FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0032862

Facility Name: Danville Care Center

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

County: Vermilion

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,110	3,110	8
9	SNF/PED					9
10	ICF	35,506	1,833		37,339	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,506	1,833	3,110	40,449	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.41%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/1/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 2,889

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	231,107	24,574	14,452	270,133		270,133		270,133			1
2	Food Purchase		264,934		264,934		264,934		264,934			2
3	Housekeeping	278,553	39,756		318,309		318,309		318,309			3
4	Laundry	15,980	46,008		61,988		61,988		61,988			4
5	Heat and Other Utilities			178,602	178,602		178,602	1,696	180,298			5
6	Maintenance	51,340	66,767	25,350	143,457		143,457	2,382	145,839			6
7	Other (specify):* Waste Disposal			11,889	11,889		11,889		11,889			7
8	TOTAL General Services	576,980	442,039	230,293	1,249,312		1,249,312	4,078	1,253,390			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,947,293	189,198	12,149	2,148,640		2,148,640	88,777	2,237,417			10
10a	Therapy	26,282			26,282		26,282		26,282			10a
11	Activities	57,106		2,592	59,698		59,698		59,698			11
12	Social Services	178,063		1,004	179,067		179,067		179,067			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							13,448	13,448			15
16	TOTAL Health Care and Programs	2,208,744	189,198	39,745	2,437,687		2,437,687	102,225	2,539,912			16
	C. General Administration											
17	Administrative	103,506		402,062	505,568		505,568	(316,128)	189,440			17
18	Directors Fees											18
19	Professional Services			161,737	161,737		161,737	(2,208)	159,529			19
20	Dues, Fees, Subscriptions & Promotions			15,960	15,960		15,960	1,909	17,869			20
21	Clerical & General Office Expenses	144,762	39,749	29,895	214,406		214,406	146,619	361,025			21
22	Employee Benefits & Payroll Taxes			540,707	540,707		540,707		540,707			22
23	Inservice Training & Education			6,179	6,179		6,179		6,179			23
24	Travel and Seminar			10,902	10,902		10,902	2,899	13,801			24
25	Other Admin. Staff Transportation			16,107	16,107		16,107	4,819	20,926			25
26	Insurance-Prop.Liab.Malpractice			239,783	239,783		239,783	2,033	241,816			26
27	Other (specify):*							32,504	32,504			27
28	TOTAL General Administration	248,268	39,749	1,423,332	1,711,349		1,711,349	(127,553)	1,583,796			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,033,992	670,986	1,693,370	5,398,348		5,398,348	(21,250)	5,377,098			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Danville Care Center #0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			192,000	192,000		192,000	(70,232)	121,768			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			133,307	133,307		133,307	122,607	255,914			32
33	Real Estate Taxes			70,580	70,580		70,580		70,580			33
34	Rent-Facility & Grounds			550,000	550,000		550,000	(538,491)	11,509			34
35	Rent-Equipment & Vehicles			35,262	35,262		35,262	1,324	36,586			35
36	Other (specify):*											36
37	**TOTAL Ownership**			981,149	981,149		981,149	(484,792)	496,357			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,091	434,220	505,311		505,311		505,311			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			342,000	342,000		342,000		342,000			42
43	Other (specify):* See Att Sch 4A	44,958		70,694	115,652		115,652	(106,420)	9,232			43
44	**TOTAL Special Cost Centers**	44,958	71,091	846,914	962,963		962,963	(106,420)	856,543			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,078,950	742,077	3,521,433	7,342,460		7,342,460	(612,462)	6,729,998			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Danville Care Center

Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			3,095	3,095		3,095		3,095			
	Radiology Expenses			6,137	6,137		6,137		6,137			
	Non-Allowable Expenses	44,958		16,504	61,462		61,462	(61,462)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	44,958	0	25,736	70,694	0	70,694	(61,462)	9,232			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	(17,429)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(256,232)	30		9
10	Interest and Other Investment Income	(915)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(130)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,492)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,387)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,756)	43		24
25	Fund Raising, Advertising and Promotional	(15,660)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(995)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(49,004)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (372,000)		$	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)	(240,462)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (240,462)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (612,462)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Danville Care Center

ID# 0032862

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Wages	$ (44,958)	43	1
2	Marketer Car Lease	(4,773)	35	2
3	Offset Miscellaneous Income	(1,423)	21	3
4	Expense Capitalized Repairs	2,150	6	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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**	(49,004)		49

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rita L. Geller	38.044%	Glenwood Healthcare & Rehab	Glenwood	Danville Care	Skokie	Lessor
Bradley M. Alter	22.826%	Renaissance Care Center	Canton	Center Property, LLC		
ESBT Jennifer T. W. Chow	19.565%			Certified Health	Skokie	Management
ESBT Julie Brum	19.565%			Management, Inc.		

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	30	Depreciation	$	Danville Care Center Property LLC	100.00%	$ 186,000	$ 186,000	1
2	V	32	Interest		Danville Care Center Property LLC	100.00%	116,684	116,684	2
3	V	32	Amortization Expense		Danville Care Center Property LLC	100.00%	6,838	6,838	3
4	V	34	Rent-Facility & Grounds	550,000	Danville Care Center Property LLC	100.00%		(550,000)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 550,000			$ 309,522	$ * (240,478)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	$	Certified Health Management, Inc.	100.00%	$ 1,696	$ 1,696	15
16	V	6	Maintenance		Certified Health Management, Inc.	100.00%	232	232	16
17	V	10	Nursing and Medical Records		Certified Health Management, Inc.	100.00%	88,777	88,777	17
18	V	15	Emp Benefit Alloc-Healthcare		Certified Health Management, Inc.	100.00%	13,448	13,448	18
19	V	17	Administrative	402,062	Certified Health Management, Inc.	100.00%	85,934	(316,128)	19
20	V	19	Professional Services		Certified Health Management, Inc.	100.00%	2,179	2,179	20
21	V	20	Dues, Fees, Subs & Promo		Certified Health Management, Inc.	100.00%	1,909	1,909	21
22	V	21	Clerical & Gen Office Expenses		Certified Health Management, Inc.	100.00%	148,042	148,042	22
23	V	24	Travel and Seminar		Certified Health Management, Inc.	100.00%	2,899	2,899	23
24	V	25	Other Admin Staff Transportation		Certified Health Management, Inc.	100.00%	4,819	4,819	24
25	V	26	Ins.-Prop, Liab, Malpractice		Certified Health Management, Inc.	100.00%	2,033	2,033	25
26	V	27	Emp Benefit Alloc-Gen Admin		Certified Health Management, Inc.	100.00%	32,504	32,504	26
27	V	34	Rent-Facility & Grounds		Certified Health Management, Inc.	100.00%	11,509	11,509	27
28	V	35	Rent-Equipment & Vehicle		Certified Health Management, Inc.	100.00%	6,097	6,097	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			$ 402,062			$ 402,078	$ * 16	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Bradley Alter	Owner	Administration	22.826%	See Att Sch 7A	15.35	30.70	Alloc. Salary	56,778	L17, C7	1
2	Zev Geller	Relative	Clerical	0.00	See Att Sch 7A	12.28	30.69	Alloc. Salary	20,716	L21, C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										9
10	anticipated to be considered allowable by the IL. Dept. of HFS.										10
11											11
12											12
13								TOTAL	$ 77,494		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Census Days	131,793	3	$ 5,526	$	40,449	$ 1,696	1
2	6	Maintenance	Census Days	131,793	3	755		40,449	232	2
3	10	Nursing and Medical Records	Census Days	131,793	3	289,259	289,259	40,449	88,777	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	131,793	3	43,817		40,449	13,448	4
5	17	Administrative	Census Days	131,793	3	279,995	279,995	40,449	85,934	5
6	19	Professional Services	Census Days	131,793	3	7,100		40,449	2,179	6
7	20	Dues, Fees, Subs & Promo	Census Days	131,793	3	6,220		40,449	1,909	7
8	21	Clerical & Gen Office Expenses	Census Days	131,793	3	482,357	419,164	40,449	148,042	8
9	24	Travel and Seminar	Census Days	131,793	3	9,445		40,449	2,899	9
10	25	Other Admin Staff Transportatior	Census Days	131,793	3	15,701		40,449	4,819	10
11	26	Ins.-Prop, Liab, Malpractice	Census Days	131,793	3	6,623		40,449	2,033	11
12	27	Emp Benefit Alloc-Gen Admin	Census Days	131,793	3	105,906		40,449	32,504	12
13	34	Rent-Facility & Grounds	Census Days	131,793	3	37,500		40,449	11,509	13
14	35	Rent-Equipment & Vehicle	Census Days	131,793	3	19,864		40,449	6,097	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,310,068	$ 988,418		$ 402,078	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Mortgage			$ 2,500,000	$ 2,270,418		0.0500	$ 116,684	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				1,042,141		0.0550	131,425	6
7	Insurance Financing										1,182	7
8	Brickyard Bank/Charles Schwab										700	8
9	TOTAL Facility Related						$ 2,500,000	$ 3,312,559			$ 249,991	9
	B. Non-Facility Related*											
10												10
11												11
12								Offset Interest Income			(915)	12
13								Amortization Expense			6,838	13
14	TOTAL Non-Facility Related						$	$			$ 5,923	14
15	TOTALS (line 9+line14)						$ 2,500,000	$ 3,312,559			$ 255,914	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 70,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2017	$ 69,940	2
3. Under or (over) accrual (line 2 minus line 1).		$ (60)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,640	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.		$ 70,580	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	79,510	8
	2014	81,648	9
	2015	67,231	10
	2016	70,646	11
	2017	69,940	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Danville Care Center COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0032862

CONTACT PERSON REGARDING THIS REPORT Brad Alter

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

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-33-200-016-0060	Long Term Care Property	$ 41,264.88	$ 41,264.88
2.	18-34-100-005-0060	Long Term Care Property	$ 28,675.60	$ 28,675.60
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,940.48	$ 69,940.48

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1987	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1987	1974	$ 2,954,225	$		$	$	$ 2,954,225	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	34,167		20			34,167	9
10	Various			1990	17,344		20			17,344	10
11	Various			1991	45,376		20			45,376	11
12	Various			1992	12,043		20			12,043	12
13	Various			1993	9,213		20			9,213	13
14	Various			1994	8,304		20			8,304	14
15	Various			1995	39,047		20			39,047	15
16	Various			1996	44,007		20			44,007	16
17	Various			1997	28,811		20			28,811	17
18	Various			1998	394,658		20			394,658	18
19	Various			1999	42,329		20	2,116	2,116	41,269	19
20	Various			2000	51,980		20	2,599	2,599	48,243	20
21	Various			2001	1,377		20	69	69	1,205	21
22	Various			2002	11,592		20	580	580	9,347	22
23	Various			2003	122,592		20	6,130	6,130	95,023	23
24	Various			2004	68,558		20	3,428	3,428	49,228	24
25	Various			2005	83,307		20	4,165	4,165	56,450	25
26	Various			2006	46,793		20	2,340	2,340	29,385	26
27	Various			2007	6,180		20	309	309	3,708	27
28	Various			2008	10,918		20	546	546	5,802	28
29	Various			2009	68,627		20	3,431	3,431	42,149	29
30	Various			2011	24,148		20	1,207	1,207	20,991	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Rooftop A/C Units - Lennox	2012	$ 8,421	$	20	$ 421	$ 421	$ 2,947	37
38	Light Fixtures & Corner Guards	2012	3,402		20	170	170	2,665	38
39	Millwork, Plumbing, Paint, Wallcovering, Handrails, Corner Gua	2012	281,764		20	14,088	14,088	244,195	39
40	Sprinkler System	2012	128,750		20	6,438	6,438	40,772	40
41	Replaced Failed Compressor	2012	2,773		20	139	139	845	41
42	Hot Water Boiler System Storage Tank, Temperature Gauge, And	2013	2,695		20	135	135	697	42
43	Outlets For Kiosks	2013	9,341		20	467	467	6,383	43
44	Lennox Gas/Electric Rooftop Unit	2013	17,354		20	868	868	4,556	44
45	Hot Water Storage Tank	2013	5,475		20	274	274	1,415	45
46	Birch Wood Doors (6) And Installation	2013	3,273		20	164	164	887	46
47	4,345 Sq Ft Of Facility Roof	2014	35,009		20	1,750	1,750	8,022	47
48	Hallway Carpets/Baroque Modular Plush/ Vinyl Mouldings/Base	2014	31,256		20	1,563	1,563	14,066	48
49	Driveway Upgrade	2014	3,055		20	153	153	714	49
50	Drywall Rooms' Ceilings & Admin Offices	2014	4,500		20	225	225	938	50
51	Parking Lot Seal Coat	2014	4,597		20	230	230	1,048	51
52	Roof Powerwash, Scrubbing & Application Of Coating	2014	4,615		20	231	231	981	52
53	Concrete Work	2014	3,055		20	153	153	650	53
54	Fence Project	2015	5,652		20	283	283	1,037	54
55	Heat/Cool Units 230V Qty.5	2015	3,230		20	162	162	917	55
56	Code Alert System-Wandering Management Solution	2015	7,441		20	372	372	1,984	56
57	South Wing Dining Room Metrofloor Tile/Vinyl Planking	2015	8,507		20	425	425	1,842	57
58	Painting Trim, Shutters, Roof Vents, Etc	2015	6,000		20	300	300	1,200	58
59	Replace Doors (4)	2016	10,177		20	509	509	1,527	59
60	50 Gallon Water Heater	2016	10,375		20	519	519	1,557	60
61	PTACS (14)	2018	9,364		20	234	234	234	61
62	Install Security Door and Gate	2018	10,146		20	254	254	254	62
63	Install New Furnace Condensor	2018	6,100		20	153	153	153	63
64	Generator Repair	2018	3,623		20	91	91	91	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,755,546	$		$ 57,691	$ 57,691	$ 4,332,572	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,755,546	$		$ 57,691	$ 57,691	$ 4,332,572	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements (Real Estate Entity):								8
9	Parking Lot Paving	2011	108,929		20	5,446	5,446	43,568	9
10	Nurse Call Station	2015	63,648		20	3,182	3,182	11,728	10
11	South Wing Renovation-Flooring, Lighting, Plumbing, Signage								11
12	Valances, Acrovyn, Handrails, Grab Bars	2016	281,598		20	14,080	14,080	42,240	12
13	Glass Dividers	2016	7,200		20	360	360	360	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	Allocated from Certified Health Management	1997	29,595		20			29,595	25
26	Allocated from Certified Health Management	2014	8,321		20	416	416	2,289	26
27									27
28									28
29									29
30	Financial Statement Depreciation			192,000			(192,000)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,254,837	$ 192,000		$ 81,175	$ (110,825)	$ 4,462,352	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 398,477	$	$ 39,848	$ 39,848	10	$ 324,088	71
72	Current Year Purchases	9,201		460	460	10	460	72
73	Fully Depreciated Assets	930,747					930,747	73
74								74
75	TOTALS	$ 1,338,425	$	$ 40,308	$ 40,308		$ 1,255,295	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		2006 Ford F-350	2011	$ 17,072	$	$ 285	$ 285	5	$ 17,072	76
77										77
78										78
79										79
80	TOTALS			$ 17,072	$	$ 285	$ 285		$ 17,072	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,960,334	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 192,000	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 121,768	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (70,232)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,734,719	85	

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				11,509			5
6								6
7	TOTAL				$ 11,509 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 13,232 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Shuttle	Ford Challenger 2014	$ 899.00	$ 10,788	17
18	Patient Shuttle	Ford E350 2005	592.83	7,114	18
19					19
20	Allocated from Management Co.			5,452	20
21	TOTAL		$ 1,492	$ 23,354	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Danville Care Center**
IDPH License ID Number: **0032862**
Fiscal Year End: **12/31/2018**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	10,430
Dishwasher	2,157
Allocated from Mgmt Co	645
Total - Line 16	**13,232**

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$		$ 186,973	$		$ 186,973	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			20,720			20,720	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs			226,527	1,340		227,867	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				69,751		69,751	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			$		$ 434,220	$ 71,091		$ 505,311	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 162,589	$ 169,515	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 267,104)	1,591,863	1,591,863	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,240	122,240	6
7	Other Prepaid Expenses	131,694	131,694	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(615)	(615)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,007,771	$ 2,014,697	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		2,954,225	14
15	Leasehold Improvements, at Historical Cost	1,833,003	2,300,612	15
16	Equipment, at Historical Cost	1,016,348	1,355,497	16
17	Accumulated Depreciation (book methods)	(2,213,383)	(5,734,719)	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):	59,873	59,873	22
23	Other(specify): Loan Costs, Net		15,574	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 695,841	$ 1,301,062	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,703,612	$ 3,315,759	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,745,632	$ 1,745,632	26
27	Officer's Accounts Payable	431,020	431,020	27
28	Accounts Payable-Patient Deposits	10,500	10,500	28
29	Short-Term Notes Payable	1,042,141	1,042,141	29
30	Accrued Salaries Payable	209,825	209,825	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,227	12,227	31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,640	70,640	32
33	Accrued Interest Payable		2,434	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Deferred Rent	147,375	147,375	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,669,360	$ 3,671,794	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,270,418	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Payable	3,257,891	5,667,320	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,257,891	$ 7,937,738	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,927,251	$ 11,609,532	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,223,639)	$ (8,293,773)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,703,612	$ 3,315,759	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,691,223)	1
2	Restatements (describe):		2
3	See Attached Schedule 18A	(361,994)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,053,217)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(170,422)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (170,422)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,223,639)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Danville Care Center**
IDPH License ID Number: **0032862**
Fiscal Year End: **12/31/2018**

Schedule 18A

XVI. Statement of Changes in Equity
Line 2 Restatements

Description	Amount
Adjustment to Retained Earning	(128,753)
Income Adjustments	3,170
Provider Tax	(19,128)
Bad Debt Expense	(253,639)
Repairs & Maint	(20,792)
Bank Charges	(4,825)
Rent	(3,800)
Real Estate Taxes	(17,654)
Interest Expense	22,369
Depreciation	52,785
Amortization Expense	8,273
Total	**(361,994)**

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,987,817	1
2	Discounts and Allowances for all Levels	(22,770)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,965,047	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	198,007	6
7	Oxygen	36	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 198,043	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	955	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	372	19
20	Radiology and X-Ray	165	20
21	Other Medical Services	5,118	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,610	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	915	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 915	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	1,423	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,423	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,172,038	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,249,312	31
32	Health Care	2,437,687	32
33	General Administration	1,711,349	33
	B. Capital Expense		
34	Ownership	981,149	34
	C. Ancillary Expense		
35	Special Cost Centers	620,963	35
36	Provider Participation Fee	342,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,342,460	40
41	**Income before Income Taxes (line 30 minus line 40)****	(170,422)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (170,422)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,099,543	44
45	Private Pay - Net Inpatient Revenue	385,979	45
46	Medicare - Net Inpatient Revenue	1,378,370	46
47	Other-(specify) Managed Care	101,155	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,965,047	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	666	666	$ 31,368	$ 47.10	1
2	Assistant Director of Nursing	1,875	2,080	71,793	34.52	2
3	Registered Nurses	19,763	21,210	655,322	30.90	3
4	Licensed Practical Nurses	11,602	12,385	332,216	26.82	4
5	CNAs & Orderlies	55,625	60,995	725,807	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,955	1,774	26,282	14.82	8
9	Activity Director	1,780	2,005	27,070	13.50	9
10	Activity Assistants	3,142	3,261	30,036	9.21	10
11	Social Service Workers	7,345	7,884	142,411	18.06	11
12	Dietician					12
13	Food Service Supervisor	1,606	1,732	35,213	20.33	13
14	Head Cook	7,925	8,075	77,518	9.60	14
15	Cook Helpers/Assistants	8,901	9,151	118,376	12.94	15
16	Dishwashers					16
17	Maintenance Workers	2,450	2,653	51,340	19.35	17
18	Housekeepers	22,705	25,026	278,553	11.13	18
19	Laundry	1,514	1,606	15,980	9.95	19
20	Administrator	1,945	2,080	103,506	49.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,684	8,387	144,762	17.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,508	1,668	41,554	24.91	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	8,011	8,700	169,843	19.52	33
34	TOTAL (lines 1 - 33)	168,002	181,338	$ 3,078,950 *	$ 16.98	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	588	$ 14,452	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	34	2,394	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,755	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	1,156	7,004	L12, C3	45
46	Other(specify) Psychosocial	Monthly	(6,000)	L12,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,778	$ 50,605		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Danville Care Center

Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		2,735	3,046	89,233	29.30
Transportation		3,381	3,574	35,652	9.98
Marketing		1,895	2,080	44,958	21.61
	TOTAL	8,011	8,700	169,843	

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathy Murphy	Administrator	0	$ 30,300
Jeremy Rieman	Administrator	0	73,206
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,506

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 402,062
TOTAL (agree to Schedule V, line 17, col. 3)	$ 402,062
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Service	$ 25,200
Templin Healthcare Accounting	Accounting Service	3,175
PayChex/Paycor	Payroll Service	26,731
Transworld Systems, Inc.	Billing Service	1,042
MPRO	Peer Review Consultants	1,535
Personnel Planners	Unemployment Consulting	1,305
Wescom Solutions Inc	Data Processing	48,065
Availity	Data Processing	6,522
Health Technologies	Web Based Menu	540
On Shift	Data Processing	300
Ernesto Hufana	Recruitmrnt Fee	9,833
See Attached Legal Schedule	Legal Fees	37,489
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 161,737

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,643
Unemployment Compensation Insurance	54,006
FICA Taxes	228,314
Employee Health Insurance	140,529
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	8,710
Pension Plan Contribution	5,038
Drug Testing	1,467
TOTAL (agree to Schedule V, line 22, col.8)	$ 540,707

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,419
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 149	1,486
Dues & Subscriptions	3,750
Licenses & Permits	3,305
Allocated from Management Co.	1,909
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,869

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,902
Seminar Expense	
Allocated from Management Co.	2,899
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,801

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,347** 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. $ **342,000**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **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 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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