FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0053272

Facility Name: Paxton Healthcare and Rehab

Address: 1240 North Market St (Number) Paxton (City) 60957 (Zip Code)

County: Ford

Telephone Number: (217) 379-4896 **Fax #** (217) 379-2561

HFS ID Number:

Date of Initial License for Current Owners: 10/15/14

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT
(Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	76	Skilled (SNF)	76	27,816	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	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	10,247	842	3,231	14,320	8
9	SNF/PED					9
10	ICF	5,999	1,390		7,389	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,246	2,232	3,231	21,709	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.05%

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] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 10/15/14

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/15/14 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 1,803

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	158,749	12,263	7,298	178,310		178,310		178,310			1
2	Food Purchase		140,305		140,305		140,305	(301)	140,004			2
3	Housekeeping	137,199	17,714		154,913		154,913		154,913			3
4	Laundry	32,005	18,967		50,972		50,972		50,972			4
5	Heat and Other Utilities			97,991	97,991		97,991	461	98,452			5
6	Maintenance	52,812	17,875	33,150	103,837		103,837	122	103,959			6
7	Other (specify):* Waste Removal			5,054	5,054		5,054		5,054			7
8	TOTAL General Services	380,765	207,124	143,493	731,382		731,382	282	731,664			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,362,293	113,478	7,213	1,482,984		1,482,984	52,319	1,535,303			10
10a	Therapy	21,270		180	21,450		21,450		21,450			10a
11	Activities	47,808		4,162	51,970		51,970		51,970			11
12	Social Services	45,404		2,376	47,780		47,780		47,780			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. Emp Benefits							8,935	8,935			15
16	TOTAL Health Care and Programs	1,476,775	113,478	25,931	1,616,184		1,616,184	61,254	1,677,438			16
	C. General Administration											
17	Administrative	89,748		176,898	266,646		266,646	(139,554)	127,092			17
18	Directors Fees											18
19	Professional Services			62,119	62,119		62,119	3,770	65,889			19
20	Dues, Fees, Subscriptions & Promotions			8,708	8,708		8,708	888	9,596			20
21	Clerical & General Office Expenses	63,757	5,195	51,132	120,084		120,084	79,019	199,103			21
22	Employee Benefits & Payroll Taxes			340,742	340,742		340,742		340,742			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,727	3,727		3,727	5,273	9,000			24
25	Other Admin. Staff Transportation			7,427	7,427		7,427	2,586	10,013			25
26	Insurance-Prop.Liab.Malpractice			76,424	76,424		76,424	507	76,931			26
27	Other (specify):* Alloc. Emp Benefits							18,111	18,111			27
28	TOTAL General Administration	153,505	5,195	727,177	885,877		885,877	(29,400)	856,477			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,011,045	325,797	896,601	3,233,443		3,233,443	32,136	3,265,579			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Paxton Healthcare and Rehab #0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			24,000	24,000		24,000	(5,347)	18,653			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,174	38,174		38,174	(667)	37,507			32
33	Real Estate Taxes			27,500	27,500		27,500		27,500			33
34	Rent-Facility & Grounds			335,194	335,194		335,194	3,941	339,135			34
35	Rent-Equipment & Vehicles			9,276	9,276		9,276	(659)	8,617			35
36	Other (specify):*											36
37	**TOTAL Ownership**			434,144	434,144		434,144	(2,732)	431,412			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		70,518	294,972	365,490		365,490		365,490			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,000	168,000		168,000		168,000			42
43	Other (specify):* See Att Sch 4A			68,801	68,801		68,801	(62,682)	6,119			43
44	**TOTAL Special Cost Centers**		70,518	531,773	602,291		602,291	(62,682)	539,609			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,011,045	396,315	1,862,518	4,269,878		4,269,878	(33,278)	4,236,600			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Paxton Healthcare and Rehab

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			5,975	5,975		5,975		5,975			
	Radiology Expenses			144	144		144		144			
	Non-Allowable Expenses			62,682	62,682		62,682	(62,682)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	0	0	68,801	68,801	0	68,801	(62,682)	6,119			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(301)	2		4
5	Telephone, TV & Radio in Resident Rooms	(18,444)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,347)	30		9
10	Interest and Other Investment Income	(667)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,200)	43		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	(30,000)	43		24
25	Fund Raising, Advertising and Promotional	(12,027)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(7,035)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (76,032)		$	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)	42,754		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 42,754		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (33,278)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Paxton Healthcare and Rehab

ID# 0053272

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Wages	(2,603)	21	1
2	Offset Miscellaneous Income Against Expense	(311)	21	2
3	Marketer Car Lease	(4,121)	35	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
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27				27
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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**	(7,035)		49

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	5	Heat and Other Utilities	$		100.00%	$ 461	$ 461	1
2	V	6	Maintenance			100.00%	122	122	2
3	V	10	Nursing and Medical Records			100.00%	52,319	52,319	3
4	V	15	Emp Benefit Alloc-Healthcare			100.00%	8,935	8,935	4
5	V	17	Administrative	176,898		100.00%	37,344	(139,554)	5
6	V	19	Professional Services			100.00%	3,770	3,770	6
7	V	20	Dues, Fees, Subs & Promo			100.00%	888	888	7
8	V	21	Clerical & Gen Office Expenses			100.00%	81,933	81,933	8
9	V	24	Travel and Seminar			100.00%	5,273	5,273	9
10	V	25	Other Admin Staff Transportation			100.00%	2,586	2,586	10
11	V	26	Ins.-Prop, Liab, Malpractice			100.00%	507	507	11
12	V	27	Emp Benefit Alloc-Gen Admin			100.00%	18,111	18,111	12
13	V	34	Rent-Facility & Grounds			100.00%	3,941	3,941	13
14	Total			$ 176,898			$ 216,190	$ * 39,292	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	35	Rent-Equipment & Vehicle	$	Certified Health Management, Inc.	100.00%	$ 3,462	$ 3,462	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			$			$ 3,462	$ * 3,462	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Atied Associates, LLC	30	Glenwood Healthcare & Rehab	Glenwood	Certified Health	Skokie	Management	1
2	Bradley M. Alter	70	Prairie View Care Center of Lewistown	Lewistown	Management, Inc.			2
3			Renaissance Care Center	Canton				3
4			Danville Care Center	Danville				4
5			Pontiac Healthcare and Rehab	Pontiac				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Daniel Alter	Relative	Financial	0.00	See Att Sch 7A	4.38	10.95	Alloc. Salary	$ 5,544	L21, C7	1
2	Zev Geller	Relative	Clerical	0.00	See Att Sch 7A	4.38	10.95	Alloc. Salary	7,318	L21, C7	2
3	Bradley Alter	Owner	Administration	70.00	See Att Sch 7A	5.47	10.94	Alloc. Salary	20,253	L17, C7	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	$ 33,115		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Certified Health Management, Inc.
Street Address: 3856 W. Oakton
City / State / Zip Code: Skokie, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	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	Heat and Other Utilities	Census Days	198,295	6	$ 4,208	$	21,709	$ 461	1
2	6	Maintenance	Census Days	198,295	6	1,116		21,709	122	2
3	10	Nursing and Medical Records	Census Days	198,295	6	477,896	477,896	21,709	52,319	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	198,295	6	81,613		21,709	8,935	4
5	17	Administrative	Census Days	198,295	6	341,110	341,110	21,709	37,344	5
6	19	Professional Services	Census Days	198,295	6	34,439		21,709	3,770	6
7	20	Dues, Fees, Subs & Promo	Census Days	198,295	6	8,110		21,709	888	7
8	21	Clerical & Gen Office Expenses	Census Days	198,295	6	748,394	627,598	21,709	81,933	8
9	24	Travel and Seminar	Census Days	198,295	6	48,168		21,709	5,273	9
10	25	Other Admin Staff Transportatior	Census Days	198,295	6	23,623		21,709	2,586	10
11	26	Ins.-Prop, Liab, Malpractice	Census Days	198,295	6	4,628		21,709	507	11
12	27	Emp Benefit Alloc-Gen Admin	Census Days	198,295	6	165,432		21,709	18,111	12
13	34	Rent-Facility & Grounds	Census Days	198,295	6	36,000		21,709	3,941	13
14	35	Rent-Equipment & Vehicle	Census Days	198,295	6	31,619		21,709	3,462	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,006,356	$ 1,446,604		$ 219,652	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				887,174			37,025	6
7	Auto Loan		X					24,715				7
8	Insurance Financing										1,149	8
9	TOTAL Facility Related						$	$ 911,889			$ 38,174	9
	B. Non-Facility Related*											
10												10
11												11
12								Offset Interest Income			(667)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (667)	14
15	TOTALS (line 9+line14)						$	$ 911,889			$ 37,507	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 32,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2015	$ 32,040	2
3. Under or (over) accrual (line 2 minus line 1).		$ 40	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 27,460	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ ____ **For** ____ **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 27,500	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013		10
2014	31,058	11
2015	32,040	12

Accrual based on prior year tax bill.

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

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Paxton Healthcare and Rehab COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0053272

CONTACT PERSON REGARDING THIS REPORT Bruce Harris

TELEPHONE (847) 674-4700 FAX #: (847) 674-4733

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-14-05-300-007	Long Term Care Property	$ 32,039.96	$ 32,039.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,039.96	$ 32,039.96

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. 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				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Shingles And Sheeting Garage			2015	7,200		20	360	360	600	9
10	Asphalt Guest Parking Lot, Drive To North And South Drive			2015	37,535		20	1,877	1,877	2,972	10
11	Installed Cables For Office Areas, Wing 1 And Wing 2			2015	6,000		20	300	300	1,000	11
12	New Roof Installed			2015	29,840		20	1,492	1,492	2,114	12
13	Replace Water Heaters			2016	10,685		20	534	534	534	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	Financial Statement Depreciation					24,000			(24,000)		28
29											29
30											30
31											31
32											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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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	Allocated from Certified Health Management	1997	10,317		20			10,317	42
43	Allocated from Certified Health Management	2014	2,901		20	145	145	508	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 104,478	$ 24,000		$ 4,708	$ (19,292)	$ 18,045	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 27,308	$	$ 2,731	$ 2,731	10	$ 5,462	71
72	Current Year Purchases	11,111		1,111	1,111	10	1,111	72
73	Fully Depreciated Assets					10		73
74								74
75	TOTALS	$ 38,419	$	$ 3,842	$ 3,842		$ 6,573	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		Conversion to 2014 Ford E-350	2015	$ 17,481	$	$ 3,496	$ 3,496	5	$ 5,369	76
77		Ford E350	2015	33,035		6,607	6,607	5	10,146	77
78										78
79										79
80	TOTALS			$ 50,516	$	$ 10,103	$ 10,103		$ 15,515	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)	$ 193,413	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,000	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 18,653	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,347)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 40,133	85	

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Paxton Healthcare Property LLC

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. [X] 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:	1972	76	10/15/14	$ 335,194	10		3
4	Additions							4
5	Allocated from Management Co.				3,941			5
6								6
7	TOTAL		76		$ 339,135 **			7

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

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 10/15/14
Ending 10/31/24

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

	Fiscal Year Ending	Annual Rent
12.	10/31/17	$ 346,750
13.	10/31/18	$ 360,620
14.	10/31/19	$ 374,490

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 5,155 Description: Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	Allocated from Management Co.			3,462	18
19					19
20					20
21	TOTAL		$	$ 3,462	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$		$ 131,671	$		$ 131,671	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			23,134			23,134	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			140,167			140,167	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				70,518		70,518	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 294,972	$ 70,518		$ 365,490	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab **#** 0053272 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16 **(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	$ 24,641	$ 24,641	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 23,511)	1,845,467	1,845,467	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,085	50,085	6
7	Other Prepaid Expenses	49,727	49,727	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	30,741	30,741	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,000,661	$ 2,000,661	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	74,575	104,478	15
16	Equipment, at Historical Cost	113,714	88,935	16
17	Accumulated Depreciation (book methods)	(38,383)	(40,133)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe LTC Mgmt Stock	17,000	17,000	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 166,906	$ 170,280	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,167,567	$ 2,170,941	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 447,398	$ 447,398	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	911,889	911,889	29
30	Accrued Salaries Payable	130,814	130,814	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,421	10,421	31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,460	27,460	32
33	Accrued Interest Payable	5,970	5,970	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	2,000	2,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,535,952	$ 1,535,952	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	See Attached Schedule 17A	979,770	979,770	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 979,770	$ 979,770	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,515,722	$ 2,515,722	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (348,155)	$ (344,781)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,167,567	$ 2,170,941	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Paxton Healthcare and Rehab**
IDPH License ID Number: **0053272**
Fiscal Year End: **12/31/16**

Schedule 17A

XV. Balance Sheet
Line 9 Other Current Assets (specify):

Description	Operating	After Consolidation
RE Escrow	28,923	28,923
Employee Loans	1,818	1,818
Total - Line 9	**30,741**	**30,741**

XV. Balance Sheet
Line 43 Other Long-Term Liabilities (specify):

Description	Operating	After Consolidation
Due to Prior Owner	28,700	28,700
Intercompany Payable	751,070	751,070
Due to Shareholders	200,000	200,000
Total - Line 43	**979,770**	**979,770**

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,619)	1
2	Restatements (describe): Bad Debt Expense		2
3	**Bad Debt Expense**	(176,914)	3
4	**Rounding**	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (184,531)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(163,624)	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)**	$ (163,624)	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)**	$ (348,155)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,958,284	1
2	Discounts and Allowances for all Levels	(58,833)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,899,451	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	204,640	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 204,640	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	301	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	884	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,185	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	667	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 667	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	311	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 311	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,106,254	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	731,382	31
32	Health Care	1,616,184	32
33	General Administration	885,877	33
	B. Capital Expense		
34	Ownership	434,144	34
	C. Ancillary Expense		
35	Special Cost Centers	434,291	35
36	Provider Participation Fee	168,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,269,878	40
41	**Income before Income Taxes (line 30 minus line 40)****	(163,624)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (163,624)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,234,823	44
45	Private Pay - Net Inpatient Revenue	453,136	45
46	Medicare - Net Inpatient Revenue	780,213	46
47	Other-(specify) Managed Care	309,369	47
48	Other-(specify) Hospice	121,910	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,899,451	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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	1,359	1,493	$ 69,091	$ 46.28	1
2	Assistant Director of Nursing	496	585	11,929	20.39	2
3	Registered Nurses	8,855	9,575	283,602	29.62	3
4	Licensed Practical Nurses	11,609	12,410	300,231	24.19	4
5	CNAs & Orderlies	50,399	52,816	635,954	12.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,436	1,704	21,270	12.48	8
9	Activity Director	1,904	2,033	30,335	14.92	9
10	Activity Assistants	1,732	1,752	17,473	9.97	10
11	Social Service Workers	1,720	1,928	34,266	17.77	11
12	Dietician					12
13	Food Service Supervisor	3,453	3,874	54,251	14.00	13
14	Head Cook	4,662	4,981	58,359	11.72	14
15	Cook Helpers/Assistants	4,668	4,934	46,139	9.35	15
16	Dishwashers					16
17	Maintenance Workers	2,650	2,757	52,812	19.16	17
18	Housekeepers	11,069	11,784	137,199	11.64	18
19	Laundry	2,661	2,870	32,005	11.15	19
20	Administrator	1,856	1,960	89,748	45.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,247	3,623	63,757	17.60	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 Sch 20A	2,276	2,439	72,624	29.78	33
34	TOTAL (lines 1 - 33)	116,052	123,518	$ 2,011,045 *	$ 16.28	34

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	162	$ 7,298	L1,C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant	54	2,477	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	79	4,736	L10,C3	39
40	Physical Therapy Consultant	3	180	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	48	2,376	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	346	$ 29,067		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Paxton Healthcare and Rehab

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,567	1,674	61,486	36.73
Transportation	709	765	11,138	14.56
TOTAL	2,276	2,439	72,624	

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tish Harty	Administrator	0	$ 89,748
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,748

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 176,898
TOTAL (agree to Schedule V, line 17, col. 3)	$ 176,898
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Service	$ 13,960
E-Health Data Solutions	MDS Computer	900
Paychex	Payroll Service	18,141
On Shift	Data Processing	1,481
Ability Network	Data Processing	3,744
MPRO	Peer Review Consulting	475
Personnel Planners	Unemployment Consulting	3,195
Wescom Solutions Inc	Data Processing	15,069
See Attached Legal Schedule	Legal Fees	5,154
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 62,119

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,127
Unemployment Compensation Insurance	40,861
FICA Taxes	149,170
Employee Health Insurance	89,684
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	7,929
Pension Plan Contribution	971
TOTAL (agree to Schedule V, line 22, col.8)	$ 340,742

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	4,929
Health Care Worker Background Check	
(Indicate # of checks performed 69)	693
Patient Background Checks	
Licenses & Permits	1,096
Allocated from Management Co.	888
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,596

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,727
Allocated from Management Co.	5,273
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,000

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Paxton Healthcare and Rehab # 0053272 Report Period Beginning: 1/1/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **None**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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. $ **1,474** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **168,000**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **301**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 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? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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