

		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: <u>0055640</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>ALLURE OF PROPHETSTOWN</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>310 MOSHER DRIVE</u> <u>PROPHETSTOWN</u> <u>61277</u>																																																	
Number City Zip Code																																																	
County: <u>WHITESIDE</u>																																																	
Telephone Number: <u>825-537-5175</u> Fax # <u>825-537-2628</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td><u>5/28/2021</u></td></tr><tr><td>(Type or Print Name) <u>Leo LaFranco</u></td><td>(Date)</td></tr><tr><td>(Title) <u>CFO</u></td><td></td></tr><tr><td>(Signed) _____</td><td><u>5/27/2021</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Aaron Mauer</u> <u>President</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>GGM ASSOCIATES, INC</u> <u>5683 NORTH LINCOLN AVE CHICAGO, IL 60659</u></td><td></td></tr><tr><td>(Telephone) <u>773-747-4506 EXT 601</u></td><td>Fax # <u>773-747-4725</u></td></tr><tr><td colspan="2">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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	<u>5/28/2021</u>	(Type or Print Name) <u>Leo LaFranco</u>	(Date)	(Title) <u>CFO</u>		(Signed) _____	<u>5/27/2021</u>	Paid Preparer	(Print Name and Title) <u>Aaron Mauer</u> <u>President</u>		(Firm Name & Address) <u>GGM ASSOCIATES, INC</u> <u>5683 NORTH LINCOLN AVE CHICAGO, IL 60659</u>		(Telephone) <u>773-747-4506 EXT 601</u>	Fax # <u>773-747-4725</u>	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																													
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Date of Initial License for Current Owners: <u>07/01/19</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>☐</td><td>IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	☐	IRS Exemption Code _____	☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
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		☐	Trust																																														
		☐	Other _____																																														
In the event there are further questions about this report, please contact:																																																	
Name: <u>AARON MAUER</u> Telephone Number: <u>773-747-4506</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number ALLURE OF PROPHETSTOWN

0055640 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	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	70	Skilled (SNF)	70	25,620	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	70	TOTALS	70	25,620	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,036	6,106	389	13,531	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,036	6,106	389	13,531	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.81%

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 ☒

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 07/01/19

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/01/19 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 70 and days of care provided 2,288

Medicare Intermediary NORIDIAN ADMINISTRATIVE SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ 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 PROPHETSTOWN** # **0055640** 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 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	168,701	18,039	4,152	190,892		190,892		190,892			1
2	Food Purchase		89,332		89,332		89,332		89,332			2
3	Housekeeping	83,941	11,764		95,705		95,705		95,705			3
4	Laundry	26,942	7,511		34,453		34,453		34,453			4
5	Heat and Other Utilities			144,852	144,852		144,852	(7,290)	137,562			5
6	Maintenance	98,679	44,921	20,006	163,606		163,606	(1,526)	162,080			6
7	Other (specify):*											7
8	TOTAL General Services	378,263	171,567	169,010	718,840		718,840	(8,816)	710,024			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,035,719	86,927	81,564	1,204,210		1,204,210	(37)	1,204,173			10
10a	Therapy			307,913	307,913		307,913		307,913			10a
11	Activities	77,445	4,592		82,037		82,037		82,037			11
12	Social Services			1,690	1,690		1,690		1,690			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			2,541	2,541		2,541		2,541			15
16	TOTAL Health Care and Programs	1,113,164	91,519	406,908	1,611,591		1,611,591	(37)	1,611,554			16
	C. General Administration											
17	Administrative	72,733			72,733		72,733	4,922	77,655			17
18	Directors Fees											18
19	Professional Services			271,940	271,940		271,940	203,323	475,263			19
20	Dues, Fees, Subscriptions & Promotions			17,074	17,074		17,074	1,939	19,013			20
21	Clerical & General Office Expenses	117,352	70,081	72,030	259,463		259,463	(218,557)	40,906			21
22	Employee Benefits & Payroll Taxes			261,030	261,030		261,030	19,825	280,855			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,394	11,394		11,394	2,794	14,188			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,342	79,342		79,342	(1,713)	77,629			26
27	Other (specify):*											27
28	TOTAL General Administration	190,085	70,081	712,810	972,976		972,976	12,533	985,509			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,681,512	333,167	1,288,728	3,303,407		3,303,407	3,680	3,307,087			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			31,499	31,499		31,499	25,513	57,012			30
31	Amortization of Pre-Op. & Org.							5,840	5,840			31
32	Interest			52	52		52	24,052	24,104			32
33	Real Estate Taxes			9,933	9,933		9,933		9,933			33
34	Rent-Facility & Grounds			77,435	77,435		77,435	(55,290)	22,145			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			118,919	118,919		118,919	114	119,033			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			(821)	(821)		(821)	(800)	(1,621)			38
39	Ancillary Service Centers		74,085		74,085		74,085		74,085			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,409	116,409		116,409		116,409			42
43	Other (specify):* Bad Debt			63,576	63,576		63,576	(63,576)				43
44	TOTAL Special Cost Centers		74,085	179,164	253,249		253,249	(64,376)	188,873			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,681,512	407,252	1,586,811	3,675,575		3,675,575	(60,582)	3,614,993			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(346,355)	30		9
10	Interest and Other Investment Income	(3,285)	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	(1,506)	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	(63,576)	43		24
25	Fund Raising, Advertising and Promotional	(17,143)	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	(13,770)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (448,968)		\$	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	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)			34
35	Other- Attach Schedule	388,385	Various	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 388,385		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (60,583)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income Garage fees	\$ (3,816)	5	1
2	Misc income Medical Records	(37)	10	2
3	Misc income Transportation	(800)	38	3
4	Independent Living Expenses	(139)	20	4
5	Independent Living Expenses	(287)	21	5
6	Independent Living Expenses	(1,713)	26	6
7	Independent Living Expenses	(1,939)	34	7
8	Independent Living Expenses	(3,475)	5	8
9	Independent Living Expenses	(402)	6	9
10	Independent Living Expenses	(38)	21	10
11	Independent Living Expenses	(1,124)	6	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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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	(13,770)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(7,291)	1	0	0	0	0	0	0	0	0	0	(7,290)	5
6	Maintenance	(1,526)	0	0	0	0	0	0	0	0	0	0	(1,526)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,817)	1	0	0	0	0	0	0	0	0	0	(8,816)	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	(37)	0	0	0	0	0	0	0	0	0	0	(37)	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	(37)	0	0	0	0	0	0	0	0	0	0	(37)	16
	C. General Administration													
17	Administrative	0	4,922	0	0	0	0	0	0	0	0	0	4,922	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	183,302	20,021	0	0	0	0	0	0	0	0	203,323	19
20	Fees, Subscriptions & Promotions	(139)	2,078	0	0	0	0	0	0	0	0	0	1,939	20
21	Clerical & General Office Expenses	(22,307)	(196,250)	0	0	0	0	0	0	0	0	0	(218,557)	21
22	Employee Benefits & Payroll Taxes	0	19,825	0	0	0	0	0	0	0	0	0	19,825	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,794	0	0	0	0	0	0	0	0	0	2,794	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(1,713)	0	0	0	0	0	0	0	0	0	0	(1,713)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(24,159)	16,671	20,021	0	0	0	0	0	0	0	0	12,533	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,013)	16,672	20,021	0	0	0	0	0	0	0	0	3,680	29

Summary B

Facility Name & ID Number	ALLURE OF PROPHESTTOWN	#	0055640	Report Period Beginning:	01/01/20	Ending:	12/31/20
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number	<u>ALLURE OF PROPHESTOWN</u>
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0055640

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 GENESEO LLC	GENESEO	ALLURE Healthcare S	CHICAGO	MGMT COMPANY
JEREMY GOLDBERG	33	ALLURE OF PROPHETSTOWN LLC	PROPHETSTOWN	Prophetstown Property	CHICAGO	
MEYER OSEROFF	33	ALLURE OF Lake Storey	Galesburg			
		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. ☒ 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	21	Management Fees	\$ 206,792	ALLURE Healthcare Services		\$	(206,792)	1
2	V	5	Heat and Other Utilities		ALLURE Healthcare Services		1	1	2
3	V	17	Administrative		ALLURE Healthcare Services		4,922	4,922	3
4	V	19	Professional Services		ALLURE Healthcare Services		183,302	183,302	4
5	V	20	Dues, Fees, Subscriptions & Promotions		ALLURE Healthcare Services		2,078	2,078	5
6	V	21	Clerical & General Office Expenses		ALLURE Healthcare Services		10,542	10,542	6
7	V	22	Employee Benefits & Payroll Taxes		ALLURE Healthcare Services		19,825	19,825	7
8	V	24	Travel and Seminar		ALLURE Healthcare Services		2,794	2,794	8
9	V	30	Depreciation		ALLURE Healthcare Services		775	775	9
10	V	34	Rent-Facility & Grounds		ALLURE Healthcare Services		3,709	3,709	10
11	V	34	Rent	57,060	Prophetstownw Property			(57,060)	11
12	V								12
13	V								13
14	Total			\$ 263,852			\$ 227,947	\$ * (35,905)	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	19	Professional Services	\$	Prophetstwonw Property		\$ 20,021	\$ 20,021	15
16	V	31	Ammoritzation		Prophetstwonw Property		5,840	5,840	16
17	V	30	Depreciation		Prophetstwonw Property		371,093	371,093	17
18	V	32	Interest		Prophetstwonw Property		27,337	27,337	18
19	V								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			\$			\$ 424,290	\$ * 424,290	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								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

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 PROPHETSTOWN # 0055640 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 ☐
- 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	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						\$	\$			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

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	\$41,737.00	7/1/2020	\$ 1,505,144	\$ 1,490,744	6/30/2025	4.7500	\$ 27,337	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$41,737.00		\$ 1,505,144	\$ 1,490,744			\$ 27,337	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,505,144	\$ 1,490,744			\$ 27,337	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NA 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.)

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.)			\$ 7,539	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 7,539	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 2,394	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.			\$ 9,933	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 PROPHETSTOWN COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0055640

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)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 15-33-151-011		\$ 5,653.74	\$ 5,653.74
2. 15-33-151-013		\$ 1,885.44	\$ 1,885.44
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 7,539.18	\$ 7,539.18

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 providecopies of their original second installment tax bill.

A. Square Feet: 22,848

B. General Construction Type: Exterior Frame Number of Stories

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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

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	70		2020	1967	\$ 711,091	\$ 25,711	39	\$ 9,117	\$ (16,594)	\$ 25,711
5										
6										
7										
8										
	Improvement Type**									
9	NEW FLOORING IN rooms 301,305,302,304,310,314 on the third floor 30			2020	9,904	9,904	39	127	(9,777)	9,904
10	NEW FLOORING IN Rooms 200,208,210 on second floor 200 hall			2020	3,104	3,104	39	40	(3,064)	3,104
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$724,099	\$38,719		\$9,283	\$(29,436)	\$38,719	70

**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	\$ 37,804	\$ 12,601	\$ 12,601	\$ 0	3	\$ 20,162	71
72	Current Year Purchases	351,271	351,271	35,127	(316,144)	5	351,271	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 389,075	\$ 363,872	\$ 47,728	\$ (316,144)		\$ 371,433	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	1,113,174
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	402,591
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	57,012
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(345,579)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	410,152

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:PROPHETSTOWN 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.☒ 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:	1967	70	07/01/19	\$20,375	10		3
4	Additions							4
5								5
6								6
7	TOTAL		70		\$20,375			7

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

9. Option to Buy:☒ YES☐ NO
- Terms:2,083,333*

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: \$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

10. Effective dates of current rental agreement:
Beginning07/01/19
Ending07/01/29

11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2021 | \$ |
| 13. | /2022 | \$ |
| 14. | /2023 | \$ |

* 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.

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

☒ 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		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	10a-3	hrs	\$	1,723	\$	212,132	\$	1,723	\$	212,132	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs		180		5,027		180		5,027	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10a-3	hrs		2,266		90,754		2,266		90,754	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					66,028			66,028	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): X-Ray	39-2						1,041			1,041	12	
13	Other (specify): Lab	39-2						7,017			7,017	13	
14	TOTAL			\$	4,169	\$	307,913	\$	74,086	4,169	\$	381,999	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.

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	\$ 813,627	\$ 844,128	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	686,516	688,701	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,870	28,870	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)	\$ 1,529,013	\$ 1,561,699	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		1,046,429	14
15	Leasehold Improvements, at Historical Cost	13,008	13,008	15
16	Equipment, at Historical Cost	43,694	389,076	16
17	Accumulated Depreciation (book methods)	(39,060)	(410,153)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		29,201	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(5,840)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Replacement reserve</u>	11,151	11,151	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 28,793	\$ 1,172,872	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,557,806	\$ 2,734,571	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 294,311	\$ 296,711	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,777	21,777	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,404	84,404	30
31	Accrued Taxes Payable (excluding real estate taxes)	77,844	77,844	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	<u>PPP Loan</u>	307,294	307,294	36
37	<u>Intercompany Loan</u>		129,478	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 785,630	\$ 917,508	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,490,744	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)	\$	\$ 1,490,744	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 785,630	\$ 2,408,252	46
47	TOTAL EQUITY(page 18, line 24)	\$ 772,176	\$ 326,319	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,557,806	\$ 2,734,571	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 195,240	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 195,240	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	950,149	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	(518,211)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Roudning	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 431,936	17
	B. Transfers (Itemize):		
18	Paid In Capital	145,000	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 145,000	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 772,176	24

* This must agree with page 17, line 47.

Facility Name & ID Number ALLURE OF PROPHETSTOWN

0055640

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**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,994,330	1
2	Discounts and Allowances for all Levels	(48,190)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,946,140	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	167,979	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 167,979	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	452,565	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	43,158	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	575	19
20	Radiology and X-Ray	980	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 497,278	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,285	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,285	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		11,042	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,042	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,625,724	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	718,840	31
32	Health Care	1,611,591	32
33	General Administration	972,976	33
	B. Capital Expense		
34	Ownership	118,919	34
	C. Ancillary Expense		
35	Special Cost Centers	253,249	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)*	\$ 3,675,575	40
41	Income before Income Taxes (line 30 minus line 40)**	950,149	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 950,149	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,088,353	44
45	Private Pay - Net Inpatient Revenue	1,185,691	45
46	Medicare - Net Inpatient Revenue	1,287,060	46
47	Other-(specify) <u>Insurance</u>	385,036	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,946,140	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.

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	1,352	1,360	\$ 98,282	\$ 72.27	1
2	Assistant Director of Nursing	880	880	38,673	43.95	2
3	Registered Nurses	5,509	5,905	248,878	42.15	3
4	Licensed Practical Nurses	6,589	6,802	235,891	34.68	4
5	CNAs & Orderlies	20,872	21,878	391,607	17.90	5
6	CNA Trainees	104	107		0.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,317	4,559	76,451	16.77	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,946	12,336	168,701	13.68	15
16	Dishwashers					16
17	Maintenance Workers	5,444	5,711	99,673	17.45	17
18	Housekeepers	5,946	6,328	83,942	13.27	18
19	Laundry	2,238	2,340	26,942	11.51	19
20	Administrator	1,280	1,280	72,733	56.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,683	5,056	118,596	23.46	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					31
32	Other Health Care(specify)					32
33	Other(specify) MDS	1,638	1,706	21,143	12.39	33
34	TOTAL (lines 1 - 33)	72,798	76,248	\$ 1,681,512 *	\$ 22.05	34

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	\$ 4,152	1-3	35
36	Medical Director	Monthly	13,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	14,213	10-3	38
39	Pharmacist Consultant	Monthly	2,541	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	1,690	12-3	45
46	Other(specify) MDS	Monthly	4,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 40,296		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	74	\$ 8,740	10-3	50
51	Licensed Practical Nurses	8	25,459	10-3	51
52	Certified Nurse Assistants/Aides	940	28,652	10-3	52
53	TOTAL (lines 50 - 52)	1,022	\$ 62,851		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Letha M Dolph	Administrator	0	\$ 13,203
Cherish La Marche	Administrator	0	58,469
Tannis Tyler	Administrator	0	1,061
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,733
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
Mendel Schneider	Accounting Fees	\$	6,000
Alan Goodman	Accounting Fees		550
GGM	Accounting Fees		14,500
Allure Healthcare Services	Management Fees		206,792
Steve Scher	Legal Fees		5,000
Fuchs and Roselli	Legal Fees		200
MEYER MAGENCE	Legal Fees		150
SKIDELSKY & ASSOCIATES	Legal Fees		875
See Professional Fees Sheet	Total		37,873
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 271,940
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance	\$		30,884
Unemployment Compensation Insurance			28,792
FICA Taxes			125,098
Employee Health Insurance			73,995
Employee Meals			59
Illinois Municipal Retirement Fund (IMRF)*			
Pension			6,525
Employee Other benefits			15,225
Background Checks			278
TOTAL (agree to Schedule V, line 22, col.8)			\$ 280,856
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	\$		2,694
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks			
Illinois Health Care			7,420
Secretary of State			153
Whiteside county health dept			330
Other Dues			8,416
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 19,013
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel	\$		
In-State Travel			
Auto Allowance			13,546
Seminar Expense			
Education & Seminars			643
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 14,189

*** Attach copy of IMRF notifications**

****See instructions.**

C. Professional Services		
Vendor/Payee	Type	Amount
GCHMO	Professional Fees	24,117
August Mack	Professional Fees	4,000
PERSONAL PLANNERS	Professional Fees	975
Madison Specs	Professional Fees	4,850
MTS Consulting	Professional Fees	1,570
CJL Consulting	Professional Fees	1,536
Other Professional fees	Professional Fees	825
See Professional Fees Sheet		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		\$ 37,873

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?
If YES, give association name and amount.

HCCI \$3,435

(3)

Did the nursing home make political contributions or payments to a political organization?
If YES, have these costs been properly adjusted out of the cost report?

NO
N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 6,159 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

YES

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO
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)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 116,409

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

(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?
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.

NO

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
N/A
Indicate the amount. \$ N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO
\$ 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?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

NO
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.
Attach invoices and a summary of services for all architect and appraisal fees

N/A