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: 0032029

Facility Name: Hickory Nursing Pavilion

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 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)
** Subject to the attached Accountants' Consulting Report*
(Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,174	101	892	10,167	8
9	SNF/PED					9
10	ICF	9,098	39		9,137	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,272	140	892	19,304	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.47%

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]

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

I. On what date did you start providing long term care at this location?
Date started 03/10/1987

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 892

Medicare Intermediary Wisonsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	159,123	22,482	5,760	187,365		187,365		187,365			1
2	Food Purchase		111,340		111,340		111,340	(8)	111,332			2
3	Housekeeping	116,058	32,778		148,836		148,836		148,836			3
4	Laundry	25,770	8,361		34,131		34,131		34,131			4
5	Heat and Other Utilities			65,840	65,840		65,840	(4,024)	61,816			5
6	Maintenance	45,481	13,592	60,103	119,176		119,176	(5,579)	113,597			6
7	Other (specify):*							254	254			7
8	TOTAL General Services	346,432	188,553	131,703	666,688		666,688	(9,357)	657,331			8
	B. Health Care and Programs											
9	Medical Director			16,506	16,506		16,506		16,506			9
10	Nursing and Medical Records	918,700	44,593	4,819	968,112		968,112		968,112			10
10a	Therapy	30,264		3,103	33,367		33,367		33,367			10a
11	Activities	61,416	1,934	1,087	64,437		64,437		64,437			11
12	Social Services	72,096		2,414	74,510		74,510		74,510			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,082,476	46,527	27,929	1,156,932		1,156,932		1,156,932			16
	C. General Administration											
17	Administrative	80,645		203,250	283,895		283,895	(131,773)	152,122			17
18	Directors Fees											18
19	Professional Services			67,900	67,900	(12,113)	55,787	(4,055)	51,732			19
20	Dues, Fees, Subscriptions & Promotions			18,137	18,137		18,137	(6,569)	11,568			20
21	Clerical & General Office Expenses	31,427	26,729	44,024	102,180		102,180	13,590	115,770			21
22	Employee Benefits & Payroll Taxes			232,541	232,541		232,541		232,541			22
23	Inservice Training & Education											23
24	Travel and Seminar			255	255		255	75	330			24
25	Other Admin. Staff Transportation			10,877	10,877		10,877	2,328	13,205			25
26	Insurance-Prop.Liab.Malpractice			104,501	104,501		104,501	1,297	105,798			26
27	Other (specify):*							27,903	27,903			27
28	TOTAL General Administration	112,072	26,729	681,485	820,286	(12,113)	808,173	(97,204)	710,969			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,540,980	261,809	841,117	2,643,906	(12,113)	2,631,793	(106,561)	2,525,232			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Hickory Nursing Pavilion #0032029 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,278	28,278		28,278	63,347	91,625			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			267	267		267	(267)				32
33	Real Estate Taxes			163,495	163,495	12,113	175,608	3,356	178,964			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles							2,616	2,616			35
36	Other (specify):*											36
37	**TOTAL Ownership**			372,040	372,040	12,113	384,153	(110,948)	273,205			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,895	99,786	129,681		129,681		129,681			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			158,454	158,454		158,454		158,454			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		29,895	258,240	288,135		288,135		288,135			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,540,980	291,704	1,471,397	3,304,081		3,304,081	(217,509)	3,086,572			45

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,696)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	26,666	30		9
10	Interest and Other Investment Income	(1,006)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,547)	21		24
25	Fund Raising, Advertising and Promotional	(491)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(602)	20		28
29	Other-Attach Schedule	(33,500)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (31,184)		$	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)	(186,325)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (186,325)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (217,509)		37

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

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

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

Hickory Nursing Pavilion

ID# 0032029

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MCA Sequester Reduction	$ (7,706)	21	1
2	Capitalized R&M	(10,015)	06	2
3	PAC Dues	(5,476)	20	3
4	Non Allowable Legal	(6,593)	19	4
5	Building Co - Accounting Fees	(1,425)	19	5
6	Building Co - Replacement Tax	(2,035)	21	6
7	Building Co - Annual Report	(250)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(33,500)		49

Hickory Nursing Pavilion

ID# 0032029

Report Period Beginning: 01/01/17

Ending: 12/31/17

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickory Nursing Pavilion **#** 0032029 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(8)											(8)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,696)		672									(4,024)	5
6	Maintenance	(10,015)		1,982	2,454								(5,579)	6
7	Other (specify):*				254								254	7
8	**TOTAL General Services**	(14,719)		2,654	2,708								(9,357)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(188,761)	56,988								(131,773)	17
18	Directors Fees													18
19	Professional Services	(8,018)	1,425	2,164		374							(4,055)	19
20	Fees, Subscriptions & Promotions	(6,819)	250										(6,569)	20
21	Clerical & General Office Expenses	(27,288)	2,035	38,843									13,590	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			75									75	24
25	Other Admin. Staff Transportation			2,328									2,328	25
26	Insurance-Prop.Liab.Malpractice			1,060		237							1,297	26
27	Other (specify):*			24,183	3,720								27,903	27
28	**TOTAL General Administration**	(42,125)	3,710	(120,108)	60,708	611							(97,204)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,844)	3,710	(117,454)	63,416	611							(106,561)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Hickory Nursing Pavilion **#** 0032029 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	26,666	35,397	150		1,134							63,347	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,006)	(4)	3		740							(267)	32
33	Real Estate Taxes					3,356							3,356	33
34	Rent-Facility & Grounds		(180,000)	6,832		(6,832)							(180,000)	34
35	Rent-Equipment & Vehicles			2,616									2,616	35
36	Other (specify):*													36
37	**TOTAL Ownership**	25,660	(144,607)	9,601		(1,602)							(110,948)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(31,184)	(140,897)	(107,853)	63,416	(991)							(217,509)	45

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 180,000	Hickory Health Care Associates	100.00%	$	$ (180,000)	1
2	V	32	Interest Income	4	Hickory Health Care Associates	100.00%		(4)	2
3	V	19	Accounting Fees		Hickory Health Care Associates	100.00%	1,425	1,425	3
4	V	30	Depreciation		Hickory Health Care Associates	100.00%	35,397	35,397	4
5	V	20	Annual Report		Hickory Health Care Associates	100.00%	250	250	5
6	V	21	ILL. RT		Hickory Health Care Associates	100.00%	2,035	2,035	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 180,004			$ 39,107	$ * (140,897)	14

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	STAYCARE MANAGEMENT, LTD.	100.00%	$ 672	$ 672	15
16	V	6	REPAIRS AND MAINT.		STAYCARE MANAGEMENT, LTD.	100.00%	1,982	1,982	16
17	V	17	ADMIN. SALARY		STAYCARE MANAGEMENT, LTD.	100.00%	14,489	14,489	17
18	V	19	PROFESSIONAL FEES		STAYCARE MANAGEMENT, LTD.	100.00%	2,164	2,164	18
19	V	21	CLERICAL & GENERAL - SALARIES		STAYCARE MANAGEMENT, LTD.	100.00%	33,626	33,626	19
20	V	21	CLERICAL & GENERAL - OTHER		STAYCARE MANAGEMENT, LTD.	100.00%	5,217	5,217	20
21	V	24	SEMINARS		STAYCARE MANAGEMENT, LTD.	100.00%	75	75	21
22	V	25	ADMIN. STAFF TRAVEL		STAYCARE MANAGEMENT, LTD.	100.00%	2,328	2,328	22
23	V	26	INSURANCE		STAYCARE MANAGEMENT, LTD.	100.00%	1,060	1,060	23
24	V	27	EMPLOYEE BENEFITS		STAYCARE MANAGEMENT, LTD.	100.00%	24,183	24,183	24
25	V	30	DEPRECIATION		STAYCARE MANAGEMENT, LTD.	100.00%	150	150	25
26	V	32	INTEREST		STAYCARE MANAGEMENT, LTD.	100.00%	3	3	26
27	V	34	BUILDING RENT		STAYCARE MANAGEMENT, LTD.	100.00%	6,832	6,832	27
28	V	35	EQUIP. RENTAL-AUTO		STAYCARE MANAGEMENT, LTD.	100.00%	2,616	2,616	28
29	V								29
30	V	17	MANAGEMENT FEE	203,250	STAYCARE MANAGEMENT, LTD.	100.00%		(203,250)	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			$ 203,250			$ 95,397	$ * (107,853)	39

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIET. COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.	100.00%	$	$	15
16	V	1	DIET. COMP - D. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%			16
17	V	6	MAINT. COMP.		STAY CARE MANAGEMENT, LTD.	100.00%	2,454	2,454	17
18	V	7	EMP. BEN. - S. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%			18
19	V	7	EMP. BEN. - D. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%			19
20	V	7	EMP. BEN. - MAINT. NON-OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	254	254	20
21	V	17	ADMIN. COMP - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	42,734	42,734	21
22	V	17	ADMIN. COMP - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	14,254	14,254	22
23	V	27	EMP. BEN. - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	2,827	2,827	23
24	V	27	EMP. BEN. - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	893	893	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			$			$ 63,416	$ * 63,416	39

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	19	PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC	100.00%	306	$ 306	15
16	V	26	INSURANCE		DOUBLE YOU REALTY, LLC	100.00%	237	237	16
17	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC	100.00%	1,134	1,134	17
18	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC	100.00%	740	740	18
19	V	19	RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC	100.00%	68	68	19
20	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC	100.00%	3,356	3,356	20
21	V								21
22	V	34	RENT	6,832	DOUBLE YOU REALTY, LLC	100.00%		(6,832)	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			$ 6,832			$ 5,841	$ * (991)	39

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Jeffrey Webster	Owner	Administrative	14.19%	See Attached	5	7.14%	Alloc Salary	$ 14,254	17-07	1
2	Howard Wengrow	Owner	Administrative	14.19%	See Attached	15	23.08%	Alloc Salary	42,734	17-07	2
3	Ephraim Braunstein	Relative	Clerical		See Attached	3.7	9.25%	Alloc Salary	7,924	21-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 64,912		13

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	208,514	6	$ 7,261	$	19,304	$ 672	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	208,514	6	21,410		19,304	1,982	2
3	17	ADMIN. SALARY	PATIENT DAYS	208,514	6	156,508	156,508	19,304	14,489	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	208,514	6	23,378		19,304	2,164	4
5	21	CLERICAL & GENERAL - SALA	PATIENT DAYS	208,514	6	363,209	363,209	19,304	33,626	5
6	21	CLERICAL & GENERAL - OTH	PATIENT DAYS	208,514	6	56,356		19,304	5,217	6
7	24	SEMINARS	PATIENT DAYS	208,514	6	810		19,304	75	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	208,514	6	25,144		19,304	2,328	8
9	26	INSURANCE	PATIENT DAYS	208,514	6	11,450		19,304	1,060	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	208,514	6	261,220		19,304	24,183	10
11	30	DEPRECIATION	PATIENT DAYS	208,514	6	1,621		19,304	150	11
12	32	INTEREST	PATIENT DAYS	208,514	6	34		19,304	3	12
13	34	BUILDING RENT	PATIENT DAYS	208,514	6	73,800		19,304	6,832	13
14	35	EQUIP. RENTAL-AUTO	PATIENT DAYS	208,514	6	28,262		19,304	2,616	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,030,464	$ 519,717		$ 95,397	25

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104			1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000			2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	4	2,454	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	928				4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,524				5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,741		4	254	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	185,182	185,182	15	42,734	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	199,550	199,550	5	14,254	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,252		15	2,827	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,502		5	893	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 482,293	$ 451,346		$ 63,416	25

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	208,514	6	3,310		19,304	306	1
2	26	INSURANCE	PATIENT DAYS	208,514	6	2,559		19,304	237	2
3	30	DEPRECIATION	PATIENT DAYS	208,514	6	12,254		19,304	1,134	3
4	32	INTEREST EXPENSE	PATIENT DAYS	208,514	6	7,994		19,304	740	4
5	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	208,514	6	735		19,304	68	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	208,514	6	36,251		19,304	3,356	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 63,103	$		$ 5,841	25

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X				$	$			$ 267	1
2	Allocated from Double You Realty		X								740	2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Staycare Management		X								3	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 1,010	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,006)	10
11	Interest Income - Bldg. Co		X								(4)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,010)	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion **#** 0032029 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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.**	$ 161,917	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.)		$ 163,658	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,741	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 76,940	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.)		$ 12,113	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** $ 19,847 **For** 2005 **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.		$ 90,794	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	132,632	8
	2013	137,763	9
	2014	155,155	10
	2015	157,201	11
	2016	160,302	12

2016 Accrual: $160,302 x 1.03 - 88,171 prepayment = $76,940
Allocated from Double You Realty = $3,356
Due to Prepayments of $88,170.89 and refunds, Line 7 (above) and page 4 line 33 do not match

	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hickory Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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.	23-02-420-008-0000	Long Term Care Property	$ 69,002.14	$ 69,002.14
2.	23-02-420-016-0000	Long Term Care Property	$ 68,969.80	$ 68,969.80
3.	23-01-302-021-0000	Long Term Care Property	$ 11,023.29	$ 11,023.29
4.	23-02-420-015-0000	Long Term Care Property	$ 8,186.81	$ 8,186.81
5.	23-02-420-007-0000	Long Term Care Property	$ 3,119.57	$ 3,119.57
6.	10-35-329-014-0000	Home Office	$ 23,388.05	$ 2,165.24
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 183,689.66	$ 162,466.85

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hickory Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	16,200	1990	$ 74,000	1
2	Allocated from Double You Realty			4,629	2
3	TOTALS	16,200		$ 78,629	3

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1990	1961	$ 1,115,000	$ 35,397	35	$ 31,857	$ (3,540)	$ 1,115,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	22,801		20			19,708	9
10	Various			1988	50,319		20			44,178	10
11	Various			1989	7,409		20			6,346	11
12	Various			1990	38,661		20			35,350	12
13	Various			1991	6,422		20			5,916	13
14	Various			1993	30,582		20			29,642	14
15	Various			1994	13,592		20			13,542	15
16	Various			1995	102,781		20			102,757	16
17	Various			1996	139,610		20			139,355	17
18	Various			1997	54,749		20	1,204	1,204	54,476	18
19	Various			1998	53,522		20	2,676	2,676	52,653	19
20	Various			1999	18,879		20	944	944	17,407	20
21	Various			2000	2,520		20	126	126	2,142	21
22	Various			2001	7,081		20	354	354	5,700	22
23	Various			2002	23,923		20			23,923	23
24	Various			2003	67,353		20	3,178	3,178	49,127	24
25	Various			2004	2,732		20	137	137	1,835	25
26	Various			2005	5,239		20			5,239	26
27	Various			2006	9,298		20	290	290	6,930	27
28	Various			2007	12,000		20	217	217	12,000	28
29	Various			2008	24,350		20	2,435	2,435	22,321	29
30	Various			2009	33,827		20	3,383	3,383	29,705	30
31	Various			2010	62,992		20	6,149	6,149	47,254	31
32	Various			2011	76,314		20	7,307	7,307	45,994	32
33	Various			2012	3,080		20	154	154	783	33
34	Various			2013	72,730		20	3,531	3,531	17,588	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		48,704	1,134		1,356	222	18,665	68
69	Financial Statement Depreciation			28,278			(28,278)		69
70	TOTAL (lines 4 thru 69)		$ 2,106,469	$ 64,809		$ 65,298	$ 489	$ 1,925,535	70

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,106,469	$ 64,809		$ 65,298	$ 489	$ 1,925,535	1
2	Fence	2014	9,976		20	665	665	2,494	2
3	Fire System Upgrades	2014	2,804		20	280	280	1,075	3
4	Patch & Paint Rms 103,105,106,108,115,117,119,122,127,129,123,1	2014	4,500		20	225	225	844	4
5	Hic Pumps For Boilers	2014	3,469		20	173	173	679	5
6	Public Bathroom Plumbing Fixtures, Tile & Flooring, Drywall	2014	17,951		20	898	898	3,216	6
7	Tuckpointing & Brickwork	2014	37,500		20	1,875	1,875	5,938	7
8	Security Cameras	2015	5,055		20	253	253	653	8
9	Boiler	2015	10,450		20	523	523	1,350	9
10	Remove Rear Entry Cove Base/Carpet, Install New Carpet, Walk	2015	2,961		20	148	148	419	10
11	Replace Leaky Pipes/Concrete & Rodding Shower Room Drain	2016	3,900		20	390	390	748	11
12	Parapet Wall Repair	2016	16,500		20	1,650	1,650	2,750	12
13	Water Heater	2016	12,310		20	1,231	1,231	1,949	13
14	Rodded Out Main Sewer From North/South End Of Building	2016	6,325		20	633	633	896	14
15	Removal/Replacement Of Facility Exterior Subsoil/Concrete	2016	4,783		20	478	478	638	15
16	Plumbing Improvement- Catch Basin	2016	13,500		20	386	386	546	16
17	Installed Electrical Improvement To Emergency System - Main Pc	2017	9,500		20	249	249	249	17
18	Installed Handrails And Bumper Guards - North Wing	2017	3,350		20	223	223	223	18
19	Removed Flooring, Replaced Piping, Reinstalled Ice Machine - Kit	2017	7,128		20	85	85	85	19
20	Installed New Control Board And Delay Card - Transformer	2017	3,906		20	781	781	781	20
21	Removed/Installed New Cove Base, Prepped Flooring - Nurses Sta	2017	3,059		20	612	612	612	21
22	Installed New Circuit Breaker And Baseboard Heater - Room 124	2017	3,050		20	153	153	153	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,288,446	$ 64,809		$ 77,208	$ 12,399	$ 1,951,832	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,288,446	$ 64,809		$ 77,208	$ 12,399	$ 1,951,832	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,288,446	$ 64,809		$ 77,208	$ 12,399	$ 1,951,832	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,288,446	$ 64,809		$ 77,208	$ 12,399	$ 1,951,832	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,288,446	$ 64,809		$ 77,208	$ 12,399	$ 1,951,832	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,288,446	$ 64,809		$ 77,208	$ 12,399	$ 1,951,832	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,288,446	$ 64,809		$ 77,208	$ 12,399	$ 1,951,832	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Double You Realty	2003	44,247	1,134	35	1,134		16,972	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare Management	2003	2,050		20	102	102	1,492	9
10	Allocated from Staycare Management	2016	2,407		20	120	120	201	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 48,704	$ 1,134		$ 1,356	$ 222	$ 18,665	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 48,704	$ 1,134		$ 1,356	$ 222	$ 18,665	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 48,704	$ 1,134		$ 1,356	$ 222	$ 18,665	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 138,669	$	$ 13,293	$ 13,293	10	$ 98,469	71
72	Current Year Purchases	10,333		743	743	10	743	72
73	Fully Depreciated Assets	310,670				10	310,670	73
74								74
75	TOTALS	$ 459,671	$	$ 14,036	$ 14,036		$ 409,882	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Staycare Manage	2012	$ 3,133	$ 150	$ 382	$ 232	5	$ 2,418	76
77										77
78										78
79										79
80	TOTALS			$ 3,133	$ 150	$ 382	$ 232		$ 2,418	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,829,880	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 64,959	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 91,625	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,666	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,364,132	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Staycare Management		$	$ 2,616	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,616	21

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 44,677	$		$ 44,677	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,083			6,083	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			49,026			49,026	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				29,895		29,895	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			$		$ 99,786	$ 29,895		$ 129,681	14

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

STATE OF ILLINOIS

Facility Name & ID Number Hickory Nursing Pavilion **#** 0032029 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 540,320	$ 582,241	1
2	Cash-Patient Deposits	53,642	53,642	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	432,796	432,796	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	147,241	147,241	6
7	Other Prepaid Expenses	2,481	2,481	7
8	Accounts Receivable (owners or related parties)		14,039	8
9	Other(specify): See Attached Schedule	1,011	1,011	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,177,491	$ 1,233,451	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,000	13
14	Buildings, at Historical Cost		1,115,000	14
15	Leasehold Improvements, at Historical Cost	846,652	846,652	15
16	Equipment, at Historical Cost	347,001	458,001	16
17	Accumulated Depreciation (book methods)	(847,349)	(1,918,501)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 346,304	$ 575,152	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,523,795	$ 1,808,603	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 159,817	$ 159,817	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,642	53,642	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	104,785	104,785	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,872	2,872	31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,940	76,940	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	59,445	59,445	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 457,501	$ 457,501	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	211,678		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 211,678	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 669,179	$ 457,501	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 854,616	$ 1,351,102	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,523,795	$ 1,808,603	48

***(See instructions.)**

Facility Name & ID Number Hickory Nursing Pavilion **#** 0032029 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 895,074	1
2	Restatements (describe):		2
3			3
4	Equity Rounding	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 895,076	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(40,460)	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)**	$ (40,460)	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)**	$ 854,616	24 *

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 3,189,391	1
2	Discounts and Allowances for all Levels	(208,365)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,981,026	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	220,546	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 220,546	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	29,518	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,116	19
20	Radiology and X-Ray	60	20
21	Other Medical Services	2,060	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 32,754	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,712	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,712	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	26,583	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,583	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,263,621	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	666,688	31
32	Health Care	1,156,932	32
33	General Administration	820,286	33
	B. Capital Expense		
34	Ownership	372,040	34
	C. Ancillary Expense		
35	Special Cost Centers	129,681	35
36	Provider Participation Fee	158,454	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,304,081	40
41	**Income before Income Taxes (line 30 minus line 40)****	(40,460)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (40,460)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,673,878	44
45	Private Pay - Net Inpatient Revenue	24,500	45
46	Medicare - Net Inpatient Revenue	282,648	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,981,026	49

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,976	2,064	$ 87,956	$ 42.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,639	2,703	81,780	30.26	3
4	Licensed Practical Nurses	12,188	13,023	353,069	27.11	4
5	CNAs & Orderlies	20,775	25,552	303,974	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,682	2,003	30,264	15.11	8
9	Activity Director	1,877	2,141	27,032	12.63	9
10	Activity Assistants	2,498	2,836	34,384	12.12	10
11	Social Service Workers	3,727	3,907	72,096	18.45	11
12	Dietician					12
13	Food Service Supervisor	1,987	2,134	40,011	18.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,214	10,231	119,112	11.64	15
16	Dishwashers					16
17	Maintenance Workers	1,980	2,106	45,481	21.60	17
18	Housekeepers	9,880	10,902	116,058	10.65	18
19	Laundry	2,151	2,313	25,770	11.14	19
20	Administrator	1,800	2,032	80,645	39.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,921	2,045	31,427	15.37	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)	2,386	2,870	91,921	32.03	33
34	TOTAL (lines 1 - 33)	78,681	88,862	$ 1,540,980 *	$ 17.34	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,760	01-03	35
36	Medical Director	Monthly	16,506	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,819	10-03	39
40	Physical Therapy Consultant	22	1,619	10a-03	40
41	Occupational Therapy Consultant	19	1,371	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	113	10a-03	43
44	Activity Consultant	21	1,087	11-03	44
45	Social Service Consultant	42	2,414	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	106	$ 33,689		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gina McCarthy	Administrator		$ 80,645
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,645

B. Administrative - Other

Description	Amount
Staycare Management - Management Fees	$ 203,250
TOTAL (agree to Schedule V, line 17, col. 3)	$ 203,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 17,672
See Attached	Legal Fees	14,454
Personnel Planners	Unemployment Consulting	869
Staycare Management, Ltd	Reimbursement Consulting	13,234
E Health Solutions	E-Charting	10,084
Sigmacare	E-Charting	5,042
Sarnoff & Baccash	Real Estate Protest Fee	6,545
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 67,900

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,342
Unemployment Compensation Insurance	23,955
FICA Taxes	114,604
Employee Health Insurance	49,589
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	1,075
Union Pension Expense	10,849
Christmas Expense	3,127
TOTAL (agree to Schedule V, line 22, col.8)	$ 232,541

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	90
Health Care Worker Background Check	
(Indicate # of checks performed 208)	
Patient Background Checks	2,079
Licenses and Fees	3,923
Dues and Subscriptions	5,476
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,568

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	255
Allocated from Staycare Management	75
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 330

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC: $10,952**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,106** 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. $ **158,454**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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