

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0046367</u></p> <p>Facility Name: <u>Hawthorne Inn of Danville</u></p> <p>Address: <u>3222 Independence Dr</u> <u>Danville</u> <u>61832</u> Number City Zip Code</p> <p>County: <u>Vermilion</u></p> <p>Telephone Number: <u>(217) 431-1600</u> Fax # <u>(217) 431-3782</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>07/01/2003</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (c) 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>4/1/2016</u> to <u>3/31/2017</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hawthorne Inn of Danville

0046367 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	60	Sheltered Care (SC)	60	21,900	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,402	13,733	7,711	26,846	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		15,683		15,683	12
13	DD 16 OR LESS					13
14	TOTALS	5,402	29,416	7,711	42,529	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.23%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 80 and days of care provided 5,107

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

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

Facility Name & ID Number Hawthorne Inn of Danville # 0046367 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	339,282	36,577	15,086	390,945		390,945		390,945		1
2	Food Purchase		282,773		282,773		282,773	(46,812)	235,961		2
3	Housekeeping	199,520	44,755	100	244,375		244,375		244,375		3
4	Laundry	48,513	28,525	27	77,065		77,065		77,065		4
5	Heat and Other Utilities			137,956	137,956		137,956		137,956		5
6	Maintenance	105,117	39,410	93,513	238,040		238,040		238,040		6
7	Other (specify):*										7
8	TOTAL General Services	692,432	432,040	246,682	1,371,154		1,371,154	(46,812)	1,324,342		8
	B. Health Care and Programs										
9	Medical Director			22,000	22,000		22,000		22,000		9
10	Nursing and Medical Records	2,958,168	241,325	17,067	3,216,560		3,216,560		3,216,560		10
10a	Therapy										10a
11	Activities	79,204	1,704		80,908		80,908		80,908		11
12	Social Services	87,667			87,667		87,667		87,667		12
13	CNA Training										13
14	Program Transportation			11,214	11,214		11,214		11,214		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,125,039	243,029	50,281	3,418,349		3,418,349		3,418,349		16
	C. General Administration										
17	Administrative	122,583			122,583		122,583		122,583		17
18	Directors Fees							3,013	3,013		18
19	Professional Services			340,265	340,265		340,265	9,725	349,990		19
20	Dues, Fees, Subscriptions & Promotions			21,618	21,618		21,618	9	21,627		20
21	Clerical & General Office Expenses	108,741	20,607	56,583	185,931		185,931	287	186,218		21
22	Employee Benefits & Payroll Taxes			525,860	525,860		525,860		525,860		22
23	Inservice Training & Education			3,826	3,826		3,826		3,826		23
24	Travel and Seminar			521	521		521		521		24
25	Other Admin. Staff Transportation			88	88		88		88		25
26	Insurance-Prop.Liab.Malpractice			44,790	44,790		44,790	18,607	63,397		26
27	Other (specify):*										27
28	TOTAL General Administration	231,324	20,607	993,551	1,245,482		1,245,482	31,641	1,277,123		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,048,795	695,676	1,290,514	6,034,985		6,034,985	(15,171)	6,019,814		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

Hawthorne Inn of Danville

#0046367

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			123,327	123,327		123,327	595,677	719,004			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							389,949	389,949			32
33	Real Estate Taxes							139,440	139,440			33
34	Rent-Facility & Grounds			1,013,280	1,013,280		1,013,280	(1,013,280)				34
35	Rent-Equipment & Vehicles			35,449	35,449		35,449		35,449			35
36	Other (specify):* MIP							64,640	64,640			36
37	TOTAL Ownership			1,172,056	1,172,056		1,172,056	176,426	1,348,482			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			628	628		628		628			38
39	Ancillary Service Centers		213,047	767,179	980,226		980,226		980,226			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			7,374	7,374		7,374	(6,484)	890			41
42	Provider Participation Fee			163,390	163,390		163,390		163,390			42
43	Other (specify):* Disallowed Costs	44,571		214,273	258,844		258,844	(258,844)				43
44	TOTAL Special Cost Centers	44,571	213,047	1,152,844	1,410,462		1,410,462	(265,328)	1,145,134			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,093,366	908,723	3,615,414	8,617,503		8,617,503	(104,073)	8,513,430			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hawthorne Inn of Danville

0046367

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(46,812)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,696)	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	(1,131)	30		9
10	Interest and Other Investment Income	(495)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(688)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,242)	43		24
25	Fund Raising, Advertising and Promotional	(66,945)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(105,445)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (314,454)		\$	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)	210,381		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 210,381		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (104,073)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Hawthorne Inn of Danville

ID# 0046367

Report Period Beginning: 4/1/2016

Ending: 3/31/3017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Marketing Salary	\$ (44,571)	43	1
2	Offset Medicare Pt. A Lab	(37,384)	43	2
3	Offset Medicare Pt. A X-Ray	(17,006)	43	3
4	Offset Vending Machine revenue	(6,484)	41	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
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(105,445)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:				
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)				
1	V	18	Director Fees	\$	Residential Alternatives of Illinois, Inc.	100.00%	\$	3,013	3,013	1	
2	V	19	Professional Services		Residential Alternatives of Illinois, Inc.	100.00%		10,413	10,413	2	
3	V	20	Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%		9	9	3	
4	V	21	Clerical & General Office		Residential Alternatives of Illinois, Inc.	100.00%		287	287	4	
5	V	26	Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%		950	950	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		\$				\$	14,672	\$ *	14,672	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	26 Insurance		Danville Independence, LLC	100.00%	\$ 17,657	\$	17,657	15
16	V	30 Depreciation Expense		Danville Independence, LLC	100.00%	596,808		596,808	16
17	V	32 Interest	544	Danville Independence, LLC	100.00%	390,988		390,444	17
18	V	33 Real Estate		Danville Independence, LLC	100.00%	139,440		139,440	18
19	V	34 Facility Rent	1,013,280	Danville Independence, LLC	100.00%			(1,013,280)	19
20	V	36 Property/MIP Insurance		Danville Independence, LLC	100.00%	64,640		64,640	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 1,013,824			\$ 1,209,533	\$ *	195,709	39

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

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Hawthorne Inn of Danville

0046367

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

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	John Kniery	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	\$ 432	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	709	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	709	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	709	L18, C7	4
5	Ben McMahan	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	354	L18, C7	5
6											6
7											7
8											8
9	No board members provide services or have business entities that provide services to the facility.										9
10											10
11											11
12											12
13								TOTAL	\$ 2,913		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 Hawthorne Inn of Danville

0046367

Report Period Beginning:

4/1/2016

Ending: 3/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	Director Fees	Weighted Avg BDA	339,815	18	\$ 25,500	\$ 40,150	\$ 3,013	1
2	19	Professional Services	Weighted Avg BDA	339,815	18	88,134	\$ 40,150	10,413	2
3	20	Dues, Fees & Subscriptions	Weighted Avg BDA	339,815	18	75	40,150	9	3
4	21	Clerical & General Office	Weighted Avg BDA	339,815	18	2,430	40,150	287	4
5	26	Property Insurance	Weighted Avg BDA	339,815	18	8,040	40,150	950	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					\$ 124,179	\$	\$ 14,672	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Hawthorne Inn of Danville

0046367

Report Period Beginning:

4/1/2016

Ending:

3/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	Cambridge Realty Capital		X	Facility Purchase (Refinance)	\$56,176.00	02/01/13	\$ 12,627,000	\$ 12,002,923	09/01/43	3.5000	\$ 390,988	1						
2	Ltd. Of Illinois - SNF			Including trade premium on								2						
3				note of \$371,176 as of 3/31/17								3						
4												4						
5												5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$56,176.00		\$ 12,627,000	\$ 12,002,923			\$ 390,988	9						
	B. Non-Facility Related*																	
10												10						
11									Interest Income Offset		(1,039)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (1,039)	14						
15	TOTALS (line 9+line14)						\$ 12,627,000	\$ 12,002,923			\$ 389,949	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 64,640 Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.			\$	151,778	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.)		2015	\$	132,775	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(19,003)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	158,443	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.			\$	139,440	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2012	123,633	8	FOR BHF USE ONLY	
	2013	126,957	9	13	FROM R. E. TAX STATEMENT FOR 2016 \$
	2014	126,355	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2015	132,775	11	15	LESS REFUND FROM LINE 6 \$
	2016	131,781	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
This facility was purchased from an unrelated for profit entity. A tax exemption has not yet been obtained.					
Amount accrued includes the 12 months of 2016 and 3 months of 2017. Estimate is based on 2015 tax bill.					
Taxes paid were for the 2015 tax bill.					

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hawthorne Inn of Danville

0046367 Report Period Beginning:

4/1/2016 Ending:

3/31/2017

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: 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Facility (194,800 sq ft, 2008, \$886,000), Facility (18,480 sq ft, 2011, \$55,000), and TOTALS (213,280 sq ft, \$941,000).

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hawthorne Inn of Danville

0046367

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	140	2008	1999	\$ 12,503,803	\$	25	\$ 500,157	\$ 500,157	\$ 4,334,670	4
5			2010	914,486		25	36,579	36,579	237,768	5
6										6
7										7
8										8
	Improvement Type**									
9	Backflow Installment, exterior sign		2000	4,732		15			4,732	9
10	Carpet, door lock system, concrete		2001	13,544	100	5 to 15	100		13,544	10
11	Curtain Tracking		2003	4,979		5			4,979	11
12	Light/surge protection		2004	28,000		11			28,000	12
13	Electric Sign,Asphalt,Condenser fan,Asphalt,Floor tile,Lighting-parking l		2005	66,071		5 to 10			66,071	13
14	Stage area-entry way,sign,kitchen remodel,countertops,circle head		2006	41,830	1,761	10 to 15	1,761		36,777	14
15	Nurse call system,cabinet/countertop rep,wall rep, paint, roof, landscaping		2008	360,639	20,955	5 to 15	30,622	9,667	262,919	15
16	Sidewalks replacement and repairs		2009	4,071	271	15	271		2,103	16
17	Compressor for Furnace		2010	2,997	200	15	200		1,316	17
18	Sign		2010	2,930	293	10	293		2,027	18
19	AC Units		2011	2,997		5			2,997	19
20	Furnace/AC for Kitchen		2011	6,275	628	10	628		3,609	20
21	Carpet-corridor/LR/Vestibule Replacements		2011	22,825	1,522	5	1,522		22,825	21
22	Vinyl - Activity Room		2011	3,444	344	10	344		1,837	22
23	Parking Lot -Asphalt		2011	5,147	643	8	643		3,431	23
24	Skilled Rooms Remodel-Chairs/Paint/Wallpaper/VCT Tile/Cubicles/Wind		2012	93,501	7,792	12	7,792		39,609	24
25	Water Heater		2012	4,969	497	10	497		2,360	25
26	Window Replacement		2013	6,516	434	15	434		1,701	26
27	AC Compressor		2013	5,752	383	15	383		1,406	27
28	New Countertops in Nurses Station		2013	27,536	2,754	10	2,754		9,638	28
29	New Shower Room tiles		2014	4,212	211	20	211		650	29
30	Cabinets/Counter Tops - AL Bedrooms		2014	6,045	504	12	504		1,512	30
31	Drapes/Wood Blinds - Dining Room & Lounge		2015	7,935	1,587	5	1,587		3,439	31
32	Condensor		2015	13,939	929	15	929		1,936	32
33	Water Damage -Paint/Drywall/Insulation/Carpet - Main level/office 1 and		2015	35,080	2,923	12	2,923		6,090	33
34	Resident Rooms/Office-Carpet/Paint/Chairs - AL 40 Rooms		2015	61,448	5,121	12	5,121		10,668	34
35	10' Ton Carrier Unit - Van Dyke Hall		2015	15,332	1,533	10	1,533		2,300	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 Hawthorne Inn of Danville

0046367

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Concrete Parking Lot	2015	\$ 124,691	\$ 8,313	15	\$ 8,313	\$	\$ 12,469	37
38	Water Heater	2015	5,647	565	10	565		753	38
39	Replace Windows - rooms 318-322	2015	3,690	246	15	246		328	39
40	Fire Panel Update	2015	7,700	770	10	770		1,091	40
41	Replace Condenser/Coils for East Side Dining Room	2015	8,276	828	10	828		1,173	41
42	Replace Sprinkler Pipes - Van Dyke Wing	2016	4,700	470	10	470		548	42
43	Paint - Garden Court	2016	12,385	2,477	5	2,477		2,683	43
44	New Hot Water Heater	2017	3,148	79	10	79		79	44
45	New Nurse Call System	2016	102,632	5,987	10	5,987		5,987	45
46	Painting - Town Center/Dining Room/Main Entrance Doors	2017	5,646	94	5	94		94	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)		\$ 14,549,550	\$ 71,214		\$ 617,617	\$ 546,403	\$ 5,136,119	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$ 812,415	\$ 35,499	\$ 85,904	\$ 50,405	3-15 yrs	\$ 601,134	71
72	Current Year Purchases	42,059	2,644	2,644		5-15 yrs	2,644	72
73	Fully Depreciated Assets	219,529					219,529	73
74								74
75	TOTALS	\$ 1,074,003	\$ 38,143	\$ 88,548	\$ 50,405		\$ 823,307	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2003 GMC Van	2005	\$ 29,800	\$	\$	\$	4	\$ 29,800	76
77	Patient Care	2013 Ford E350 Van	2013	51,355	12,839	12,839		4	50,285	77
78										78
79										79
80	TOTALS			\$ 81,155	\$ 12,839	\$ 12,839	\$		\$ 80,085	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)	\$ 16,645,708	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 122,196	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 719,004	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 596,808	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,039,511	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	2017 Toyota Corolla	\$ 18,089	\$ 1,131	\$ 1,131	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 18,089	\$ 1,131	\$ 1,131	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

N/A

N/A

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 35,449 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			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Hawthorne Inn of Danville
IDPH License ID Number: 0046367
Fiscal Year End: 3/31/3017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	33,612
Office Equipment	899
Other Equipment Rental	938
Total - Line 16	35,449

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			
		1	2	3	4
		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.)

	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	\$	4,032	\$ 290,278	\$	4,032	\$ 290,278	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,427	102,744		1,427	102,744	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		4,616	332,381		4,616	332,381	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 prescripts				213,047		213,047	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(3)			580	41,776		580	41,776	12
13	Other (specify):									13
14	TOTAL			\$	10,655	\$ 767,179	\$ 213,047	10,655	\$ 980,226	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

Facility Name & ID Number Hawthorne Inn of Danville

0046367

Report Period Beginning: 4/1/2016

Ending:

3/31/3017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/3017

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 191,638	\$ 424,442	1
2	Cash-Patient Deposits	6,284	6,284	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 188,000)	771,705	778,796	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,756	61,756	6
7	Other Prepaid Expenses	2,652	5,530	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	13,624,605	10,756,569	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 14,649,640	\$ 12,033,377	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		941,000	13
14	Buildings, at Historical Cost	1,015,785	14,404,550	14
15	Leasehold Improvements, at Historical Cost		145,000	15
16	Equipment, at Historical Cost	639,723	1,155,158	16
17	Accumulated Depreciation (book methods)	(947,589)	(6,039,511)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP)			22
23	Other(specify): <u>Escrow Deposits</u>		874,719	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 707,919	\$ 11,480,916	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,357,559	\$ 23,514,293	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 115,205	\$ 115,205	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,284	6,284	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,065	113,065	30
31	Accrued Taxes Payable (excluding real estate taxes)	82,002	82,002	31
32	Accrued Real Estate Taxes(Sch.IX-B)		158,443	32
33	Accrued Interest Payable		33,926	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 316,556	\$ 508,925	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,002,923	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposits</u>	97,515	97,515	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 97,515	\$ 12,100,438	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 414,071	\$ 12,609,363	46
47	TOTAL EQUITY(page 18, line 24)	\$ 14,943,488	\$ 10,904,930	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,357,559	\$ 23,514,293	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 14,044,497	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 14,044,497	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	898,991	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)	\$ 898,991	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)	\$ 14,943,488	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hawthorne Inn of Danville

0046367

Report Period Beginning: 4/1/2016

Ending: 3/31/3017

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,284,700	1
2	Discounts and Allowances for all Levels	(78,899)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,205,801	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	196,019	6
7	Oxygen	14,725	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 210,744	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	52,831	12
13	Barber and Beauty Care	17,548	13
14	Non-Patient Meals	465	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	80	16
17	Sale of Drugs	254	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	23,483	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 94,661	23
D. Non-Operating Revenue			
24	Contributions	393	24
25	Interest and Other Investment Income***	495	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 888	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Income</u>	3,900	28
28a	<u>Gain on Disposal of Asset</u>	500	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,400	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,516,494	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,371,154	31
32	Health Care	3,418,349	32
33	General Administration	1,245,482	33
B. Capital Expense			
34	Ownership	1,172,056	34
C. Ancillary Expense			
35	Special Cost Centers	1,247,072	35
36	Provider Participation Fee	163,390	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,617,503	40
41	Income before Income Taxes (line 30 minus line 40)**	898,991	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 898,991	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,566,485	44
45	Private Pay - Net Inpatient Revenue	4,998,878	45
46	Medicare - Net Inpatient Revenue	2,449,476	46
47	Other-(specify) <u>Medicare Replacement</u>	139,154	47
48	Other-(specify) <u>Managed Care</u>	51,808	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,205,801	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hawthorne Inn of Danville

0046367

Report Period Beginning: 4/1/2016

Ending: 3/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,940	2,080	\$ 73,320	\$ 35.25	1
2	Assistant Director of Nursing	2,016	2,080	61,815	29.72	2
3	Registered Nurses	30,036	32,120	802,661	24.99	3
4	Licensed Practical Nurses	20,700	21,463	428,770	19.98	4
5	CNAs & Orderlies	123,024	128,910	1,508,618	11.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,967	7,431	79,204	10.66	10
11	Social Service Workers	5,677	6,065	87,667	14.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,422	32,423	339,282	10.46	15
16	Dishwashers					16
17	Maintenance Workers	6,689	7,121	105,117	14.76	17
18	Housekeepers	19,182	20,199	199,520	9.88	18
19	Laundry	5,421	5,625	48,513	8.62	19
20	Administrator	1,892	2,080	122,583	58.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,647	8,120	108,741	13.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,056	2,200	55,734	25.33	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,416	2,548	27,250	10.69	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,988	2,080	44,571	21.43	33
34	TOTAL (lines 1 - 33)	268,072	282,544	\$ 4,093,366 *	\$ 14.49	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 15,086	L1, C3	35
36	Medical Director	Monthly	22,000	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,855	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 44,941		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hawthorne Inn of Danville# 0046367Report Period Beginning: 4/1/2016Ending: 3/31/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 8,778 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 67,999 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 163,390
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 53,296
- (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% line 1
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT