

			FOR BHF USE				

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

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.

<p>I. IDPH License ID Number: <u>0037747</u></p> <p>Facility Name: <u>Kanthak House</u></p> <p>Address: <u>724 2nd Avenue</u> <u>Ottawa</u> <u>61350</u> Number City Zip Code</p> <p>County: <u>LaSalle</u></p> <p>Telephone Number: <u>(815) 434-4444</u> Fax # <u>(815) 434-4565</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>01/28/92</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"> <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)3</u> </td> <td style="border: none;"> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other </td> <td style="border: none;"> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)3</u>	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>4/1/2016</u> to <u>3/31/2017</u> 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.</p> <p align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:15%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;"> (Signed) _____ (Type or Print Name) <u>Lisa Winnett</u> (Title) <u>Director of Operations</u> </td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;"> (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # () </td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Lisa Winnett</u> (Title) <u>Director of Operations</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Lisa Winnett</u> (Title) <u>Director of Operations</u>										
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()										

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kanthak House

0037747 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,529			5,529	13
14	TOTALS	5,529			5,529	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.67%

D. How many bed reserve days during this year were paid by the Department?
111 (Do not include bed reserve days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 02/06/92

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/13/92 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 3/31/2017 Fiscal Year: 3/31/2017

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

Facility Name & ID Number Kanthak House # 0037747 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	39,153	3,659	1,289	44,101		44,101		44,101		1
2	Food Purchase		41,610		41,610		41,610		41,610		2
3	Housekeeping	21,754	4,678		26,432		26,432		26,432		3
4	Laundry		3,371		3,371		3,371		3,371		4
5	Heat and Other Utilities			15,841	15,841		15,841		15,841		5
6	Maintenance	4,524	9,833	13,009	27,366		27,366		27,366		6
7	Other (specify):*										7
8	TOTAL General Services	65,431	63,151	30,139	158,721		158,721		158,721		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	122,609	7,527	17,044	147,180		147,180		147,180		10
10a	Therapy										10a
11	Activities		1,903	1,693	3,596		3,596		3,596		11
12	Social Services										12
13	CNA Training	2,107			2,107		2,107		2,107		13
14	Program Transportation			5,562	5,562		5,562		5,562		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	124,716	9,430	26,699	160,845		160,845		160,845		16
	C. General Administration										
17	Administrative	5,594			5,594		5,594		5,594		17
18	Directors Fees							1,676	1,676		18
19	Professional Services			67,014	67,014		67,014	5,680	72,694		19
20	Dues, Fees, Subscriptions & Promotions			1,886	1,886		1,886	7	1,893		20
21	Clerical & General Office Expenses	17,234	5,464	5,932	28,630		28,630	7	28,637		21
22	Employee Benefits & Payroll Taxes			31,830	31,830		31,830	1	31,831		22
23	Inservice Training & Education			4,030	4,030		4,030		4,030		23
24	Travel and Seminar			164	164		164		164		24
25	Other Admin. Staff Transportation			1,903	1,903		1,903		1,903		25
26	Insurance-Prop.Liab.Malpractice			4,723	4,723		4,723	1,918	6,641		26
27	Other (specify):*										27
28	TOTAL General Administration	22,828	5,464	117,482	145,774		145,774	9,289	155,063		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	212,975	78,045	174,320	465,340		465,340	9,289	474,629		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number

Kanthak House

#0037747

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			41,347	41,347		41,347		41,347			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,377	1,377		1,377		1,377			35
36	Other (specify):*											36
37	TOTAL Ownership			42,724	42,724		42,724		42,724			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			40,028	40,028		40,028		40,028			42
43	Other (specify):* Disallowed Costs			108	108		108	(108)				43
44	TOTAL Special Cost Centers			40,136	40,136		40,136	(108)	40,028			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	212,975	78,045	257,180	548,200		548,200	9,181	557,381			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Kanthak House**

0037747

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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				24
25	Fund Raising, Advertising and Promotional	(108)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (108)		\$	30

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	2	
		Amount	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)	9,289		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 9,289		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 9,181		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Kanthak House

ID# 0037747

Report Period Beginning: 4/1/2016

Ending: 3/31/3017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Frances House, Inc.	100	Frances House, Inc. (FH)		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Residential Alternatives of Illinois, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	18 Director Fees	\$	Frances House, Inc.	100.00%	\$ 1,676	\$ 1,676	1	
2	V	19 Professional Services		Frances House, Inc.	100.00%	5,680	5,680	2	
3	V	26 Property Insurance		Frances House, Inc.	100.00%	1,918	1,918	3	
4	V	20 Dues, Fees & Subscriptions		Frances House, Inc.	100.00%	7	7	4	
5	V	21 Clerical & General Office Exp		Frances House, Inc.	100.00%	7	7	5	
6	V	22 Employee Benefits		Frances House, Inc.	100.00%	1	1	6	
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$			\$ 9,289	\$ *	9,289	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

Facility Name & ID Number

Kanthak House

0037747

Report Period Beginning:

4/1/2016

Ending:

3/31/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule 7A								\$ 1,676	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,676		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kanthak House

0037747

Report Period Beginning:

4/1/2016

Ending: 3/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Frances House, Inc.
 Street Address 285 S. Farnham
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309) 343-1550
 Fax Number (309) 343-2857

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	Director Fees	Bed Days Avail-FH only	3,168	17	\$ 27,652	\$ 192	\$ 1,676	1
2	19	Professional Services	Bed Days Avail-FH only	3,168	17	93,710	\$ 192	5,680	2
3	26	Property Insurance	Bed Days Avail-FH only	3,168	17	31,641	192	1,918	3
4	20	Dues, Fees & Subscriptions	Bed Days Available	5,916	33	207	192	7	4
5	21	Clerical & General Office Exp	Bed Days Available	5,916	33	211	192	7	5
6	22	Employee Benefits	Bed Days Available	5,916	33	26	192	1	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					\$ 153,447	\$	\$ 9,289	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Kanthak House

0037747

Report Period Beginning:

4/1/2016

Ending:

3/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.

\$ **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.)

\$ **2**

3. Under or (over) accrual (line 2 minus line 1).

\$ **3**

4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **4**

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ **5**

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ **6**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>N/A</u>	<u>8</u>
	2013	<u>N/A</u>	<u>9</u>
	2014	<u>N/A</u>	<u>10</u>
	2015	<u>N/A</u>	<u>11</u>
	2016	<u>N/A</u>	<u>12</u>

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	\$ <u> </u> 13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u> 14
15	LESS REFUND FROM LINE 6	\$ <u> </u> 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u> 16

The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Kanthak House COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0037747

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Kanthak House

0037747 Report Period Beginning:

4/1/2016 Ending:

3/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (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 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>49,200</u>	<u>1997</u>	<u>\$ 30,600</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	49,200		\$ 30,600	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Kanthak House**

0037747

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1997	1992	\$ 631,210	\$ 25,242	30	\$ 25,242		\$ 507,059	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Garage		1992	10,000		15			10,000	9
10	Parking Lot & Sidewalks		1997	21,000		15			21,000	10
11	Mixing Valve		2004	1,077	71	15	71		910	11
12	Carpet/Vinyl		2008	3,769		8			3,769	12
13	Roof		2009	19,610	1,960	10	1,960		14,708	13
14	Bathroom Remodel (plumbing, vanity, shower, tub, paint, prime, file)		2010	108,889	7,259	15	7,259		50,815	14
15	Goodman AC units with new coils		2011	2,850	284	10	284		1,639	15
16	Furnaces - 2		2012	4,350	290	15	290		1,258	16
17	Kitchen Remodel-Ceiling/Vinyl Tile/Baseboards/Cabinets/Counters		2016	17,995	625	12	625		625	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$ 820,750		\$ 35,731	\$	\$ 611,783	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number **Kanthak House**

0037747

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

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	\$ 74,482	\$ 5,616	\$ 5,616	\$	3-15 yrs	\$ 31,499	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 74,482	\$ 5,616	\$ 5,616	\$		\$ 31,499	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2004 GMC G350 Van	2005	\$ 38,500	\$	\$	\$	4	\$ 38,500	76
77										77
78										78
79										79
80	TOTALS			\$ 38,500	\$	\$	\$		\$ 38,500	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)	\$ 964,332	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,347	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,347	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 681,782	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	1992 Ford Van - 1993	\$ 12,600	\$	\$ 12,600	86
87	2003 Ford Van - 2003	19,500		19,500	87
88					88
89					89
90					90
91	TOTALS	\$ 32,100	\$	\$ 32,100	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A- Facility Owned

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

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 _____.

N/A

N/A

9. Option to Buy: YES NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 1,377 Description: Miscellaneous

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>138</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		2,107		2,107
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,107	\$	\$ 2,107
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,107		

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$				\$								1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													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			\$				\$		\$				\$		14

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

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **3/31/3017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>9,000</u>)	34,976	34,976	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	2,568,636	2,568,636	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,603,612	\$ 2,603,612	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,600	30,600	13
14	Buildings, at Historical Cost	820,750	820,750	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	145,082	112,982	16
17	Accumulated Depreciation (book methods)	(713,882)	(681,782)	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)	\$ 282,550	\$ 282,550	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,886,162	\$ 2,886,162	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,042	\$ 5,042	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	4,233	4,233	30
31	Accrued Taxes Payable (excluding real estate taxes)	282	282	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,557	\$ 9,557	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,557	\$ 9,557	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,876,605	\$ 2,876,605	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,886,162	\$ 2,886,162	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,729,857	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(164)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,729,693	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	146,912	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)	\$ 146,912	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)	\$ 2,876,605	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 692,705	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 692,705	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	2,107	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,107	23
D. Non-Operating Revenue			
24	Contributions	125	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 125	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income	175	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 175	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 695,112	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	158,721	31
32	Health Care	160,845	32
33	General Administration	145,774	33
B. Capital Expense			
34	Ownership	42,724	34
C. Ancillary Expense			
35	Special Cost Centers	108	35
36	Provider Participation Fee	40,028	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 548,200	40
41	Income before Income Taxes (line 30 minus line 40)**	146,912	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 146,912	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 692,705	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 692,705	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Kanthak House

0037747

Report Period Beginning:

4/1/2016

Ending:

3/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses				3	
4	Licensed Practical Nurses				4	
5	CNAs & Orderlies	9,265	9,978	94,058	9.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,619	3,619	39,153	10.82	15
16	Dishwashers					16
17	Maintenance Workers	406	440	4,524	10.28	17
18	Housekeepers	2,005	2,211	21,754	9.84	18
19	Laundry					19
20	Administrator	210	281	5,594	19.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,634	1,714	17,234	10.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,856	1,900	30,658	16.14	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)					33
34	TOTAL (lines 1 - 33)	18,995	20,143	\$ 212,975 *	\$ 10.57	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 1,289	L1, C3	35
36	Medical Director	Monthly	2,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	11,112	L10, C3	38
39	Pharmacist Consultant	Monthly	1,177	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental</u>	Monthly	340	L10, C3	46
47	<u>Psychological Consultant</u>	Monthly	4,415	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,733		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Kimberly Kersmarki-Clakl</u>	<u>Administrator</u>	<u>None</u>	\$ <u>5,594</u>	<u>Workers' Compensation Insurance</u>	\$ <u>3,428</u>	<u>IDPH License Fee</u>	\$ _____	
				<u>Unemployment Compensation Insurance</u>		<u>Advertising: Employee Recruitment</u>	_____ <u>200</u>	
				<u>FICA Taxes</u>	_____ <u>16,168</u>	<u>Health Care Worker Background Check</u>	_____ <u>300</u>	
				<u>Employee Health Insurance</u>	_____ <u>9,404</u>	(Indicate # of checks performed <u>30</u>)		
				<u>Employee Meals</u>	_____ <u>1,178</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>				
				<u>401k</u>	_____ <u>734</u>	<u>Subscriptions</u>	_____ <u>474</u>	
				<u>Other Employee Benefits</u>	_____ <u>918</u>	<u>IHCA Dues</u>	_____ <u>912</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>5,594</u>			<u>Other Licenses & Fees</u>		
(List each licensed administrator separately.)						<u>Indirect costs</u>	_____ <u>7</u>	
B. Administrative - Other				<u>Indirect costs</u>	_____ <u>1</u>	<u>Less: Public Relations Expense</u>	(_____)	
Description			Amount				<u>Non-allowable advertising</u>	(_____)
<u>N/A</u>			\$ _____				<u>Yellow page advertising</u>	(_____)
				TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>31,831</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ _____				TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>1,893</u>
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Amount	
Vendor/Payee	Type	Amount		Line #	Amount			
<u>RFMS, Inc.</u>	<u>Administrative Services</u>	\$ <u>33,990</u>			\$ _____		<u>Out-of-State Travel</u>	
<u>LTC Support Services, LLC</u>	<u>Support Services</u>	_____ <u>26,448</u>		<u>N/A</u>				
<u>McGladrey LLP</u>	<u>Accounting Services</u>	_____ <u>2,321</u>						
<u>Templin Healthcare Accounting</u>	<u>Accounting Services</u>	_____ <u>1,001</u>					<u>In-State Travel</u>	
<u>Polsinelli</u>	<u>Legal Services</u>	_____ <u>3,254</u>						
							<u>Seminar Expense</u>	
							_____ <u>164</u>	
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>67,014</u>	TOTAL			\$ _____	<u>Entertainment Expense</u>
(For legal fee disclosure, see page 39 of instructions)							(_____)	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							_____ <u>164</u>	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Kanthak House# 0037747Report Period Beginning: 4/1/2016Ending: 3/31/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 912 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,495 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,028
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. \$ 1,178 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? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (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

SEE ACCOUNTANTS' PREPARATION REPORT