



Facility Name & ID Number Hawthorne Inn of Danville

# 0046367 Report Period Beginning: 04/01/2008 Ending: 03/31/2009

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	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	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	76	Sheltered Care (SC)	76	27,740	5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	3,478	10,917	6,308	20,703	8	
9	SNF/PED					9	
10	ICF		0			10	
11	ICF/DD					11	
12	SC		23,082		23,082	12	
13	DD 16 OR LESS					13	
14	TOTALS	3,478	33,999	6,308	43,785	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.68%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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 07/01/03

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 07/01/03 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 64 and days of care provided 6,301

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 03/31/09 Fiscal Year: 03/31/09

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

Facility Name & ID Number Hawthorne Inn of Danville # 0046367 Report Period Beginning: 04/01/2008 Ending: 03/31/2009

**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
	<b>A. General Services</b>										
1	Dietary	206,807	25,289	4,290	236,386		236,386		236,386		1
2	Food Purchase		319,487		319,487		319,487		319,487		2
3	Housekeeping	123,790	39,531		163,321		163,321		163,321		3
4	Laundry	43,547	17,804		61,351		61,351		61,351		4
5	Heat and Other Utilities			154,985	154,985		154,985		154,985		5
6	Maintenance	58,794	37,295	48,117	144,206		144,206		144,206		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	432,938	439,406	207,392	1,079,736		1,079,736		1,079,736		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,045	7,045		7,045		7,045		9
10	Nursing and Medical Records	1,637,988	335,705	3,260	1,976,953		1,976,953		1,976,953		10
10a	Therapy			456,958	456,958		456,958		456,958		10a
11	Activities	59,645	1,871		61,516		61,516		61,516		11
12	Social Services	26,847			26,847		26,847		26,847		12
13	CNA Training										13
14	Program Transportation			1,259	1,259	3,595	4,854		4,854		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,724,480	337,576	468,522	2,530,578	3,595	2,534,173		2,534,173		16
	<b>C. General Administration</b>										
17	Administrative	121,141			121,141		121,141		121,141		17
18	Directors Fees							2,519	2,519		18
19	Professional Services			295,872	295,872		295,872	(7,152)	288,720		19
20	Dues, Fees, Subscriptions & Promotions			53,339	53,339		53,339	(49,846)	3,493		20
21	Clerical & General Office Expenses	66,353	32,525	50,642	149,520		149,520		149,520		21
22	Employee Benefits & Payroll Taxes			340,228	340,228		340,228		340,228		22
23	Inservice Training & Education			5,062	5,062		5,062		5,062		23
24	Travel and Seminar			2,768	2,768		2,768		2,768		24
25	Other Admin. Staff Transportation			7,190	7,190	(3,595)	3,595		3,595		25
26	Insurance-Prop.Liab.Malpractice			68,367	68,367		68,367	88,198	156,565		26
27	Other (specify):* <b>See Att Sch V</b>	38,612		58,007	96,619		96,619	(96,619)			27
28	<b>TOTAL General Administration</b>	226,106	32,525	881,475	1,140,106	(3,595)	1,136,511	(62,900)	1,073,611		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,383,524	809,507	1,557,389	4,750,420		4,750,420	(62,900)	4,687,520		29

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

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

Facility Name & ID Number Hawthorne Inn of Danville

#0046367

Report Period Beginning:

04/01/2008

Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			60,254	60,254		60,254	372,293	432,547		30
31	Amortization of Pre-Op. & Org.							475,952	475,952		31
32	Interest							8,717	8,717		32
33	Real Estate Taxes			45,500	45,500		45,500	63,700	109,200		33
34	Rent-Facility & Grounds			1,027,645	1,027,645		1,027,645	(1,027,645)			34
35	Rent-Equipment & Vehicles			5,395	5,395		5,395		5,395		35
36	Other (specify):* <a href="#">See Att Sch XI</a>							2,718	2,718		36
37	<b>TOTAL Ownership</b>			1,138,794	1,138,794		1,138,794	(104,265)	1,034,529		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops			5,548	5,548		5,548		5,548		41
42	Provider Participation Fee			35,040	35,040		35,040		35,040		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			40,588	40,588		40,588		40,588		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,383,524	809,507	2,736,771	5,929,802		5,929,802	(167,165)	5,762,637		45

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

**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	(678)	V-30		9
10	Interest and Other Investment Income	(253)	V-32		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	(21,219)	V-21		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	(55,372)	V-27		24
25	Fund Raising, Advertising and Promotional	(28,692)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(52,124)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (158,338)		\$	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)	(22,432)		34
35	Other- Attach Schedule See Att Sch III	13,605		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (8,827)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (167,165)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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Hawthorne Inn of Danville

ID# 0046367

Report Period Beginning: 04/01/2008

Ending: 03/31/2009

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
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49



## STATE OF ILLINOIS

Facility Name & ID Number Hawthorne Inn of Danville# 0046367

Report Period Beginning:

04/01/2008 Ending:

Summary B

03/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(22,432)	0	0	0	0	0	0	0	0	0	(22,432)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	0	(22,432)	0	0	0	0	0	0	0	0	0	(22,432)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	0	(22,432)	0	0	0	0	0	0	0	0	0	(22,432)	45

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	See Attached Schedule I		See Attached Schedule I		

**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	34 Facility rent	\$ 1,027,645	Danville Independence LLC	N/A	\$ 1,005,213	\$	(22,432)	1
2	V								2
3	V			See Att Schedule XI					3
4	V								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		\$ 1,027,645			\$ 1,005,213	\$ *	(22,432)	14

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

Facility Name & ID Number Hawthorne Inn of Danville # 0046367 Report Period Beginning: 04/01/2008 Ending: 03/31/2009

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 Schedules III								\$ 2,519	18-7	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	\$ 2,519		13

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

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

Facility Name & ID Number Hawthorne Inn of Danville

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Ending: 3/31/2009

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 Residential Alternatives of Illinois, 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	See Attached Schedule II & III				\$	\$		\$ 13,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 13,605	25

Facility Name & ID Number

Hawthorne Inn of Danville

# 0046367

Report Period Beginning:

04/01/2008

Ending:

03/31/2009

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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Cambridge Realty Capital					\$		\$		1									
2	Ltd. Of Illinois	X	Facility Purchase	\$73,530.64	8/1/08		12,627,000	12,575,329	09/01/2043	6.1800	475,952	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Home office allocation adj	X									8,970	6							
7	Less Interest Income		X	from page 5, line 10							(253)	7							
8												8							
9	<b>TOTAL Facility Related</b>			\$73,530.64		\$	12,627,000	\$ 12,575,329			\$ 484,669	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>					\$		\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>					\$	12,627,000	\$ 12,575,329			\$ 484,669	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 79,691 Line # 26

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

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





Facility Name & ID Number Hawthorne Inn of Danville

# 0046367

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**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 44,122 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>4.472 acres</u>	<u>2008</u>	<u>\$ 886,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 886,000</b>	<b>3</b>

Facility Name &amp; ID Number Hawthorne Inn of Danville

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	140	2008	1999	\$ 12,503,803	\$ 333,432	25	\$ 333,432	\$	\$ 333,432	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	BackFlow Installment, exterior sign	2000		4,732	315	15	315		2,701	9
10	Carpet, door lock system, concrete	2001		13,544	1,088	5 to 15	1,088		9,787	10
11	Curtain tracking	2003		4,979		5			4,979	11
12	Light/surge protection	2004		28,000	2,545	15	1,867	(678)	11,879	12
13	Electric sign	2005		19,957	1,996	10	1,996		7,484	13
14	Asphalt	2005		20,717	2,590	8	2,590		9,495	14
15	Condensor fan	2005		3,150	630	5	630		2,468	15
16	Asphalt	2005		11,086	1,386	8	1,386		5,081	16
17	Floor tile	2005		2,815	282	10	282		1,009	17
18	Lighting for parking lot	2005		7,607	761	10	761		2,536	18
19	Alarm system	2005		739	92	8	92		354	19
20	Stage area- entry way	2006		2,967	297	10	297		964	20
21	Sign	2006		4,817	482	10	482		1,566	21
22	Kitchen remodel	2006		11,289	753	15	753		2,258	22
23	Counter tops	2006		7,506	500	15	500		1,460	23
24	Circle head window replacement	2006		15,251	1,525	10	1,525		4,067	24
25	Nurse call system	2008		4,382	219	10	219		219	25
26	Cabinet/countertop repair	2008		5,808	387	15	387		387	26
27	Wall repair - dining areas	2008		4,480	149	10	149		149	27
28	Paint	2008		4,150	138	5	138		138	28
29	Roof	2008		196,819	6,561	10	6,561		6,561	29
30	Landscaping	2008		145,000	9,664	10	9,664		9,664	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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)	\$ 13,023,598	\$ 365,792		\$ 365,114	\$ (678)	\$ 418,638	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 284,262	\$ 25,475	\$ 25,475	\$	3-15 years	\$ 145,557	71
72	Current Year Purchases	529,791	34,508	34,508		5-12 years	34,508	72
73	Fully Depreciated Assets							73
74	Indirect costs							74
75	TOTALS	\$ 814,053	\$ 59,983	\$ 59,983	\$		\$ 180,065	75

D. Vehicle Depreciation (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	2003 GMC Van	2005	\$ 29,800	\$ 7,450	\$ 7,450	\$	4	\$ 29,800	76
77										77
78										78
79										79
80	TOTALS			\$ 29,800	\$ 7,450	\$ 7,450	\$		\$ 29,800	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)	\$ 14,753,451	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 433,225	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 432,547	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (678)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 628,503	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	2006- Toyota Corolla - 2006	\$ 14,900	\$ 3,725	\$ 10,865	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 14,900	\$ 3,725	\$ 10,865	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Danville Indence, LLC

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

If NO, see instructions.  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:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule X</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			6
7	TOTAL				\$			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 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: \$ Amt not determined Description: N/A  
(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					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	<u>/2010</u>	\$ <u>N/A</u>
13.	<u>/2011</u>	\$ <u>N/A</u>
14.	<u>/2012</u>	\$ <u>N/A</u>

\* 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.

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 type="checkbox"/> YES <input checked="" 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</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		3	4
		1	2		
		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.

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

	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		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.

Facility Name & ID Number **Hawthorne Inn of Danville**# **0046367**Report Period Beginning: **04/01/2008**Ending: **03/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **03/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 255,860	\$ 483,307	1
2	Cash-Patient Deposits	9,008	9,008	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>19,037</u> )	1,063,595	1,063,595	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,212	88,910	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Ach X</u>	5,531,257	5,687,236	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 6,886,932	\$ 7,332,056	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		886,000	13
14	Buildings, at Historical Cost		12,503,803	14
15	Leasehold Improvements, at Historical Cost	374,795	519,795	15
16	Equipment, at Historical Cost	354,753	858,753	16
17	Accumulated Depreciation (book methods)	(262,672)	(639,368)	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): <u>See Att Ach X</u>		504,473	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 466,876	\$ 14,633,456	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,353,808	\$ 21,965,512	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 5,360	\$ 5,611	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,008	9,008	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	61,088	61,088	31
32	Accrued Real Estate Taxes(Sch.IX-B)	123,900	187,600	32
33	Accrued Interest Payable		64,763	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Interdivision payable</u>		2,277,144	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 199,356	\$ 2,605,214	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,575,329	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44	<u>Security deposits</u>	185,377	185,377	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 185,377	\$ 12,760,706	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 384,733	\$ 15,365,920	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 6,969,075	\$ 6,599,592	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 7,353,808	\$ 21,965,512	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>5,669,015</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>5,669,015</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,300,060</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,300,060</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>6,969,075</b>	<b>24</b> *

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

Facility Name &amp; ID Number Hawthorne Inn of Danville

# 0046367

Report Period Beginning: 04/01/2008

Ending: 03/31/2009

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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,185,180	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,185,180	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	13,558	6
7	Oxygen	379	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 13,937	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	10,905	12
13	Barber and Beauty Care	17,576	13
14	Non-Patient Meals	14	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	107	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	30	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 28,632	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	253	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 253	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Activity Fund Income</b>		28
28a	<b>See Att Sch VII</b>	1,860	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,860	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,229,862	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,079,736	31
32	Health Care	2,530,578	32
33	General Administration	1,140,106	33
<b>B. Capital Expense</b>			
34	Ownership	1,138,794	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	5,548	35
36	Provider Participation Fee	35,040	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,929,802	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,300,060	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,300,060	43

\* 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 Hawthorne Inn of Danville

# 0046367

Report Period Beginning:

04/01/2008

Ending:

03/31/2009

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	1,979	2,127	\$ 59,037	\$ 27.76	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,359	8,988	205,110	22.82	3
4	Licensed Practical Nurses	11,523	12,391	221,543	17.88	4
5	CNAs & Orderlies	97,619	104,967	1,023,427	9.75	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	6,042	6,497	59,645	9.18	10
11	Social Service Workers	1,997	2,148	26,847	12.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,482	22,024	206,807	9.39	15
16	Dishwashers					16
17	Maintenance Workers	4,516	4,855	58,794	12.11	17
18	Housekeepers	12,950	13,925	123,790	8.89	18
19	Laundry	5,025	5,403	43,547	8.06	19
20	Administrator	2,003	2,154	93,206	43.27	20
21	Assistant Administrator	1,823	1,960	27,935	14.25	21
22	Other Administrative	2,018	2,170	38,612	17.79	22
23	Office Manager					23
24	Clerical	6,086	6,544	66,353	10.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,013	2,164	37,878	17.50	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,111	1,195	9,561	8.00	31
32	Other Health Care(specify)	4,267	4,588	81,432	17.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,813	204,100	\$ 2,383,524 *	\$ 11.68	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	***	\$ 4,290	1-3	35
36	Medical Director	***	7,045	9-3	36
37	Medical Records Consultant	***	1,760	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	1,500	10-3	39
40	Physical Therapy Consultant	***	203,583	10a-3	40
41	Occupational Therapy Consultant	***	238,870	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	14,505	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) Dental Consultant	***	0	10-3	46
47					47
48	*** Monthly fee				48
49	TOTAL (lines 35 - 48)		\$ 471,553		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Lisa Miller	Adminsitrator	None	\$ 93,206	Workers' Compensation Insurance	\$ 68,875	IDPH License Fee	\$		
Stefanie Verando	Asst Admin	None	27,935	Unemployment Compensation Insurance	13,593	Advertising: Employee Recruitment		11,761	
				FICA Taxes	179,920	Health Care Worker Background Check			
				Employee Health Insurance	40,908	(Indicate # of checks performed <u>129</u> )		1,289	
				Employee Meals		Patient Background Checks	<u>71</u>	710	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising-Promo & Yellow pages		28,692	
				401(k)	20,420	Subscriptions		3,232	
				Other Employee Benefits	16,512	IHCA Dues		5,093	
TOTAL (agree to Schedule V, line 17, col. 1)						Other Licenses and Fees		2,562	
(List each licensed administrator separately.)			\$ 121,141			Indirect Costs-See Att Sch III		65	
B. Administrative - Other						Less: Public Relations Expense	(		
Description			Amount			Non-allowable advertising		(28,692)	
			\$			Yellow page advertising	(		
TOTAL (agree to Schedule V, line 17, col. 3)			\$		TOTAL (agree to Schedule V, line 22, col.8)	\$ 340,228		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,712
(Attach a copy of any management service agreement)									
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
RFMS, Inc	Administrative Services		\$ 171,600			\$	Out-of-State Travel	\$	
McGladrey & Pullen, LLP	Accounting Services		8,080						
LTC Support Services, LLC	Support Services		95,520						
American Healthcare	Healthcare Services		1,400				In-State Travel		
Foley & Lardner, LLP	Legal Services		7,806				Staff use of personal vehicle on facility		
Davis & Campbell, LLC	Legal Services		180				business and meals (under \$250 per		
Polsinelli & Assoc., PC	Legal Services		11,251				travel voucher)	0	
Saikley Garrison Colombo & Barney LLC	Collection Services		35				Seminar Expense	2,768	
							Less: non-allowable out-of-state travel	0	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 295,872	TOTAL		\$	Entertainment Expense	(	
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 2,768	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Hawthorne Inn of Danville

# 0046367

Report Period Beginning: 04/01/2008 Ending: 03/31/2009

**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. See Page 21 Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 9 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,249 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. \$ 35,040  
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 14
- (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. \$ NA**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.