

		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>0046128</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Elmwood Terrace Hlthcare Ctr</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>1017 West Galena</u> <u>Aurora</u> <u>60506</u>																									
Number City Zip Code																									
County: <u>Kane</u>																									
Telephone Number: <u>630-897-3100</u> Fax # ()																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>See Accountant's Report Attached</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Mendel Schneider & Associates CPA PC</u> <u>4051 Old Orchard Rd Skokie Illinois 60076</u></td></tr><tr><td>(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>See Accountant's Report Attached</u>	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Mendel Schneider & Associates CPA PC</u> <u>4051 Old Orchard Rd Skokie Illinois 60076</u>	(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>												
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	(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>																								
Date of Initial License for Current Owners: <u>02/01/03</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</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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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Mendel Schneider</u> Telephone Number: <u>847-933-1274</u>																									
Email Address: _____																									

Facility Name & ID Number Elmwood Terrace Hlthcare Ctr

0046128 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	68	Skilled (SNF)	68	24,888	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	68	TOTALS	68	24,888	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	1,400		1,377	2,777	8
9	SNF/PED					9
10	ICF	12,398	97		12,495	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,798	97	1,377	15,272	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.36%

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 02/18/03

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 02/18/03 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 68 and days of care provided 1,377

Medicare Intermediary Riverbend

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 12/31
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Elmwood Terrace Hlthcare Ctr** # **0046128** 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	170,520	328	4,700	175,548		175,548		175,548			1
2	Food Purchase		120,165		120,165	(3,000)	117,165		117,165			2
3	Housekeeping	148,514	2,712	42,321	193,547		193,547		193,547			3
4	Laundry		2,239		2,239		2,239		2,239			4
5	Heat and Other Utilities			79,484	79,484		79,484		79,484			5
6	Maintenance	47,193		72,597	119,790		119,790		119,790			6
7	Other (specify):*											7
8	TOTAL General Services	366,227	125,444	199,102	690,773	(3,000)	687,773		687,773			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,589,576	231,483	26,869	1,847,928		1,847,928		1,847,928			10
10a	Therapy											10a
11	Activities	47,281	2,101		49,382		49,382		49,382			11
12	Social Services	71,766			71,766		71,766		71,766			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,708,623	233,584	40,069	1,982,276		1,982,276		1,982,276			16
	C. General Administration											
17	Administrative	97,604		42,000	139,604		139,604		139,604			17
18	Directors Fees											18
19	Professional Services			61,368	61,368		61,368	8,500	69,868			19
20	Dues, Fees, Subscriptions & Promotions			24,943	24,943		24,943	(14,787)	10,156			20
21	Clerical & General Office Expenses	96,856	40,208	88,773	225,837		225,837	(5,453)	220,384			21
22	Employee Benefits & Payroll Taxes			384,020	384,020	3,000	387,020		387,020			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,568	5,568		5,568		5,568			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			86,941	86,941		86,941	115,192	202,133			26
27	Other (specify):* MIP							56,764	56,764			27
28	TOTAL General Administration	194,460	40,208	693,613	928,281	3,000	931,281	160,216	1,091,497			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,269,310	399,236	932,784	3,601,330		3,601,330	160,216	3,761,546			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			54,800	54,800		54,800	38,430	93,230			30
31	Amortization of Pre-Op. & Org.			3,920	3,920		3,920	7,723	11,643			31
32	Interest							267,726	267,726			32
33	Real Estate Taxes							55,288	55,288			33
34	Rent-Facility & Grounds			624,000	624,000		624,000	(624,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			682,720	682,720		682,720	(254,833)	427,887			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,560	206,413	252,973		252,973		252,973			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,845	121,845		121,845		121,845			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		46,560	328,258	374,818		374,818		374,818			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,269,310	445,796	1,943,762	4,658,868		4,658,868	(94,617)	4,564,251			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	19,548	30		9
10	Interest and Other Investment Income	(794)	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	(5,717)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,787)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,432)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,182)		\$	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)	(90,435)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (90,435)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (94,617)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Terrace Hlthcare Ctr # 0046128 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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,500	0	0	0	0	0	0	0	0	0	8,500	19
20	Fees, Subscriptions & Promotions	(14,787)	0	0	0	0	0	0	0	0	0	0	(14,787)	20
21	Clerical & General Office Expenses	(8,149)	2,696	0	0	0	0	0	0	0	0	0	(5,453)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	115,192	0	0	0	0	0	0	0	0	0	115,192	26
27	Other (specify):*	0	56,764	0	0	0	0	0	0	0	0	0	56,764	27
28	TOTAL General Administration	(22,936)	183,152	0	0	0	0	0	0	0	0	0	160,216	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(22,936)	183,152	0	0	0	0	0	0	0	0	0	160,216	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Terrace Hlthcare Ctr # 0046128 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	19,548	18,882	0	0	0	0	0	0	0	0	0	38,430	30
31	Amortization of Pre-Op. & Org.	0	7,723	0	0	0	0	0	0	0	0	0	7,723	31
32	Interest	(794)	268,520	0	0	0	0	0	0	0	0	0	267,726	32
33	Real Estate Taxes	0	55,288	0	0	0	0	0	0	0	0	0	55,288	33
34	Rent-Facility & Grounds	0	(624,000)	0	0	0	0	0	0	0	0	0	(624,000)	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	18,754	(273,587)	0	0	0	0	0	0	0	0	0	(254,833)	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	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(4,182)	(90,435)	0	0	0	0	0	0	0	0	0	(94,617)	45

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
Ari Haas	40			Elmwood LLC	Aurora	Bldg Rental
David Abell	30					
Joseph Brandman	30					

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	34	Rent	\$ 624,000	Elmwood Terrace LLC	100.00%	\$	(624,000)	1
2	V	32	Interest		Elmwood Terrace LLC		268,520	268,520	2
3	V	33	Real Estate Taxes		Elmwood Terrace LLC		55,288	55,288	3
4	V	30	Depreciation		Elmwood Terrace LLC		18,882	18,882	4
5	V	31	Amortization		Elmwood Terrace LLC		7,723	7,723	5
6	V	26	Insurance		Elmwood Terrace LLC		115,192	115,192	6
7	V	27	MIP		Elmwood Terrace LLC		56,764	56,764	7
8	V	19	Professional Fees		Elmwood Terrace LLC		8,500	8,500	8
9	V	21	Office		Elmwood Terrace LLC		2,696	2,696	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 624,000			\$ 533,565	\$ * (90,435)	14

* 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	David Abell		Mgmt	30.00		30	50.00	Mgmt Fees	\$ 21,000	17-3	1
2	Joseph Brandman		Mgmt	30.00		30	50.00	Mgmt Fees	21,000	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,000		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 Elmwood Terrace Hlthcare Ctr # 0046128 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	Pillar		X	Mortgage	\$56,307.00	11/21/14	\$ 7,760,000	\$ 7,065,172		3.8000	\$ 268,520	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$56,307.00		\$ 7,760,000	\$ 7,065,172			\$ 268,520	9	
	B. Non-Facility Related*												
10	Interest Income										(794)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (794)	14	
15	TOTALS (line 9+line14)						\$ 7,760,000	\$ 7,065,172			\$ 267,726	15	

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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	51,526	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.)			\$	52,878	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,352	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	53,936	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.			\$	55,288	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	49,576	8	
		2016	46,793	9	
		2017	48,058	10	
		2018	50,516	11	
		2019	52,878	12	
Line 4: 52878 x 1.02				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2019 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

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.

FACILITY NAME Elmwood Terrace Hlthcare Ctr COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0046128

CONTACT PERSON REGARDING THIS REPORT David Abell

TELEPHONE 773-338-4400 FAX #: ()

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.

B. Real Estate Tax Cost Allocations

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

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

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.

A. Square Feet:

15,481

B. General Construction Type:

Exterior

Brick

Frame

Brick

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:

124885/231699

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

10

3. Current Period Amortization:

3920 7723

4. Dates Incurred:

2012,2015

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	Facility	14,666	2003	\$ 50,000	1
2					2
3	TOTALS	14,666		\$ 50,000	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	68		2003		\$ 300,000	\$ 10,909	27.5	\$ 10,909		\$ 194,998
5										
6										
7										
8										
	Improvement Type**									
9	Paving		2005		11,969	436	27.5	436		6,689
10	Tiling		2005		3,895	142	27.5	142		2,215
11	Alarms		2005		9,818	357	27.5	357		5,638
12	Corridor Renovation									
13	New Floor		2010		37,224		27.5	1,354	1,354	14,894
14	Wallcoverings		2010		8,400		27.5	305	305	3,355
15	Hand Rails,Bumper Guards,Corner Guards		2010		21,479		27.5	781	781	7,881
16	Installment of Door Casing		2010		10,125		27.5	368	368	4,048
17	Light Fixtures		2010		9,880		27.5	359	359	3,949
18	Custom Signage		2010		3,661		27.5	133	133	1,463
19	Resident Room Renovation									
20	Remove Existing Cove Base and Install New Cove Base		2010		38,334		27.5	1,394	1,394	15,334
21	Room Renovations		2010		32,671		27.5	1,188	1,188	13,068
22	Bumper Guards		2010		6,984		27.5	254	254	2,794
23	Cubicle Curtains		2010		14,852		27.5	540	540	5,940
24	Head and Foot Boards		2010		7,300		27.5	265	265	2,915
25	Window Treatment		2010		10,531		27.5	383	383	4,213
26	Wall Sconser		2010		5,321		27.5	193	193	2,123
27	Light Fixtures		2010		17,953		27.5	653	653	7,183
28	Bathroom Renovation									
29	New Floor		2010		10,185		27.5	370	370	4,070
30	Mirror		2010		2,657		27.5	97	97	1,067
31	Lighting		2010		3,408		27.5	124	124	1,364
32	Nurses Station Renovation		2010		10,348		27.5	376	376	4,136
33	Dining Room Renovation									
34	New Floor		2010		8,103		27.5	295	295	3,245
35	Wallcoverings		2010		2,053		27.5	75	75	825
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 Elmwood Terrace Hlthcare Ctr

0046128

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Living Room Renovations		\$	\$		\$	\$	\$	37
38	New Carpeting	2010	1,859		27.5	68	68	748	38
39	Wallcoverings	2010	1,524		27.5	55	55	605	39
40	Window Treatments	2010	699		27.5	25	25	275	40
41	Renovated Beauty Salon								41
42	New Roof	2010	1,812		27.5	66	66	726	42
43	Wallcoverings	2010	1,415		27.5	51	51	561	43
44	Custom Cabinets	2010	8,125		27.5	295	295	3,245	44
45	Lighting	2010	1,354		27.5	49	49	539	45
46	Shampoo Station	2010	1,950		27.5	71	71	781	46
47	Corridors,Business Office,Small Dining Room								47
48	Main Dining Room,DON office, Lounge								48
49	Painting and Wallcovers	2010	69,500		27.5	2,527	2,527	27,797	49
50	Install New Windows	2010	32,000		27.5	1,164	1,164	12,804	50
51	Install Dining Room, Window Treatments	2010	743		27.5	27	27	297	51
52	Repave Parking Lot	2010	39,550		27.5	1,438	1,438	15,818	52
53	Enlarge Therapy Room and Install New Flooring								53
54	Plumbing,Lighting and Electric Install,New Sliding Doors	2012	356,721	21,064	27.5	23,781	2,717	202,139	54
55	Replace All Doorstands,Install New Lighting in Res Rooms								55
56	New Nursing Stations and Medication Rooms								56
57	New Bathroom in Dialysis Rooms,Built 2 New Showers								57
58	Generator	2014	122,400	9,806	15	10,465	659	70,073	58
59	Sign	2014	5,021	449	7	878	429	6,337	59
60	Paving	2014	15,098	891	15	1,291	400	8,644	60
61	Water Heaters	2016	11,090	739	15	739		3,326	61
62	Convert Storage Area to ADA Compliant Bathroom	2016	14,200	947	15	947		4,261	62
63	Replace Concrete Sidewalk on East and South Side of Bldg	2016	15,301	1,020	15	1,020		4,590	63
64	Air Ducts,Fan Coil,Condenser,New Drain Pipe	2018	31,448	2,689	15	2,689		7,249	64
65	Air Conditioners	2019	20,284	1,927	15	1,927		2,941	65
66	Plumbing Repairs	2019	5,943	565	15	565		862	66
67	Fox Valley	2019	106,801	10,146	15	10,146		15,486	67
68	Fox Valley Fire Equipment	2020	153,763	7,688	15	7,688		7,688	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,605,752	\$ 69,775		\$ 89,323	\$ 19,548	\$ 711,199	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	27,349	3,907	3,907		7	3,907	72
73	Fully Depreciated Assets	292,100					292,100	73
74								74
75	TOTALS	\$ 319,449	\$ 3,907	\$ 3,907	\$		\$ 296,007	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)	\$ 1,975,201	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 73,682	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 93,230	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,548	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,007,206	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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
		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)	\$			

- (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.

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	

- (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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			206,413			206,413	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				46,560		46,560	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 206,413	\$ 46,560		\$ 252,973	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 198,842	\$ 198,842	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,445,585	4,445,585	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	111,214	159,887	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrows</u>		314,743	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,755,641	\$ 5,119,057	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost	236,700	536,700	14
15	Leasehold Improvements, at Historical Cost	1,370,438	1,442,477	15
16	Equipment, at Historical Cost	199,833	299,833	16
17	Accumulated Depreciation (book methods)	(1,019,143)	(1,343,866)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	242,999	242,999	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(132,112)	(143,755)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 898,715	\$ 1,084,388	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,654,356	\$ 6,203,445	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 479,551	\$ 479,551	26
27	Officer's Accounts Payable	2,532,198	2,532,198	27
28	Accounts Payable-Patient Deposits	13,528	13,528	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,154	116,154	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,130	12,130	31
32	Accrued Real Estate Taxes(Sch.IX-B)		53,936	32
33	Accrued Interest Payable		184,719	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>PPP Loan</u>	476,817	476,817	36
37	<u>Due To Others</u>	2,010,577		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,640,955	\$ 3,869,033	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,065,172	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)	\$	\$ 7,065,172	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,640,955	\$ 10,934,205	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,401	\$ (4,730,760)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,654,356	\$ 6,203,445	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 439,691	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 439,691	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(426,290)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (426,290)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,401	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elmwood Terrace Hlthcare Ctr

0046128

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	\$ 3,662,746	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,662,746	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	119	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 119	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Stimulus Income	569,713	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 569,713	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,232,578	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	690,773	31
32	Health Care	1,982,276	32
33	General Administration	928,281	33
	B. Capital Expense		
34	Ownership	682,720	34
	C. Ancillary Expense		
35	Special Cost Centers	252,973	35
36	Provider Participation Fee	121,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,658,868	40
41	Income before Income Taxes (line 30 minus line 40)**	(426,290)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (426,290)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,790,782	44
45	Private Pay - Net Inpatient Revenue	19,400	45
46	Medicare - Net Inpatient Revenue	852,564	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,662,746	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No, CashBas 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	1,808	2,136	\$ 92,222	\$ 43.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,130	16,995	498,197	29.31	3
4	Licensed Practical Nurses	6,728	8,632	258,341	29.93	4
5	CNAs & Orderlies	36,505	47,361	740,816	15.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,793	3,985	47,281	11.86	10
11	Social Service Workers	1,920	2,080	71,766	34.50	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,094	45,777	21.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,016	9,503	124,743	13.13	15
16	Dishwashers					16
17	Maintenance Workers	2,247	2,395	47,193	19.70	17
18	Housekeepers	9,009	11,639	148,514	12.76	18
19	Laundry					19
20	Administrator	1,960	2,176	97,604	44.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,097	5,954	96,856	16.27	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)					33
34	TOTAL (lines 1 - 33)	93,069	114,950	\$ 2,269,310 *	\$ 19.74	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	47	\$ 4,700	1-3	35
36	Medical Director	Monthly	13,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	335	26,869	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	382	\$ 44,769		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Elmwood Terrace Hlthcare Ctr

0046128

Report Period Beginning:

01/01/20

Ending:

12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries <table> <tr> <th>Name</th> <th>Function</th> <th>Ownership %</th> <th>Amount</th> </tr> <tr> <td>Catherine Larson</td> <td>Administrator</td> <td>0</td> <td>\$ 97,604</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 97,604</td> </tr> </table>				Name	Function	Ownership %	Amount	Catherine Larson	Administrator	0	\$ 97,604																					TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 97,604	D. Employee Benefits and Payroll Taxes <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>Workers' Compensation Insurance</td> <td>\$ 51,843</td> </tr> <tr> <td>Unemployment Compensation Insurance</td> <td>13,299</td> </tr> <tr> <td>FICA Taxes</td> <td>172,602</td> </tr> <tr> <td>Employee Health Insurance</td> <td>146,276</td> </tr> <tr> <td>Employee Meals</td> <td>3,000</td> </tr> <tr> <td>Illinois Municipal Retirement Fund (IMRF)*</td> <td> </td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 22, col.8)</td> </tr> </table>				Description	Amount	Workers' Compensation Insurance	\$ 51,843	Unemployment Compensation Insurance	13,299	FICA Taxes	172,602	Employee Health Insurance	146,276	Employee Meals	3,000	Illinois Municipal Retirement Fund (IMRF)*														TOTAL (agree to Schedule V, line 22, col.8)		F. Dues, Fees, Subscriptions and Promotions <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>IDPH License Fee</td> <td>\$ 3,980</td> </tr> <tr> <td>Advertising: Employee Recruitment</td> <td> </td> </tr> <tr> <td>Health Care Worker Background Check (Indicate # of checks performed)</td> <td>1,606</td> </tr> <tr> <td>Patient Background Checks</td> <td> </td> </tr> <tr> <td>Comcast</td> <td>4,570</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>Less: Public Relations Expense</td> <td>()</td> </tr> <tr> <td>Non-allowable advertising</td> <td>()</td> </tr> <tr> <td>Yellow page advertising</td> <td>()</td> </tr> <tr> <td colspan="2">TOTAL (agree to Sch. V, line 20, col. 8)</td> </tr> </table>				Description	Amount	IDPH License Fee	\$ 3,980	Advertising: Employee Recruitment		Health Care Worker Background Check (Indicate # of checks performed)	1,606	Patient Background Checks		Comcast	4,570											Less: Public Relations Expense	()	Non-allowable advertising	()	Yellow page advertising	()	TOTAL (agree to Sch. V, line 20, col. 8)	
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XX. GENERAL INFORMATION:

- | | |
|---|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u>
If YES, give association name and amount. _____</p> <p>(3) Did the nursing home make political contributions or payments to a political organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>15</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>4,000</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>121,845</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation. _____</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>3,000</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? <u>No</u>
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? <u>0</u>
 d. Have vehicle usage logs been maintained? _____
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
 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. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees</p> |
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