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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0032862

Facility Name: Danville Care Center

Address: 1701 North Bowman Ave. (Number) Danville (City) 61832 (Zip Code)

County: Vermilion

Telephone Number: (217) 443-2955 **Fax #** (217) 443-0315

HFS ID Number:

Date of Initial License for Current Owners: 10/1/87

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: 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 1/1/2017 to 12/31/2017 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 Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	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			2,349	2,349	8
9	SNF/PED					9
10	ICF	37,145	2,077		39,222	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,145	2,077	2,349	41,571	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.95%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 10/1/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 1,912

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: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	214,808	27,113	15,112	257,033		257,033		257,033			1
2	Food Purchase		250,376		250,376		250,376	(33)	250,343			2
3	Housekeeping	257,093	23,020		280,113		280,113		280,113			3
4	Laundry	15,473	61,159		76,632		76,632		76,632			4
5	Heat and Other Utilities			156,005	156,005		156,005	1,363	157,368			5
6	Maintenance	51,438	37,913	23,235	112,586		112,586	8,324	120,910			6
7	Other (specify):* Waste Disposal			12,062	12,062		12,062		12,062			7
8	TOTAL General Services	538,812	399,581	206,414	1,144,807		1,144,807	9,654	1,154,461			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,167,108	186,783	13,686	2,367,577		2,367,577	82,390	2,449,967			10
10a	Therapy	34,432			34,432		34,432		34,432			10a
11	Activities	60,363		2,911	63,274		63,274		63,274			11
12	Social Services	228,512		27,481	255,993		255,993		255,993			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							14,157	14,157			15
16	TOTAL Health Care and Programs	2,490,415	186,783	68,078	2,745,276		2,745,276	96,547	2,841,823			16
	C. General Administration											
17	Administrative	87,725		187,300	275,025		275,025	(118,156)	156,869			17
18	Directors Fees											18
19	Professional Services			131,139	131,139		131,139	11,009	142,148			19
20	Dues, Fees, Subscriptions & Promotions			8,155	8,155		8,155	30	8,185			20
21	Clerical & General Office Expenses	132,579	35,773	37,715	206,067		206,067	191,468	397,535			21
22	Employee Benefits & Payroll Taxes			615,795	615,795		615,795		615,795			22
23	Inservice Training & Education			3,366	3,366		3,366		3,366			23
24	Travel and Seminar							3,715	3,715			24
25	Other Admin. Staff Transportation			8,804	8,804		8,804	7,022	15,826			25
26	Insurance-Prop.Liab.Malpractice			179,810	179,810		179,810	1,261	181,071			26
27	Other (specify):*							42,300	42,300			27
28	TOTAL General Administration	220,304	35,773	1,172,084	1,428,161		1,428,161	138,649	1,566,810			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,249,531	622,137	1,446,576	5,318,244		5,318,244	244,850	5,563,094			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 Danville Care Center #0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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			192,000	192,000		192,000	5,266	197,266			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			131,851	131,851		131,851	111,905	243,756			32
33	Real Estate Taxes			52,500	52,500		52,500	74,400	126,900			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(530,257)	9,743			34
35	Rent-Equipment & Vehicles			34,206	34,206		34,206	7,640	41,846			35
36	Other (specify):*											36
37	**TOTAL Ownership**			950,557	950,557		950,557	(331,046)	619,511			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,725	373,343	451,068		451,068		451,068			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			324,000	324,000		324,000		324,000			42
43	Other (specify):* See Att Sch 4A	47,577		188,863	236,440		236,440	(233,962)	2,478			43
44	**TOTAL Special Cost Centers**	47,577	77,725	886,206	1,011,508		1,011,508	(233,962)	777,546			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,297,108	699,862	3,283,339	7,280,309		7,280,309	(320,158)	6,960,151			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

Danville Care Center

Period Beginning **1/1/2017**
Period End **12/31/2017**

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			681	681		681		681			
	Radiology Expenses			1,797	1,797		1,797		1,797			
	Non-Allowable Expenses	47,577		186,385	233,962		233,962	(233,962)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	47,577	0	188,863	236,440	0	236,440	(233,962)	2,478			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	(33)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,250)	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	(180,734)	30		9
10	Interest and Other Investment Income	(2,058)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(169)	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	(500)	20		17
18	Fines and Penalties	(26,823)	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	(120,000)	43		24
25	Fund Raising, Advertising and Promotional	(24,143)	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	(36,796)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (406,506)		$	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)	86,348		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 86,348		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (320,158)		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

Danville Care Center

ID# 0032862

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Wages	$ (47,577)	43	1
2	Marketer Car Lease	(4,746)	35	2
3	Offset Miscellaneous Income	(1,399)	21	3
4	Expense Capitalized Repairs	8,262	6	4
5	Expense Capitalized Equipment	5,669	35	5
6	Expense Capitalized Auto Repairs	3,735	25	6
7				7
8				8
9				9
10	Building Co:			10
11	Non-allowable Accounting Fees	(740)	19	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**	(36,796)		49

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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
Rita L. Geller	38.044%	Glenwood Healthcare & Rehab	Springfield	Danville Care	Skokie	Lessor
Bradley M. Alter	22.826%	Renaissance Care Center	Canton	Center Property, LLC		
ESBT Jennifer T. W. Chow	19.565%	Prairie View Care Center of Lewistown	Lewistown	Certified Health	Skokie	Management
ESBT Julie Brum	19.565%	Paxton Healthcare and Rehab	Paxton	Management, Inc.		
		Pontiac Healthcare and Rehab	Pontiac			

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	19	Professional Fees	$	Danville Care Center Property LLC	100.00%	$ 740	$ 740	1
2	V	30	Depreciation		Danville Care Center Property LLC	100.00%	186,000	186,000	2
3	V	32	Interest		Danville Care Center Property LLC	100.00%	109,937	109,937	3
4	V	33	Real Estate Taxes		Danville Care Center Property LLC	100.00%	74,400	74,400	4
5	V	34	Rent-Facility & Grounds	540,000	Danville Care Center Property LLC	100.00%		(540,000)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 540,000			$ 371,077	$ * (168,923)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Heat and Other Utilities	$	Certified Health Management, Inc.	100.00%	$ 1,363	$ 1,363	15
16	V	6	Maintenance		Certified Health Management, Inc.	100.00%	62	62	16
17	V	10	Nursing and Medical Records		Certified Health Management, Inc.	100.00%	82,390	82,390	17
18	V	15	Emp Benefit Alloc-Healthcare		Certified Health Management, Inc.	100.00%	14,157	14,157	18
19	V	17	Administrative	187,300	Certified Health Management, Inc.	100.00%	69,144	(118,156)	19
20	V	19	Professional Services		Certified Health Management, Inc.	100.00%	11,009	11,009	20
21	V	20	Dues, Fees, Subs & Promo		Certified Health Management, Inc.	100.00%	530	530	21
22	V	21	Clerical & Gen Office Expenses		Certified Health Management, Inc.	100.00%	192,867	192,867	22
23	V	24	Travel and Seminar		Certified Health Management, Inc.	100.00%	3,715	3,715	23
24	V	25	Other Admin Staff Transportation		Certified Health Management, Inc.	100.00%	3,287	3,287	24
25	V	26	Ins.-Prop, Liab, Malpractice		Certified Health Management, Inc.	100.00%	1,261	1,261	25
26	V	27	Emp Benefit Alloc-Gen Admin		Certified Health Management, Inc.	100.00%	42,300	42,300	26
27	V	32	Interest		Certified Health Management, Inc.	100.00%	4,026	4,026	27
28	V	34	Rent-Facility & Grounds		Certified Health Management, Inc.	100.00%	9,743	9,743	28
29	V	35	Rent-Equipment & Vehicle		Certified Health Management, Inc.	100.00%	6,717	6,717	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			$ 187,300			$ 442,571	$ * 255,271	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Rita L. Geller	38.044%	Glenwood Healthcare & Rehab	Springfield	Danville Care	Skokie	Lessor	1
2	Bradley M. Alter	22.826%	Prairie View Care Center of Lewistown	Lewistown	Center Property, LLC			2
3	ESBT Jennifer T. W. Chow	19.565%	Renaissance Care Center	Canton	Certified Health	Skokie	Management	3
4	ESBT Julie Brum	19.565%	Paxton Healthcare and Rehab	Paxton	Management, Inc.			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
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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 Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	9.62	24.04	Alloc. Salary	$ 2,518	L21, C7	1
2	Zev Geller	Relative	Clerical	0.00	See Att Sch 7A	9.62	24.04	Alloc. Salary	16,287	L21, C7	2
3	Bradley Alter	Owner	Administration	22.826%	See Att Sch 7A	12.03	24.06	Alloc. Salary	44,504	L17, C7	3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										9
10	anticipated to be considered allowable by the IL. Dept. of HFS.										10
11											11
12											12
13								TOTAL	$ 63,309		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 Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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	172,810	6	$ 5,666	$	41,571	$ 1,363	1
2	6	Maintenance	Census Days	172,810	6	258		41,571	62	2
3	10	Nursing and Medical Records	Census Days	172,810	6	342,494	342,494	41,571	82,390	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	172,810	6	58,851		41,571	14,157	4
5	17	Administrative	Census Days	172,810	6	287,432	287,432	41,571	69,144	5
6	19	Professional Services	Census Days	172,810	6	45,764		41,571	11,009	6
7	20	Dues, Fees, Subs & Promo	Census Days	172,810	6	2,205		41,571	530	7
8	21	Clerical & Gen Office Expenses	Census Days	172,810	6	801,746	735,880	41,571	192,867	8
9	24	Travel and Seminar	Census Days	172,810	6	15,444		41,571	3,715	9
10	25	Other Admin Staff Transportatior	Census Days	172,810	6	13,662		41,571	3,287	10
11	26	Ins.-Prop, Liab, Malpractice	Census Days	172,810	6	5,242		41,571	1,261	11
12	27	Emp Benefit Alloc-Gen Admin	Census Days	172,810	6	175,840		41,571	42,300	12
13	32	Interest	Census Days	172,810	6	16,735		41,571	4,026	13
14	34	Rent-Facility & Grounds	Census Days	172,810	6	40,501		41,571	9,743	14
15	35	Rent-Equipment & Vehicle	Census Days	172,810	6	27,922		41,571	6,717	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,839,762	$ 1,365,806		$ 442,571	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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** 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	Bank Leumi		X	Mortgage			$ 2,500,000	$ 2,328,871		0.0500	$ 109,938	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				1,042,141		0.0550	113,093	6
7	Insurance Financing										2,837	7
8	Brickyard Bank/Charles Schwab										5,120	8
9	TOTAL Facility Related						$ 2,500,000	$ 3,371,012			$ 230,988	9
	B. Non-Facility Related*											
10												10
11								Allocated from Mgmt Co			4,026	11
12								Offset Interest Income			(2,058)	12
13								Amortization Expense			10,800	13
14	TOTAL Non-Facility Related						$	$			$ 12,768	14
15	TOTALS (line 9+line14)						$ 2,500,000	$ 3,371,012			$ 243,756	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 Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 69,963	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.)	2016	$ 70,117	2
3. Under or (over) accrual (line 2 minus line 1).		$ 154	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 126,746	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.		$ 126,900	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	79,510	8
	2013	81,648	9
	2014	67,231	10
	2015	70,646	11
	2016	70,117	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Danville Care Center COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0032862

CONTACT PERSON REGARDING THIS REPORT Brad Alter

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-33-200-016-0060	Long Term Care Property	$ 41,369.26	$ 41,369.26
2.	18-34-100-005-0060	Long Term Care Property	$ 28,748.14	$ 28,748.14
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,117.40	$ 70,117.40

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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. [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 Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	200		1987	1974	$ 2,954,225	$		$ 53,565	$ 53,565	$ 2,954,225	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	34,167		20			34,167	9
10	Various			1990	17,344		20			17,344	10
11	Various			1991	45,376		20			45,376	11
12	Various			1992	12,043		20			12,043	12
13	Various			1993	9,213		20			9,213	13
14	Various			1994	8,304		20			8,304	14
15	Various			1995	39,047		20			39,047	15
16	Various			1996	44,007		20			44,007	16
17	Various			1997	28,811		20	720	720	28,811	17
18	Various			1998	394,658		20	19,733	19,733	394,658	18
19	Various			1999	42,329		20	2,116	2,116	39,153	19
20	Various			2000	51,980		20	2,599	2,599	45,644	20
21	Various			2001	1,377		20	69	69	1,136	21
22	Various			2002	11,592		20	580	580	8,767	22
23	Various			2003	122,592		20	6,130	6,130	88,893	23
24	Various			2004	68,558		20	3,428	3,428	45,800	24
25	Various			2005	83,307		20	4,165	4,165	52,285	25
26	Various			2006	46,793		20	2,340	2,340	27,045	26
27	Various			2007	6,180		20	309	309	3,399	27
28	Various			2008	10,918		20	546	546	5,256	28
29	Various			2009	68,627		20	3,431	3,431	38,718	29
30	Various			2011	24,148		20	1,207	1,207	19,784	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 Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Rooftop A/C Units - Lennox	2012	$ 8,421	$	20	$ 421	$ 421	$ 2,526	37
38	Light Fixtures & Corner Guards	2012	3,402		20	170	170	2,495	38
39	Millwork, Plumbing, Paint, Wallcovering, Handrails, Corner Gua	2012	281,764		20	14,088	14,088	230,107	39
40	Sprinkler System	2012	128,750		20	6,438	6,438	34,334	40
41	Replaced Failed Compressor	2012	2,773		20	139	139	706	41
42	Hot Water Boiler System Storage Tank, Temperature Gauge, And	2013	2,695		20	135	135	562	42
43	Outlets For Kiosks	2013	9,341		20	467	467	5,916	43
44	Lennox Gas/Electric Rooftop Unit	2013	17,354		20	868	868	3,688	44
45	Hot Water Storage Tank	2013	5,475		20	274	274	1,141	45
46	Birch Wood Doors (6) And Installation	2013	3,273		20	164	164	723	46
47	4,345 Sq Ft Of Facility Roof	2014	35,009		20	1,750	1,750	6,272	47
48	Hallway Carpets/Baroque Modular Plush/ Vinyl Mouldings/Base	2014	31,256		20	1,563	1,563	12,503	48
49	Driveway Upgrade	2014	3,055		20	153	153	561	49
50	Drywall Rooms' Ceilings & Admin Offices	2014	4,500		20	225	225	713	50
51	Parking Lot Seal Coat	2014	4,597		20	230	230	818	51
52	Roof Powerwash, Scrubbing & Application Of Coating	2014	4,615		20	231	231	750	52
53	Concrete Work	2014	3,055		20	153	153	497	53
54	Fence Project	2015	5,652		20	283	283	754	54
55	Heat/Cool Units 230V Qty.5	2015	3,230		20	162	162	755	55
56	Code Alert System-Wandering Management Solution	2015	7,441		20	372	372	1,612	56
57	South Wing Dining Room Metrofloor Tile/Vinyl Planking	2015	8,507		20	425	425	1,417	57
58	Painting Trim, Shutters, Roof Vents, Etc	2015	6,000		20	300	300	900	58
59	Replace Doors (4)	2016	10,177		20	509	509	1,018	59
60	50 Gallon Water Heater	2016	10,375		20	519	519	1,038	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,726,313	$		$ 130,977	$ 130,977	$ 4,274,881	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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		$ 4,726,313	$		$ 130,977	$ 130,977	$ 4,274,881	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements (Real Estate Entity):								8
9	Parking Lot Paving	2011	108,929		20	5,446	5,446	38,122	9
10	Nurse Call Station	2015	63,648		20	3,182	3,182	8,546	10
11	South Wing Renovation-Flooring, Lighting, Plumbing, Signage								11
12	Valances, Acrovyn, Handrails, Grab Bars	2016	281,598		20	14,080	14,080	28,160	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	Allocated from Certified Health Management	1997	22,670		20			22,670	25
26	Allocated from Certified Health Management	2014	6,374		20	319	319	1,434	26
27									27
28									28
29									29
30	Financial Statement Depreciation			192,000			(192,000)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,209,532	$ 192,000		$ 154,004	$ (37,996)	$ 4,373,813	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 389,156	$	$ 38,916	$ 38,916	10	$ 283,308	71
72	Current Year Purchases	9,321		932	932	10	932	72
73	Fully Depreciated Assets	930,747				10	930,747	73
74								74
75	TOTALS	$ 1,329,224	$	$ 39,848	$ 39,848		$ 1,214,987	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		Ford Van	1994	$ 19,594	$	$	$	5	$ 19,594	76
77		Lift/Tie Downs	2007	8,783				5	8,783	77
78		Vehicle	2000	21,907				5	21,907	78
79		2006 Ford F-350	2011	17,072		3,414	3,414	5	16,787	79
80	TOTALS			$ 67,356	$	$ 3,414	$ 3,414		$ 67,071	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)	$ 6,606,112	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 192,000	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 197,266	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,266	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,655,871	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 Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Allocated from Management Co.				9,743			5
6								6
7	TOTAL				$ 9,743 **			7

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.	/2018	$
13.	/2019	$
14.	/2020	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 19,252 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Shuttle	Ford Challenger 2014	$ 899.00	$ 9,889	17
18	Patient Shuttle	Ford E350 2005	592.83	7,114	18
19					19
20	Allocated from Management Co.			5,591	20
21	TOTAL		$ 1,492	$ 22,594	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: **Danville Care Center**
IDPH License ID Number: **0032862**
Fiscal Year End: **12/31/2017**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	10,299
Dishwasher	2,079
Matresses/Beds	5,669
Misc	79
Allocated from Mgmt Co	1,126
Total - Line 16	**19,252**

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$		$ 180,751	$		$ 180,751	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			18,513			18,513	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), 39(3)	hrs			174,079	909		174,988	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				76,816		76,816	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			$		$ 373,343	$ 77,725		$ 451,068	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

STATE OF ILLINOIS

Facility Name & ID Number Danville Care Center **#** 0032862 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 290,188	$ 295,574	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 152,895)	1,635,515	1,635,515	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,185	79,185	6
7	Other Prepaid Expenses	1,182	1,182	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,006,070	$ 2,011,456	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		2,954,225	14
15	Leasehold Improvements, at Historical Cost	1,822,869	2,255,307	15
16	Equipment, at Historical Cost	1,056,974	1,396,580	16
17	Accumulated Depreciation (book methods)	(2,127,623)	(5,655,871)	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	59,873	59,873	22
23	Other(specify): Loan Costs	4,137	33,387	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 816,230	$ 1,043,501	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,822,300	$ 3,054,957	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,244,448	$ 1,244,448	26
27	Officer's Accounts Payable	447,814	447,814	27
28	Accounts Payable-Patient Deposits	10,500	10,500	28
29	Short-Term Notes Payable	1,042,141	1,042,141	29
30	Accrued Salaries Payable	198,355	198,355	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,427	12,427	31
32	Accrued Real Estate Taxes(Sch.IX-B)	87,405	126,746	32
33	Accrued Interest Payable	1,928	(5,125)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to IDPA	38,446	38,446	36
37	Deferred Rent	155,575	155,575	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,239,039	$ 3,271,327	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,328,871	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Payable	3,274,484	6,085,854	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,274,484	$ 8,414,725	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,513,523	$ 11,686,052	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,691,223)	$ (8,631,095)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,822,300	$ 3,054,957	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,499,991)	1
2	Restatements (describe):		2
3	See Attached Schedule 18A	(722,874)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,222,865)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(468,358)	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)**	$ (468,358)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,691,223)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Danville Care Center**
IDPH License ID Number: **0032862**
Fiscal Year End: **12/31/2017**

Schedule 18A

XVI. Statement of Changes in Equity
Line 2 Restatements

Description	Amount
Adjustment to Retained Earning	235,135
Income Adjustments	(7,777)
Provider Tax	24,000
Bad Debt Expense	290,417
Repairs & Maint	1,559
Bank Charges	(2,579)
Auto Leasing	(16,599)
Rent	184,000
Real Estate Taxes	21,000
Interest Expense	(1,595)
Depreciation	(10,131)
Organization Expense	7,584
Penalties	(2,140)
Total	**722,874**

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 6,586,894	1
2	Discounts and Allowances for all Levels	(14,948)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,571,946	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	227,248	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 227,248	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	33	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	(1)	19
20	Radiology and X-Ray		20
21	Other Medical Services	9,268	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,300	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,058	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,058	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,399	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,399	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,811,951	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,144,807	31
32	Health Care	2,745,276	32
33	General Administration	1,428,161	33
	B. Capital Expense		
34	Ownership	950,557	34
	C. Ancillary Expense		
35	Special Cost Centers	687,508	35
36	Provider Participation Fee	324,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,280,309	40
41	**Income before Income Taxes (line 30 minus line 40)****	(468,358)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (468,358)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,034,676	44
45	Private Pay - Net Inpatient Revenue	405,786	45
46	Medicare - Net Inpatient Revenue	965,900	46
47	Other-(specify) Managed Care	165,584	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,571,946	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	2,030	2,287	$ 84,220	$ 36.83	1
2	Assistant Director of Nursing	1,588	1,660	57,556	34.67	2
3	Registered Nurses	22,734	24,398	753,832	30.90	3
4	Licensed Practical Nurses	12,378	13,214	354,456	26.82	4
5	CNAs & Orderlies	60,712	66,101	784,162	11.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,324	2,562	34,432	13.44	8
9	Activity Director	1,767	1,979	30,194	15.26	9
10	Activity Assistants	3,242	3,517	30,169	8.58	10
11	Social Service Workers	7,385	7,958	188,906	23.74	11
12	Dietician					12
13	Food Service Supervisor	1,804	1,987	35,004	17.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,699	9,287	87,424	9.41	15
16	Dishwashers	9,346	9,608	92,380	9.61	16
17	Maintenance Workers	2,573	2,786	51,438	18.46	17
18	Housekeepers	23,801	26,173	257,093	9.82	18
19	Laundry	1,590	1,686	15,473	9.18	19
20	Administrator	1,484	1,581	87,725	55.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,274	10,261	132,579	12.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,868	2,159	37,358	17.30	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	8,518	9,219	182,707	19.82	33
34	TOTAL (lines 1 - 33)	183,117	198,423	$ 3,297,108 *	$ 16.62	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	360	$ 15,112	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	52	2,344	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,774	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	146	9,481	L12, C3	45
46	Other(specify) Psychosocial	Monthly	18,000	L11,C3	46
47	Psychiatric	Monthly	2,500	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	558	$ 80,211		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

Danville Care Center

Period Beginning **1/1/2017**
Period End **12/31/2017**

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		3,035	3,355	95,524	28.47
Transportation		3,550	3,753	39,606	10.55
Marketing		1,933	2,111	47,577	22.54
	TOTAL	8,518	9,219	182,707	

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Taylor	Administrator	0	$ 17,245
Jason Young	Administrator	0	37,881
Jeremy Rieman	Administrator	0	32,599
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,725

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 187,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 187,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Service	$ 25,616
Templin Healthcare Accounting	Accounting Service	95
PayChex	Payroll Service	34,257
MPRO	Peer Review Consultants	1,850
Koralynn K Dark	Data Processing Consultant	160
Personnel Planners	Unemployment Consulting	2,330
Wescom Solutions Inc	Data Processing	48,591
Ability Network	Data Processing	4,565
On Shift	Data Processing	915
See Attached Legal Schedule	Legal Fees	12,760
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 131,139

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 149,613
Unemployment Compensation Insurance	70,859
FICA Taxes	243,644
Employee Health Insurance	139,864
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	4,003
Pension Plan Contribution	6,342
Drug Testing	1,470
TOTAL (agree to Schedule V, line 22, col.8)	$ 615,795

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	1,186
Health Care Worker Background Check	
(Indicate # of checks performed 174)	
Patient Background Checks	1,740
Dues & Subscriptions	1,475
Licenses & Permits	1,764
Allocated from Management Co.	30
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,185

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocated from Management Co.	3,715
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,715

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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? **No**
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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,411** 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. $ **324,000**
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. $ **33**

(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 1**
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