			35
36	Other (specify):*											36
37	**TOTAL Ownership**			386,497	386,497	8,808	395,305	(141,830)	253,475			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,272	95,358	131,630		131,630		131,630			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			175,045	175,045		175,045		175,045			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		36,272	270,403	306,675		306,675		306,675			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,603,634	314,624	1,468,471	3,386,729		3,386,729	(239,609)	3,147,120			45

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Reference	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	(4,400)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,016)	30		9
10	Interest and Other Investment Income	(1,004)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,442)	21		24
25	Fund Raising, Advertising and Promotional	(491)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,424)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,188)	20		28
29	Other-Attach Schedule	(9,652)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (32,624)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(206,985)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (206,985)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (239,609)		37

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

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

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

Hickory Nursing Pavilion

ID# 0032029

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Building Company - Accounting Fees	$ (1,250)	19	1
2	Building Company - Replacement Tax	(2,139)	21	2
3	Building Company - Annual Report	(250)	20	3
4	PAC Dues	(2,637)	20	4
5	Additional R&M	1,310	06	5
6	Capitalized R&M	(2,961)	06	6
7	Non-Allowable Legal Fees	(1,725)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,652)		49

Hickory Nursing Pavilion

ID# 0032029

Report Period Beginning: 01/01/15

Ending: 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(7)											(7)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,400)		874									(3,526)	5
6	Maintenance	(1,651)		891	2,721								1,961	6
7	Other (specify):*				342								342	7
8	**TOTAL General Services**	(6,058)		1,765	3,063								(1,230)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(207,978)	53,978								(154,000)	17
18	Directors Fees													18
19	Professional Services	(2,975)	1,250	3,926		159							2,360	19
20	Fees, Subscriptions & Promotions	(4,566)	250	23									(4,293)	20
21	Clerical & General Office Expenses	(13,005)	2,139	37,141									26,275	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			97									97	24
25	Other Admin. Staff Transportation			2,266									2,266	25
26	Insurance-Prop.Liab.Malpractice			1,047		240							1,287	26
27	Other (specify):*			25,771	3,688								29,459	27
28	**TOTAL General Administration**	(20,546)	3,639	(137,707)	57,666	400							(96,548)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,604)	3,639	(135,942)	60,729	400							(97,779)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Hickory Nursing Pavilion** **#** **0032029** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(5,016)	35,397	238		1,258							31,877	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,004)	(4)			994							(14)	32
33	Real Estate Taxes					2,583							2,583	33
34	Rent-Facility & Grounds		(180,000)	7,575		(7,575)							(180,000)	34
35	Rent-Equipment & Vehicles			3,724									3,724	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(6,020)	(144,607)	11,537		(2,740)							(141,830)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(32,624)	(140,968)	(124,405)	60,729	(2,341)							(239,609)	45

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 180,000	Hickory Health Care Associates	100.00%	$	$ (180,000)	1
2	V	32	Interest Income	4	Hickory Health Care Associates	100.00%		(4)	2
3	V	19	Accounting Fees		Hickory Health Care Associates	100.00%	1,250	1,250	3
4	V	30	Depreciation		Hickory Health Care Associates	100.00%	35,397	35,397	4
5	V	20	Annual Report		Hickory Health Care Associates	100.00%	250	250	5
6	V	21	Illinois Replacement Tax		Hickory Health Care Associates		2,139	2,139	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 180,004			$ 39,036	$ * (140,968)	14

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	STAYCARE MANAGEMENT, LTD.	100.00%	$ 874	$ 874	15
16	V	6	REPAIRS AND MAINT.				891	891	16
17	V	17	ADMIN. SALARY				15,672	15,672	17
18	V	19	PROFESSIONAL FEES				3,926	3,926	18
19	V	20	DUES, SUBSCRIPTIONS				23	23	19
20	V	21	CLERICAL & GENERAL				37,141	37,141	20
21	V	24	SEMINARS				97	97	21
22	V	25	ADMIN. STAFF TRAVEL				2,266	2,266	22
23	V	26	INSURANCE				1,047	1,047	23
24	V	27	EMPLOYEE BENEFITS				25,771	25,771	24
25	V	30	DEPRECIATION				238	238	25
26	V	32	INTEREST EXPENSE						26
27	V	34	BUILDING RENT				7,575	7,575	27
28	V	35	EQUIPMENT RENTAL				3,724	3,724	28
29	V								29
30	V	17	MANAGEMENT FEES	223,650				(223,650)	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			$ 223,650			$ 99,245	$ * (124,405)	39

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIET. COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.	100.00%	$	$	15
16	V	1	DIET. COMP - D. WENGROW						16
17	V	6	MAINT. COMP.				2,721	2,721	17
18	V	7	EMP. BEN. - S. WEBSTER						18
19	V	7	EMP. BEN. - D. WENGROW						19
20	V	7	EMP. BEN. - MAINT. NON-OWNER				342	342	20
21	V	17	ADMIN. COMP - H. WENGROW				40,074	40,074	21
22	V	17	ADMIN. COMP - J. WEBSTER				13,904	13,904	22
23	V	27	EMP. BEN. - H. WENGROW				2,796	2,796	23
24	V	27	EMP. BEN. - J. WEBSTER				892	892	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			$			$ 60,729	$ * 60,729	39

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$		100.00%	$	$	15
16	V	19	PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		159	159	16
17	V	26	INSURANCE		DOUBLE YOU REALTY, LLC		240	240	17
18	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC		1,258	1,258	18
19	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		994	994	19
20	V	19	RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC				20
21	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		2,583	2,583	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	7,575	DOUBLE YOU REALTY, LLC			(7,575)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,575			$ 5,234	$ * (2,341)	39

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM J. STERN	1.351%	ABBINGTON REHAB & NURSING CENTER, LTD.	ROSELLE	HICKORY HEALTH CARE ASSO	LINCOLNWOOD	BUILDING CO	1
2	DEBORAH WENGROW	12.838%	ARBOUR HEALTH CARE CENTER, LTD.	CHICAGO	DOUBLE YOU REALTY	LINCOLNWOOD	BUILDING COMPANY	2
3	FRANCES MAUER	2.027%	ATRIUM HEALTH CARE CENTER, LTD., THE	CHICAGO	STAYCARE MANAGEMENT	LINCOLNWOOD	MANAGEMENT, BOOKKEEI	3
4	HOWARD L. WENGROW	14.189%	RIDGEVIEW REHAB & NURSING CENTER, LLC	CHICAGO				4
5	JEFFREY J. WEBSTER	14.189%	ZIKAINIM, INC. D/B/A ALL AMERICAN NURSING HOME	CHICAGO				5
6	MARSHALL A. MAUER	2.027%						6
7	MAURICE I. AARON	5.406%						7
8	MIRIAM LATINIK	5.406%						8
9	RALPH BROOKS	1.351%						9
10	BASHIR KAGDA	1.351%						10
11	SANDY BOKOR	1.351%						11
12	SARA WEBSTER	12.838%						12
13	SUSAN L. STERN	25.676%						13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Jeffrey Webster	Owner	Administrative	14.19%	See Attached	5.00	7.14%	Alloc. Salary	$ 13,904	17-07	1
2	Howard Wengrow	Owner	Administrative	14.19%	See Attached	15.00	23.08%	Alloc. Salary	40,074	17-07	2
3	Ephraim Braunstein	Relative	Clerical		See Attached	4.11	10.28%	Alloc. Salary	6,648	21-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 60,626		13

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X]

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

Name of Related Organization: STAYCARE MANAGEMENT, LTD.
Street Address: 3737 W ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	223,823	6	$ 8,516	$	22,975	$ 874	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	223,823	6	8,680		22,975	891	2
3	17	ADMIN. SALARY	PATIENT DAYS	223,823	6	152,674	152,674	22,975	15,672	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	223,823	6	38,246		22,975	3,926	4
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	223,823	6	222		22,975	23	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	223,823	6	361,830	307,546	22,975	37,141	6
7	24	SEMINARS	PATIENT DAYS	223,823	6	945		22,975	97	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	223,823	6	22,074		22,975	2,266	8
9	26	INSURANCE	PATIENT DAYS	223,823	6	10,203		22,975	1,047	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	223,823	6	251,057		22,975	25,771	10
11	30	DEPRECIATION	PATIENT DAYS	223,823	6	2,315		22,975	238	11
12	32	INTEREST	PATIENT DAYS	223,823	6			22,975		12
13	34	BUILDING RENT	PATIENT DAYS	223,823	6	73,800		22,975	7,575	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	223,823	6	36,278		22,975	3,724	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 966,840	$ 460,220		$ 99,245	25

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

Name of Related Organization: STAYCARE MANAGEMENT, LTD.
Street Address: 3737 W ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104			1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000			2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	4	2,721	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	1,381				4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	3,107				5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	3,328		4	342	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	173,652	173,652	15	40,074	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	194,652	194,652	5	13,904	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,114		15	2,796	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,481		5	892	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					$ 467,329	$ 434,918		$ 60,729	25

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

Name of Related Organization: DOUBLE YOU REALTY, LLC
Street Address: 3737 W. ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	223,823	6	1,550		22,975	159	2
3	26	INSURANCE	PATIENT DAYS	223,823	6	2,342		22,975	240	3
4	30	DEPRECIATION	PATIENT DAYS	223,823	6	12,254		22,975	1,258	4
5	32	INTEREST EXPENSE	PATIENT DAYS	223,823	6	9,684		22,975	994	5
6	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	223,823	6			22,975		6
7	33	REAL ESTATE TAXES	PATIENT DAYS	223,823	6	25,161		22,975	2,583	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					$ 50,991	$		$ 5,234	25

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X				$	$			$ 14	1
2	Allocated from Double You		X								994	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$ 1,008	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,004)	10
11	Interest Income - Bldg. Co.		X								(4)	11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$ (1,008)	14
15	**TOTALS (line 9+line14)**						$	$			$	15

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hickory Nursing Pavilion **#** 0032029 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 141,896	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.)		$ 157,737	2
3. Under or (over) accrual (line 2 minus line 1).		$ 15,841	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 159,809	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.**		$ 8,808	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.		$ 184,459	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	93,967	8
	2011	125,930	9
	2012	132,632	10
	2013	137,763	11
	2014	155,155	12

2015 Accrual = 155,155 * 1.03 = $159,809

Allocation from Double You = $2,583

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hickory Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-02-420-008-0000	Long Term Care Property	$ 66,786.67	$ 66,786.67
2.	23-02-420-016-0000	Long Term Care Property	$ 66,755.24	$ 66,755.24
3.	23-01-302-021-0000	Long Term Care Property	$ 10,669.37	$ 10,669.37
4.	23-02-420-015-0000	Long Term Care Property	$ 7,923.93	$ 7,923.93
5.	23-02-420-007-0000	Long Term Care Property	$ 3,019.48	$ 3,019.48
6.	10-35-329-014-0000	Home Office	$ 25,158.55	$ 2,582.48
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 180,313.24	$ 157,737.17

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hickory Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,200 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [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 [X] (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 [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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	16,200	1990	$ 74,000	1
2	Allocated from Double You		2003	5,132	2
3	TOTALS	16,200		$ 79,132	3

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1990	1961	$ 1,115,000	$ 35,397	20	$	$ (35,397)	$ 1,115,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	22,801		20			22,801	9
10	Various			1988	50,319		20			50,319	10
11	Various			1989	7,409		20			7,409	11
12	Various			1990	38,661		20			38,661	12
13	Various			1991	6,422		20			6,422	13
14	Various			1993	30,582		20			30,582	14
15	Various			1994	13,592		20			13,592	15
16	Various			1995	102,781		20	3,997	3,997	102,757	16
17	Various			1996	139,610		20	6,981	6,981	137,250	17
18	Various			1997	54,749		20	2,737	2,737	50,642	18
19	Various			1998	53,522		20	2,676	2,676	47,300	19
20	Various			1999	18,879		20	944	944	15,519	20
21	Various			2000	2,520		20	126	126	1,890	21
22	Various			2001	7,081		20	354	354	4,992	22
23	Various			2002	23,923		20			23,923	23
24	Various			2003	67,353		20	3,178	3,178	42,772	24
25	Various			2004	2,732		20	137	137	1,562	25
26	Various			2005	5,239		20	145	145	5,239	26
27	Various			2006	9,298		20	640	640	6,059	27
28	Various			2007	12,000		20	1,200	1,200	10,583	28
29	Various			2008	24,350		20	2,435	2,435	17,451	29
30	Various			2009	33,827		20	3,383	3,383	22,940	30
31	Various			2010	62,992		20	6,149	6,149	34,956	31
32	Various			2011	76,314		20	7,307	7,307	31,379	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		51,332	1,258		1,372	114	17,728	68
69	Financial Statement Depreciation			33,415			(33,415)		69
70	TOTAL (lines 4 thru 69)		$ 2,033,288	$ 70,070		$ 43,761	$ (26,309)	$ 1,859,727	70

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,033,288	$ 70,070		$ 43,761	$ (26,309)	$ 1,859,727	1
2	Refinish & Install Door Frame & Handrails In Corridor	2012	3,080		20	154	154	462	2
3	Automatic Sprinkler System	2013	68,419		20	6,842	6,842	21,096	3
4	Turbo Air Conditioner Parts And Labor	2013	4,311		20	111	111	263	4
5	Fence	2014	9,976		20	665	665	1,164	5
6	Fire System Upgrades	2014	2,804		20	280	280	514	6
7	Patch & Paint Rms 103,105,106,108,115,117,119,122,127,129,123,1	2014	4,500		20	225	225	394	7
8	Hic Pumps For Boilers	2014	3,469		20	173	173	332	8
9	Public Bathroom Plumbing Fixtures, Tile & Flooring, Drywall	2014	17,951		20	898	898	1,421	9
10	Tuckpointing & Brickwork	2014	37,500		20	1,875	1,875	2,188	10
11	Security Cameras	2015	5,055		20	590	590	590	11
12	Boiler	2015	10,450		20	174	174	174	12
13	Remove Existing Rear Entry Cove Base/Carpet, Install New Carpe	2015	2,961		20	148	148	148	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,203,764	$ 70,070		$ 55,896	$ (14,174)	$ 1,888,472	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,203,764	$ 70,070		$ 55,896	$ (14,174)	$ 1,888,472	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,203,764	$ 70,070		$ 55,896	$ (14,174)	$ 1,888,472	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,203,764	$ 70,070		$ 55,896	$ (14,174)	$ 1,888,472	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,203,764	$ 70,070		$ 55,896	$ (14,174)	$ 1,888,472	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,203,764	$ 70,070		$ 55,896	$ (14,174)	$ 1,888,472	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,203,764	$ 70,070		$ 55,896	$ (14,174)	$ 1,888,472	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Double You Realty	2003	49,059	1,258	39	1,258		16,301	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare Management	2003	2,273		20	114	114	1,427	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 51,332	$ 1,258		$ 1,372	$ 114	$ 17,728	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 51,332	$ 1,258		$ 1,372	$ 114	$ 17,728	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
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 51,332	$ 1,258		$ 1,372	$ 114	$ 17,728	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 110,067	$	$ 7,804	$ 7,804	10	$ 74,898	71
72	Current Year Purchases	12,242		1,146	1,146	10	1,146	72
73	Fully Depreciated Assets	309,503				10	309,503	73
74								74
75	TOTALS	$ 431,812	$	$ 8,949	$ 8,949		$ 385,546	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Staycare	2012	$ 3,474	$ 238	$ 447	$ 209	5	$ 1,834	76
77										77
78										78
79										79
80	TOTALS			$ 3,474	$ 238	$ 447	$ 209		$ 1,834	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)	$ 2,718,182	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 70,308	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,292	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,016)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,275,852	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2016	$
13.	/2017	$
14.	/2018	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Staycare		$	$ 3,724	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,724	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 & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
   - [X] 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.

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 - 03	hrs		$		$ 38,481	$		$ 38,481	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				9,204			9,204	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				47,673			47,673	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescrpts					36,272		36,272	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): See Supplemental										13
14	TOTAL				$		$ 95,358	$ 36,272		$ 131,630	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.

STATE OF ILLINOIS

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 465,912	$ 516,796	1
2	Cash-Patient Deposits	48,855	48,855	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	848,722	848,722	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,936	88,936	6
7	Other Prepaid Expenses	495	495	7
8	Accounts Receivable (owners or related parties)		14,039	8
9	Other(specify):	361	361	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,453,281	$ 1,518,204	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,000	13
14	Buildings, at Historical Cost		1,115,000	14
15	Leasehold Improvements, at Historical Cost	772,706	772,706	15
16	Equipment, at Historical Cost	319,623	430,623	16
17	Accumulated Depreciation (book methods)	(791,729)	(1,792,087)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 300,600	$ 600,242	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,753,881	$ 2,118,446	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 107,680	$ 107,681	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	48,855	48,855	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,490	98,490	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,083	5,083	31
32	Accrued Real Estate Taxes(Sch.IX-B)	159,809	159,809	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	296,134	84,456	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 716,051	$ 504,374	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 716,051	$ 504,374	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,037,830	$ 1,614,072	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,753,881	$ 2,118,446	48

***(See instructions.)**

Facility Name & ID Number Hickory Nursing Pavilion **#** 0032029 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 953,406	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 953,408	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	84,422	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)**	$ 84,422	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)**	$ 1,037,830	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,423,950	1
2	Discounts and Allowances for all Levels	(189,895)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,234,055	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	197,468	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 197,468	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	35,262	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,039	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,559	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 37,860	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,768	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,768	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,471,151	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	657,068	31
32	Health Care	1,223,704	32
33	General Administration	812,785	33
	B. Capital Expense		
34	Ownership	386,497	34
	C. Ancillary Expense		
35	Special Cost Centers	131,630	35
36	Provider Participation Fee	175,045	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,386,729	40
41	**Income before Income Taxes (line 30 minus line 40)****	84,422	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 84,422	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,977,281	44
45	Private Pay - Net Inpatient Revenue	27,620	45
46	Medicare - Net Inpatient Revenue	229,154	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,234,055	49

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,564	1,701	$ 80,406	$ 47.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,555	5,004	140,512	28.08	3
4	Licensed Practical Nurses	9,379	10,859	269,077	24.78	4
5	CNAs & Orderlies	29,841	34,054	346,657	10.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,362	1,673	23,288	13.92	8
9	Activity Director	1,882	2,118	26,068	12.31	9
10	Activity Assistants	3,324	3,709	35,829	9.66	10
11	Social Service Workers	4,459	4,856	93,095	19.17	11
12	Dietician					12
13	Food Service Supervisor	1,948	2,068	38,841	18.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,173	10,065	106,254	10.56	15
16	Dishwashers					16
17	Maintenance Workers	2,068	2,216	51,272	23.14	17
18	Housekeepers	10,584	11,293	106,418	9.42	18
19	Laundry	1,867	1,992	17,422	8.75	19
20	Administrator	1,920	2,080	81,427	39.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,913	3,076	50,202	16.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,861	4,735	136,867	28.90	33
34	TOTAL (lines 1 - 33)	90,700	101,499	$ 1,603,635 *	$ 15.80	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,642	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant	Monthly	174	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,056	10-03	39
40	Physical Therapy Consultant	11	776	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	900	11-03	44
45	Social Service Consultant	21	1,190	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	49	$ 23,738		49

C. CONTRACT NURSES

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joseph Javier	Administrator	0	$ 81,427
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,427

B. Administrative - Other

Description	Amount
Management Fees - Staycare Management	$ 223,650
TOTAL (agree to Schedule V, line 17, col. 3)	$ 223,650
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 20,745
See Attached	Legal Services	13,817
Stay Care Management	Admission's Consultant	12,040
KBC Computer	Computer Services	4,508
MDI Achieve	Computer Services	1,319
Personnel Planners	Unemployment Consulting	1,115
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 53,544

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,068
Unemployment Compensation Insurance	38,294
FICA Taxes	112,213
Employee Health Insurance	56,846
Employee Meals	7,307
Illinois Municipal Retirement Fund (IMRF)*	
Christmas Expense	500
401K	580
Union Pension	12,393
Employee Benefits	631
TOTAL (agree to Schedule V, line 22, col.8)	$ 273,832

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,792
Health Care Worker Background Check	3,644
(Indicate # of checks performed 364)	
Patient Background Checks	
Advertising and Promotions	1,679
Licenses and Permits	4,769
ICLTC	5,355
Allocated from Staycare	23
Less: Public Relations Expense	( )
Non-allowable advertising	(491)
Yellow page advertising	(1,188)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,582

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,155
Allocated from Staycare	97
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,252

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Hickory Nursing Pavilion **#** 0032029 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $7,992**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,374** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **175,045**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,307** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Line 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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