FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0055632

Facility Name: Allure of Geneseo

Address: 704 S Illinois St (Number) Geneseo (City) 61254 (Zip Code)

County: Henry

Telephone Number: 309-944-6424 **Fax #** 309-944-6605

HFS ID Number:

Date of Initial License for Current Owners: 07/01/19

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: AARON MAUER **Telephone Number:** 773-747-4506
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) 5/28/2021 (Date)
(Type or Print Name) Leo LaFranco
(Title) CFO

Paid Preparer

(Signed) 5/27/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM ASSOCIATES, INC, 5683 NORTH LINCOLN AVE CHICAGO, IL 60659
(Telephone) 773-747-4506 EXT 601 Fax # 773-747-4725

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,352	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,352	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,476	8,389	617	16,482	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,476	8,389	617	16,482	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.55%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 07/01/2019

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/2019 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 3,295

Medicare Intermediary NORIDIAN ADMINISTRATIVE SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	259,450	25,039	13,440	297,929		297,929		297,929			1
2	Food Purchase		125,150		125,150		125,150	(2,293)	122,857			2
3	Housekeeping	124,520	22,625		147,145		147,145		147,145			3
4	Laundry		1,004		1,004		1,004		1,004			4
5	Heat and Other Utilities			229,126	229,126		229,126	(22,425)	206,701			5
6	Maintenance	129,927	49,327	11,447	190,701		190,701	(3,050)	187,651			6
7	Other (specify):*											7
8	TOTAL General Services	513,897	223,145	254,013	991,055		991,055	(27,768)	963,287			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,269,626	114,843	318,693	1,703,162		1,703,162	(20)	1,703,142			10
10a	Therapy			447,990	447,990		447,990		447,990			10a
11	Activities	61,030	7,658		68,688		68,688		68,688			11
12	Social Services	30,280		2,730	33,010		33,010		33,010			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			2,665	2,665		2,665		2,665			15
16	TOTAL Health Care and Programs	1,360,936	122,501	784,078	2,267,515		2,267,515	(20)	2,267,495			16
	C. General Administration											
17	Administrative	204,543			204,543		204,543	6,222	210,765			17
18	Directors Fees											18
19	Professional Services			402,259	402,259		402,259	(24,884)	377,375			19
20	Dues, Fees, Subscriptions & Promotions			19,247	19,247		19,247	2,626	21,873			20
21	Clerical & General Office Expenses	269,752	52,743	69,266	391,761		391,761	996	392,757			21
22	Employee Benefits & Payroll Taxes			417,291	417,291		417,291	25,058	442,349			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,178	9,178		9,178	3,532	12,710			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			106,571	106,571		106,571		106,571			26
27	Other (specify):*											27
28	TOTAL General Administration	474,295	52,743	1,023,812	1,550,850		1,550,850	13,550	1,564,400			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,349,128	398,389	2,061,903	4,809,420		4,809,420	(14,238)	4,795,182			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 Allure of Geneseo #0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			35,439	35,439		35,439	103,477	138,916			30
31	Amortization of Pre-Op. & Org.							11,651	11,651			31
32	Interest			4,198	4,198		4,198	63,200	67,398			32
33	Real Estate Taxes			42,652	42,652		42,652		42,652			33
34	Rent-Facility & Grounds			205,342	205,342		205,342	(158,590)	46,752			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			287,631	287,631		287,631	19,738	307,369			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			150	150		150		150			38
39	Ancillary Service Centers		139,203		139,203		139,203	(180)	139,023			39
40	Barber and Beauty Shops							(90)	(90)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,896	143,896		143,896		143,896			42
43	Other (specify):* **Bad Debt**			105,830	105,830		105,830	(105,830)				43
44	**TOTAL Special Cost Centers**		139,203	249,876	389,079		389,079	(106,100)	282,979			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,349,128	537,592	2,599,410	5,486,130		5,486,130	(100,600)	5,385,530			45

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,066,428)	30		9
10	Interest and Other Investment Income	(3,397)	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	(1,964)	21		18
19	Entertainment				19
20	Contributions	(3,333)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(105,830)	43		24
25	Fund Raising, Advertising and Promotional	(1,718)	21		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	(67,989)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,250,659)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	1,150,059	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,150,059		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (100,600)		37

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

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

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

Allure of Geneseo

ID# 0055632

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income Medical records	$ (20)	10	1
2	Misc Income Beauty shop	(90)	40	2
3	Misc Income Food	(2,293)	2	3
4	Misc Income Garage fees	(1,900)	6	4
5	Misc Income 100	(100)	21	5
6	Independent Living Expenses - Clerical	(6,958)	21	6
7	Independent Living Expenses - Rent	(20,628)	34	7
8	Independent Living Expenses - Utilities	(22,426)	5	8
9	Independent Living Expenses - Grounds Maint	(1,150)	6	9
10	Misc Income therapy	(180)	39	10
11	Indipendent Living - Depreciation	(12,244)	30	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(67,989)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,293)	0	0	0	0	0	0	0	0	0	0	(2,293)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(22,426)	1	0	0	0	0	0	0	0	0	0	(22,425)	5
6	Maintenance	(3,050)	0	0	0	0	0	0	0	0	0	0	(3,050)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(27,769)	1	0	0	0	0	0	0	0	0	0	(27,768)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(20)	0	0	0	0	0	0	0	0	0	0	(20)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(20)	0	0	0	0	0	0	0	0	0	0	(20)	16
	C. General Administration													
17	Administrative	0	6,222	0	0	0	0	0	0	0	0	0	6,222	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(58,765)	33,881	0	0	0	0	0	0	0	0	(24,884)	19
20	Fees, Subscriptions & Promotions	0	2,626	0	0	0	0	0	0	0	0	0	2,626	20
21	Clerical & General Office Expenses	(14,073)	13,325	1,745	0	0	0	0	0	0	0	0	996	21
22	Employee Benefits & Payroll Taxes	0	25,058	0	0	0	0	0	0	0	0	0	25,058	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,532	0	0	0	0	0	0	0	0	0	3,532	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(14,073)	(8,003)	35,626	0	0	0	0	0	0	0	0	13,550	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,862)	(8,002)	35,626	0	0	0	0	0	0	0	0	(14,238)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,078,672)	979	1,181,170	0	0	0	0	0	0	0	0	103,477	30
31	Amortization of Pre-Op. & Org.	0	0	11,651	0	0	0	0	0	0	0	0	11,651	31
32	Interest	(3,397)	0	66,597	0	0	0	0	0	0	0	0	63,200	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(20,628)	(137,962)	0	0	0	0	0	0	0	0	0	(158,590)	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	TOTAL Ownership	(1,102,697)	(136,982)	1,259,418	0	0	0	0	0	0	0	0	19,738	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(180)	0	0	0	0	0	0	0	0	0	0	(180)	39
40	Barber and Beauty Shops	(90)	0	0	0	0	0	0	0	0	0	0	(90)	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):*	(105,830)	0	0	0	0	0	0	0	0	0	0	(105,830)	43
44	TOTAL Special Cost Centers	(106,100)	0	0	0	0	0	0	0	0	0	0	(106,100)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,250,659)	(144,984)	1,295,043	0	0	0	0	0	0	0	0	(100,600)	45

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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
Michael Nudell	34	ALLURE OF MT CARROLL	Mt Carroll	Allure Healthcare Serv	Chicago	Consulting Co
Jeremy Goldberg	33	ALLURE OF PROPHETSTOWN	PROPHETSTOWN	Geneseo Property	Chicago	Realty Co
Meyer Oseroff	33	ALLURE OF Lake Storey	Gelesburg			
		ALLURE OF Galesburg	Galesburg			
		ALLURE OF Moline	Moline			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management Fees	$ 290,459	ALLURE Healthcare Services		$	$ (290,459)	1
2	V	5	Heat and Other Utilities		ALLURE Healthcare Services		1	1	2
3	V	17	Administrative		ALLURE Healthcare Services		6,222	6,222	3
4	V	19	Professional Services		ALLURE Healthcare Services		231,693	231,693	4
5	V	20	Dues, Fees, Subscriptions & Promotions		ALLURE Healthcare Services		2,626	2,626	5
6	V	21	Clerical & General Office Expenses		ALLURE Healthcare Services		13,325	13,325	6
7	V	22	Employee Benefits & Payroll Taxes		ALLURE Healthcare Services		25,058	25,058	7
8	V	24	Travel and Seminar		ALLURE Healthcare Services		3,532	3,532	8
9	V	30	Depreciation		ALLURE Healthcare Services		979	979	9
10	V	34	Rent-Facility & Grounds		ALLURE Healthcare Services		4,688	4,688	10
11	V	34	Rent	142,650	Geneseo Property			(142,650)	11
12	V								12
13	V								13
14	Total			$ 433,109			$ 288,124	$ * (144,984)	14

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	Geneseo Property		$ 33,881	$ 33,881	15
16	V	31	Amortization of Pre-Op. & Org.		Geneseo Property		11,651	11,651	16
17	V	21	Clerical & General Office Expenses		Geneseo Property		1,745	1,745	17
18	V	30	Depreciation		Geneseo Property		1,181,170	1,181,170	18
19	V	32	Interest		Geneseo Property		66,597	66,597	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 1,295,043	$ * 1,295,043	39

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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									$		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	$		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 Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CIBC		X	Mortgage	Various	7/1/2020	$ 3,762,860	$ 3,726,860	6/30/2025	4.7500	$ 66,597	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,762,860	$ 3,726,860			$ 66,597	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,762,860	$ 3,726,860			$ 66,597	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

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

** 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 Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 52,930	2
3. Under or (over) accrual (line 2 minus line 1).		$ 52,930	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (10,278)	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.		$ 42,652	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2015	8
	2016	9
	2017	10
	2018	11
	2019	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Allure of Geneseo COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0055632

CONTACT PERSON REGARDING THIS REPORT AARON MAUER

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-21-407-058		$ 2,145.42	$ 2,145.42
2.	08-21-407-026		$ 230.10	$ 230.10
3.	08-21-407-027		$ 880.00	$ 880.00
4.	08-21-407-031		$ 894.14	$ 894.14
5.	08-21-407-032		$ 1,675.82	$ 1,675.82
6.	08-21-407-033		$ 344.52	$ 344.52
7.	08-21-407-037		$ 893.34	$ 893.34
8.	08-21-407-043		$ 2,121.98	$ 2,121.98
9.	08-21-407-044		$ 2,155.44	$ 2,155.44
10.	08-21-407-045		$ 2,091.04	$ 2,091.04
		TOTALS	$ 13,431.80	$ 13,431.80

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Allure of Geneseo COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0055632

CONTACT PERSON REGARDING THIS REPORT AARON MAUER

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-21-407-046		$ 2,096.80	$ 2,096.80
2.	08-21-407-047		$ 2,096.80	$ 2,096.80
3.	08-21-407-048		$ 2,096.80	$ 2,096.80
4.	08-21-407-052		$ 8,437.94	$ 8,437.94
5.	08-21-407-055		$ 2,145.42	$ 2,145.42
6.	08-21-407-056		$ 2,145.34	$ 2,145.34
7.	08-21-407-057		$ 2,145.42	$ 2,145.42
8.	08-21-407-059		$ 16,415.58	$ 16,415.58
9.	08-21-407-060		$ 1,091.56	$ 1,091.56
10.	08-21-407-038		$ 826.50	$ 826.50
		TOTALS	$ 39,498.16	$ 39,498.16

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,848 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (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? [X] (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).

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		2020	1971	$ 1,006,564	$ 69,486	39	$ 12,905	$ (56,581)	$ 69,486	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,006,564	$ 69,486		$ 12,905	$ (56,581)	$ 69,486	70

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 41,422	$ 13,807	$ 13,807	$	3	$ 22,091	71
72	Current Year Purchases	1,122,052	1,122,052	112,205	(1,009,847)	5	1,122,052	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,163,474	$ 1,135,859	$ 126,012	$ (1,009,847)		$ 1,144,143	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,170,038	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,205,345	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 138,917	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,066,428)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,213,629	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Geneseo Property 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. [X] 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:	1971	72	07/01/19	$ 62,692	10		3
4	Additions							4
5								5
6								6
7	TOTAL		72		$ 62,692 **			7

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

9. Option to Buy: [X] YES [ ] NO Terms: 2,083,333 *

10. Effective dates of current rental agreement:
Beginning 07/01/19
Ending 07/01/29

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					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.

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	2,268	$ 308,850	$	2,268	$ 308,850	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		832	36,668		832	36,668	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,238	102,473		3,238	102,473	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				80,674		80,674	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					1,513		1,513	12
13	Other (specify): Lab	39-2					57,016		57,016	13
14	TOTAL			$	6,338	$ 447,991	$ 139,203	6,338	$ 587,194	14

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

STATE OF ILLINOIS

Facility Name & ID Number Allure of Geneseo **#** 0055632 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/20 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,793,128	$ 1,835,120	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,323,850	1,325,629	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,868	37,868	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,154,846	$ 3,198,617	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,537,843	14
15	Leasehold Improvements, at Historical Cost	11,265	11,265	15
16	Equipment, at Historical Cost	144,798	1,256,481	16
17	Accumulated Depreciation (book methods)	(43,723)	1,236,544	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		58,254	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Replacement reserve	27,838	27,838	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 140,178	$ 5,228,225	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,295,024	$ 8,426,842	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 441,119	$ 443,519	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	853,195	853,195	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,412	124,412	30
31	Accrued Taxes Payable (excluding real estate taxes)	100,004	100,004	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	PPP Loan	488,250	488,250	36
37	Intercompany Loan		201,591	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,006,980	$ 2,210,971	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,726,860	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,726,860	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,006,980	$ 5,937,831	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,288,044	$ 2,489,011	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,295,024	$ 8,426,842	48

***(See instructions.)**

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 199,810	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 199,810	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,210,231	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	(222,000)	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)**	$ 988,231	17
	B. Transfers (Itemize):		
18	**Paid in Capital**	100,000	18
19	**Rounding**	3	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 100,003	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,288,044	24 *

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,884,927	1
2	Discounts and Allowances for all Levels	(47,087)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,837,840	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	249,432	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 249,432	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	521,217	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,635	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,615	19
20	Radiology and X-Ray	608	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 574,075	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,397	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,397	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		31,617	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,617	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,696,361	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	991,055	31
32	Health Care	2,267,515	32
33	General Administration	1,550,850	33
	B. Capital Expense		
34	Ownership	287,631	34
	C. Ancillary Expense		
35	Special Cost Centers	389,079	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,486,130	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,210,231	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,210,231	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,138,964	44
45	Private Pay - Net Inpatient Revenue	2,547,831	45
46	Medicare - Net Inpatient Revenue	1,743,463	46
47	Other-(specify) Insurance	407,582	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,837,840	49

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

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

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

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

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	74	147	$ 79,796	$ 542.83	1
2	Assistant Director of Nursing	780	788	31,736	40.27	2
3	Registered Nurses	4,990	5,260	185,745	35.31	3
4	Licensed Practical Nurses	10,298	10,917	319,407	29.26	4
5	CNAs & Orderlies	28,334	30,191	570,479	18.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,433	3,658	61,030	16.68	10
11	Social Service Workers	1,171	1,326	30,280	22.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,324	18,272	259,449	14.20	15
16	Dishwashers					16
17	Maintenance Workers	4,672	5,068	129,926	25.64	17
18	Housekeepers	8,596	9,267	124,520	13.44	18
19	Laundry					19
20	Administrator	4,160	4,160	204,543	49.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,938	6,425	271,308	42.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,786	1,893	52,258	27.61	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	673	720	28,650	39.79	33
34	TOTAL (lines 1 - 33)	92,229	98,092	$ 2,349,127 *	$ 23.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 13,440	1-3	35
36	Medical Director	Monthly	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	16,287	10-3	38
39	Pharmacist Consultant	Monthly	2,665	15-3	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	Monthly	2,730	12-3	45
46	Other(specify) MDS		3,000	10-3	46
47	Marketing		6,000	21-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 56,122		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 12,811	10-3	50
51	Licensed Practical Nurses	1,103	18,978	10-3	51
52	Certified Nurse Assistants/Aides	8,227	257,716	10-3	52
53	TOTAL (lines 50 - 52)	9,338	$ 289,505		53

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cassie Baker	Administrative	0	$ 104,735
David Wengrow	Assist Admin	0	99,808
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 204,543

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
GGM	Accounting Fees	$ 14,500
Mendel Schneider	Accounting Fees	6,000
Allan Goodman	Accounting Fees	550
Steve Scher	Legal Fees	5,000
Benney Morey	Legal Fees	(109)
Meyer Magence	Legal Fees	75
Skidelsky & Associates	Legal Fees	15,655
See Attached Schedule		360,588
See Professional Fees Sheet		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 402,259

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,256
Unemployment Compensation Insurance	28,374
FICA Taxes	157,064
Employee Health Insurance	177,630
Employee Meals	74
Illinois Municipal Retirement Fund (IMRF)*	720
Background Checks	22,043
Employee Other benefits	17,188
Pension	
TOTAL (agree to Schedule V, line 22, col.8)	$ 442,349

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,056
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois Health Care Council	10,224
Illinois dept of health	
Secretary of StATE	3,231
See Attached Other Dues & Subs	3,362
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,873

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	12,119
Seminar Expense	
Education & Seminar	591
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,710

* Attach copy of IMRF notifications

**See instructions.

TOTAL (agree to Schedule V, line 17, col. 3)		**$ #REF!**
(Attach a copy of any management service agreement)		
C. Professional Services		
Vendor/Payee	**Type**	**Amount**
GGM	**Accounting Fees**	**$ 14,500**
Mendel Schneider	**Accounting Fees**	**6,000**
Allan Goodman	**Accounting Fees**	**550**
Steve Scher	**Legal Fees**	**5,000**
Benney Morey	**Legal Fees**	**(109)**
Meyer Magence	**Legal Fees**	**75**
Skidelsky & Associates	**Legal Fees**	**15,655**
GCHMO	**Professional Fees - Reimbursement Consult**	**32,550**
August Mack	**Professional Fees**	**4,200**
Personal Planners	**Professional Fees**	**750**
Madison Specs	**Professional Fees**	**4,850**
Universal	**Professional Fees**	**26,542**
MTS Consulting	**Professional Fees**	**453**
RESIDE ADMISSIONS	**Professional Fees**	**(200)**
Other Professional Fes	**Professional Fees**	**985**
Allure Healthcare	**Management fees**	**290,459**
See Professional Fees Sheet		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		**$ 402,259**

F. Dues, Fees, Subscriptions and Promotions Description		Amount	
IDPH License Fee	$		
Advertising: Employee Recruitment			
Health Care Worker Background Check			
(Indicate # of checks performed)			
Illinois Health Care Council		10,224	
Illinois dept of health		5,056	
Secretary of StATE		605	
MATTHEW BENDER & CO., INC		321	
Other dues and subs		2,460	
Henry County		306	
Lee News		275	3,362
See Attached Other Dues & Subs			
Less: Public Relations Expense	(		
Non-allowable advertising	(		
Yellow page advertising	(		
TOTAL (agree to Sch. V,	$	19,247	

Facility Name & ID Number Allure of Geneseo # 0055632 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. **Illinois Healthcare Council $10,224**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,554** 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. $ **143,896**
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? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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