

		FOR BHF USE					

LL1

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: 0045203

Facility Name: GROSSE POINTE MANOR

Address: 6601 WEST TOUHY NILES 60714
Number City Zip Code

County: COOK

Telephone Number: (847) 679-8219 Fax # (847) 679-7377

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2001

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: KATHLEEN MCNAMARA Telephone Number: (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) SHPRINTZA MAUER
(Title) LLC MANAGER

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date) _____
(Print Name and Title) KATHLEEN MCNAMARA VICE-PRESIDENT
(Firm Name & Address) KBKB, LTD 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-3585

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

Facility Name & ID Number GROSSE POINTE MANOR

0045203 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,234</u>	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	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	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			<u>4,563</u>	<u>4,563</u>	8
9	SNF/PED					9
10	ICF	<u>21,504</u>	<u>1,009</u>		<u>22,513</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,504</u>	<u>1,009</u>	<u>4,563</u>	<u>27,076</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.73%

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 1/1/01

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 99 and days of care provided 4,563

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRUAL ☒ 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 **GROSSE POINTE MANOR** # **0045203** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**
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	648,090	37,816	9,623	695,529		695,529		695,529			1
2	Food Purchase		222,513		222,513	(30,104)	192,409	(746)	191,663			2
3	Housekeeping	234,400	49,321		283,721		283,721		283,721			3
4	Laundry	43,660	13,182	3,993	60,835		60,835		60,835			4
5	Heat and Other Utilities			125,017	125,017		125,017	979	125,996			5
6	Maintenance	131,235	44,837	58,146	234,218		234,218	15,839	250,057			6
7	Other (specify):*			6,227	6,227		6,227		6,227			7
8	TOTAL General Services	1,057,385	367,669	203,006	1,628,060	(30,104)	1,597,956	16,072	1,614,028			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,690,057	273,556	10,809	2,974,422		2,974,422	10,617	2,985,039			10
10a	Therapy		691		691		691		691			10a
11	Activities	147,750	1,026		148,776		148,776		148,776			11
12	Social Services			1,085	1,085		1,085		1,085			12
13	CNA Training											13
14	Program Transportation			1,714	1,714		1,714		1,714			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,837,807	275,273	19,608	3,132,688		3,132,688	10,617	3,143,305			16
	C. General Administration											
17	Administrative			127,200	127,200		127,200	(87,607)	39,593			17
18	Directors Fees											18
19	Professional Services			128,106	128,106		128,106	13,888	141,994			19
20	Dues, Fees, Subscriptions & Promotions			116,231	116,231		116,231	(38,495)	77,736			20
21	Clerical & General Office Expenses	256,768	40,578	206,578	503,924		503,924	(8,459)	495,465			21
22	Employee Benefits & Payroll Taxes			663,588	663,588	30,104	693,692		693,692			22
23	Inservice Training & Education			1,148	1,148		1,148		1,148			23
24	Travel and Seminar			13	13		13	230	243			24
25	Other Admin. Staff Transportation							2,290	2,290			25
26	Insurance-Prop.Liab.Malpractice			426,508	426,508		426,508	12,955	439,463			26
27	Other (specify):*			354,232	354,232		354,232	(299,763)	54,469			27
28	TOTAL General Administration	256,768	40,578	2,023,604	2,320,950	30,104	2,351,054	(404,961)	1,946,093			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,151,960	683,520	2,246,218	7,081,698		7,081,698	(378,272)	6,703,426			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				PAGE 3 COLUMN 3 OTHER			
LINE		SCHED REF	TOTAL	LINE		SCHED REF	TOTAL
1	DIETARY			10	NURSING		
	DIETITIAN CONSULTANT	XVIII B 35-2	9,623		CONTRACT NURSING	XVIII C 53-2	4,917
	REPAIRS & MAINTENANCE		0		LABORATORY & XRAY EXPENSE		0
	CONTRACTED DIETARY SERVICES		0		PURCHASED SERVICES		0
			9,623		PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
3	HOUSEKEEPING				RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	2,370
	CONTRACTED HOUSEKEEPING SERVICES		0		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,177
			0		PHARMACY CONSULTANT	XVIII B 39-2	2,345
4	LAUNDRY				UTILIZATION REVIEW FEES	XVIII B __-2	0
	EQUIPMENT REPAIRS & MAINTENANCE		3,993		PHYSICIANS	XVIII B __-2	0
	CONTRACTED LAUNDRY SERVICES		0		PSYCHIATRIC	XVIII B __-2	0
			3,993		RN CONSULTANT	XVIII B 38-2	0
5	HEAT & OTHER UTILITIES						
	GAS HEAT		21,040				
	ELECTRICITY		67,203				
	WATER		34,848				10,809
	CABLE TV - LOBBY		1,926				
			125,017	10a	THERAPY		
6	MAINTENANCE				PHYSICAL THERAPY SERVICES		0
	GROUNDS MAINTENANCE		5,251		SPEECH THERAPY SERVICES		0
	PAINTING & DECORATING		0		OCCUPATIONAL THERAPY SERVICES		0
	BUILDING REPAIRS		0		REHABILITATION CONSULTANT	XVIII B __-2	0
	MAINTENANCE TRAVEL		0		PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	EQUIPMENT MAINTENANCE & REPAIR		36,318		OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	ELEVATOR MAINTENANCE & REPAIR		11,175		RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	OUTSIDE LABOR		0		SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
	EXTERMINATING SERVICE		5,402				
	FIRE SERVICE		0				0
				11	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			58,146				0
7	OTHER			12	SOCIAL SERVICES		
	SCAVENGER		6,227		SOCIAL REHABILITATION SERVICES		0
	SECURITY SERVICE		0		SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
					SOCIAL WORKER	XVIII B 45-2	1,085
			6,227				1,085
9	MEDICAL DIRECTOR			13	NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES		6,000		NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES				PAGE 3 COLUMN 3 OTHER			
LINE		SCHED REF	TOTAL	LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION			22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	PATIENT TRANSPORTATION		1,714		FICA TAXES	XIX D	313,282
			1,714		UNEMPLOYMENT COMPENSATION	XIX D	12,737
17	ADMINISTRATIVE				WORKERS COMPENSATION INSURANCE	XIX D	96,123
	MANAGEMENT FEES	XIX B	127,200		HOSPITALIZATION INSURANCE	XIX D	238,400
	DIRECTORS FEES				EMPLOYEE BENEFITS - OTHER	XIX D	3,046
18	DIRECTORS FEES		0		EMPLOYEE PHYSICAL EXAMS	XIX D	0
19	PROFESSIONAL SERVICES				INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	DATA PROCESSING	XIX C	38,118		PENSION/PROFIT SHARING PLANS	XIX D	0
	ADMINISTRATIVE CONSULTANTS	XIX C	0				
	PROFESSIONAL FEES	XIX C	89,988				
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0				663,588
			128,106	23	INSERVICE TRAINING & EDUCATION		
20	FEES,SUBSCRIPTIONS,PROMOTIONS				EDUCATION & SEMINARS		1,148
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0				1,148
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	28,433	24	TRAVEL & SEMINARS		
	EMPLOYEE WANT ADS	XIX F	32,178		EDUCATION & SEMINARS	XIX G	0
	CONTRIBUTIONS	VI 20 XIX F	0		TRAVEL	XIX G	13
	DUES & SUBSCRIPTIONS	XIX F	27,040				13
	LICENSES & PERMITS	XIX F	15,714	25	ADMIN. STAFF TRANSPORTATION		
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0		TRANSPORTATION - STAFF		0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0				0
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	26	INSURANCE - PROP. LIAB & MALPRACTICE		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	11,823		GENERAL INSURANCE		426,508
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	33				
	PATIENT BACKGROUND CHECKS	XIX F	1,010				426,508
			116,231	27	OTHER		
21	CLERICAL & GENERAL OFFICE EXPENSES				BAD DEBTS	VI 24	354,232
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		20,926				354,232
	EQUIPMENT REPAIR & MAINTENANCE		37,618				
	OUTSIDE CLERICAL SERVICES		120,000				
	PENALTIES / OVERDRAFT CHARGES	VI 18	550				
	HOME OFFICE EXPENSE		0				
	THEFT & DAMAGE LOSS		0				
	TELEPHONE		27,484				
	MESSENGER SERVICE		0				
			206,578				

GRAND TOTAL COLUMN 3 OTHER

2,246,218

GROSSE POINTE MANOR
SCHEDULES
12/31/2020

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	222,513
LESS SALES TAX	(746)
NET FOOD	<u>221,767</u>
TOTAL PATIENT CENSUS	27,076
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	<u>81,228</u>
ADD # EMPLOYEE MEALS/DAY	35
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	<u>12,810</u>
PATIENT MEALS	81,228
ADD EMPLOYEE MEALS	12,810
TOTAL MEALS/YEAR	<u>94,038</u>
NET FOOD	221,767
DIVIDE TOTAL MEALS/YEAR	<u>94,038</u>
COST PER MEAL	2
TIMES EMPLOYEE MEALS	12,810
EMPLOYEE MEAL RECLASSIFICATION	<u><u>30,232</u></u>

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			38,000	38,000		38,000	156,852	194,852			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,684	5,684		5,684	136,173	141,857			32
33	Real Estate Taxes							313,983	313,983			33
34	Rent-Facility & Grounds			636,000	636,000		636,000	(636,000)				34
35	Rent-Equipment & Vehicles			9,924	9,924		9,924	8,805	18,729			35
36	Other (specify):*							21,954	21,954			36
37	TOTAL Ownership			689,608	689,608		689,608	1,767	691,375			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,710	483,553	593,263		593,263		593,263			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			196,281	196,281		196,281		196,281			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		109,710	679,834	789,544		789,544		789,544			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,151,960	793,230	3,615,660	8,560,850		8,560,850	(376,505)	8,184,345			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	(11,620)	30		9
10	Interest and Other Investment Income	(1,186)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(746)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(550)	21		18
19	Entertainment		20		19
20	Contributions	(11,823)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(354,232)	27		24
25	Fund Raising, Advertising and Promotional	(28,433)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A		22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (408,590)		\$	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)	32,085		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 32,085		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (376,505)		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

ID#0045203

Report Period Beginning:1/1/2020

Ending:12/31/2020

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
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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 GROSSE POINTE MANOR# 0045203

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**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	(746)	0	0	0	0	0	0	0	0	0	0	(746)	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	979	0	0	0	0	0	0	0	0	979	5
6	Maintenance	0	9,750	6,089	0	0	0	0	0	0	0	0	15,839	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(746)	9,750	7,068	0	0	0	0	0	0	0	0	16,072	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	10,617	0	0	0	0	0	0	0	0	10,617	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	10,617	0	0	0	0	0	0	0	0	10,617	16
	C. General Administration													
17	Administrative	0	0	(127,200)	39,593	0	0	0	0	0	0	0	(87,607)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,000	2,888	0	0	0	0	0	0	0	0	13,888	19
20	Fees, Subscriptions & Promotions	(40,256)	0	1,761	0	0	0	0	0	0	0	0	(38,495)	20
21	Clerical & General Office Expenses	(550)	0	(25,486)	17,577	0	0	0	0	0	0	0	(8,459)	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	230	0	0	0	0	0	0	0	0	230	24
25	Other Admin. Staff Transportation	0	0	2,290	0	0	0	0	0	0	0	0	2,290	25
26	Insurance-Prop.Liab.Malpractice	0	10,094	2,861	0	0	0	0	0	0	0	0	12,955	26
27	Other (specify):*	(354,232)	0	54,469	0	0	0	0	0	0	0	0	(299,763)	27
28	TOTAL General Administration	(395,038)	21,094	(88,187)	57,170	0	0	0	0	0	0	0	(404,961)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(395,784)	30,844	(70,502)	57,170	0	0	0	0	0	0	0	(378,272)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(11,620)	167,432	1,040	0	0	0	0	0	0	0	0	156,852	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,186)	135,431	1,928	0	0	0	0	0	0	0	0	136,173	32
33	Real Estate Taxes	0	310,360	3,623	0	0	0	0	0	0	0	0	313,983	33
34	Rent-Facility & Grounds	0	(636,000)	0	0	0	0	0	0	0	0	0	(636,000)	34
35	Rent-Equipment & Vehicles	0	0	8,805	0	0	0	0	0	0	0	0	8,805	35
36	Other (specify):*	0	21,954	0	0	0	0	0	0	0	0	0	21,954	36
37	TOTAL Ownership	(12,806)	(823)	15,396	0	0	0	0	0	0	0	0	1,767	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)	(408,590)	30,021	(55,106)	57,170	0	0	0	0	0	0	0	(376,505)	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
SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		

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	\$ 636,000	GROSS POINT MANOR REALTY LLC	100.00%	\$	\$ (636,000)	1
2	V								2
3	V	30	DEPRECIATION				167,432	167,432	3
4	V	32	INTEREST				134,188	134,188	4
5	V	33	REAL ESTATE TAXES				310,360	310,360	5
6	V	19	LEGAL & ACCOUNTING				11,000	11,000	6
7	V	26	INSURANCE				10,094	10,094	7
8	V	36	INSURANCE-MIP				21,954	21,954	8
9	V	32	AMORTIZATION				1,243	1,243	9
10	V	6	REPAIR & MAINTENANCE				9,750	9,750	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 636,000			\$ 666,021	\$ * 30,021	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	17	MANAGEMENT FEES	\$ 127,200	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$	\$ (127,200)	15
16	V	21	BOOKKEEPING SERVICES	120,000				(120,000)	16
17	V								17
18	V								18
19	V								19
20	V	5	UTILITIES				979	979	20
21	V	6	REPAIR & MAINT.-OTHER EXPENSE				6,089	6,089	21
22	V	10	NURSE CONSULTANT				10,617	10,617	22
23	V	19	PROFESSIONAL FEES				2,888	2,888	23
24	V	20	DUES AND SUBSCRIPTION				1,761	1,761	24
25	V	21	CLERICAL & GENERAL - SALARIES				72,389	72,389	25
26	V	21	CLERICAL & GENERAL-OTHER EXPENSE				22,125	22,125	26
27	V	24	SEMINARS AND TRAVEL				230	230	27
28	V	25	AUTO EXPENSE				2,290	2,290	28
29	V	26	INSURANCE				2,861	2,861	29
30	V	27	EMP. BEN. - GEN, ADMIN.				54,469	54,469	30
31	V	30	DEPRECIATION				1,040	1,040	31
32	V	32	INTEREST				1,928	1,928	32
33	V	33	REAL ESTATE TAXES				3,623	3,623	33
34	V	35	AUTO RENTAL				8,567	8,567	34
35	V	35	EQUIPMENT RENTAL				238	238	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 247,200			\$ 192,094	\$ * (55,106)	39

* 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.

X YES NO

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

1		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	6	MAINT COMP - D NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$	\$	15
16	V	17	ADMIN COMP - M MAUER				23,563	23,563	16
17	V	17	ADMIN COMP - M AARON						17
18	V	17	ADMIN COMP - F AARON						18
19	V	17	ADMIN COMP - D AARON				2,154	2,154	19
20	V	17	ADMIN COMP - S GOLDSTEIN						20
21	V	17	ADMIN COMP - R AARON						21
22	V	17	ADMIN COMP - S HARAMARAS						22
23	V	17	ADMIN COMP - D KUFTA						23
24	V	17	ADMIN COMP - HOWARD ALTER						24
25	V	17	ADMIN COMP - NON OWNER - V DAVIS						25
26	V	17	ADMIN COMP - CONTROLLER-NON OWNER				13,876	13,876	26
27	V	21	CLERICAL COMP - S AARON				11,576	11,576	27
28	V	21	CLERICAL COMP - E MARYLES				6,001	6,001	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			\$			\$ 57,170	\$ * 57,170	39

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

Facility Name & ID Number

GROSSE POINTE MANOR

0045203

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	Chana Mauer	12.50%	Bridgeview Health Care Center	Bridgeview	Grosse Pointe Manor Realty LLC		Building Company	1
2	Esther Mauer Maryles	12.50%	Ottawa Pavillion Ltd	Ottawa	Dynamic Healthcare	Skokie	Bookkeeping/Consu	2
3	Freda Mauer	30.40%	Park Ridge Care Center Ltd	Park Ridge	Seasons Hospice	Park Ridge	Hospice	3
4	Joseph Mauer	22.30%	Sterling Pavilion Ltd	Sterling				4
5	Shprintza Mauer	22.30%	Waterfront Terrace Inc	Chicago				5
6			Willow Crest Nursing Pavilion Ltd	Sandwich				6
7			Windmill Nursing Pavilion Ltd	South Holland				7
8			Woodbridge Nursing Pavilion Ltd	Chicago				8
9			Woodbridge Supportive Living Residence of Ga	Galesberg				9
10			Woodbridge Supportive Living Residence of Ga	Galesberg				10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	MARSHALL MAUER	RELATIVE	ADMINISTRATIVE		SEE	3.77	9.43	SALARY	23,563	17-07	2
3					ATTACHED						3
4	DANIEL AARON	RELATIVE				0.5	0.91	SALARY	2,154	17.-07	4
5											5
6	SHARON AARON	RELATIVE	CLERICAL			4.83	12.08	SALARY	11,576	21-07	6
7											7
8	SHERRY MAUER	OWNER	ADMINISTRATIV	22.30				MGMT FEES	127,200	17-03	8
9											9
10	ESTHER MARYLES	SHAREHOLDER	CLERICAL	12.50		8.33	3.33	SALARY	6,001	21-07	10
11											11
12											12
13								TOTAL	\$ 170,494		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 GROSSE POINTE MANOR# 0045203

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

DYNAMIC HEALTH CARE CONSULTANTS

Street Address

3359 W MAIN STREET

City / State / Zip Code

SKOKIE, IL 60076

Phone Number

(847) 679-8219

Fax Number

(847) 679-7377

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	5	UTILITIES	PATIENT DAYS	296,074	9	\$ 10,707	\$ 27,076	\$ 979	1
2	6	REPAIR & MAINT.-OTHER EXPEN	PATIENT DAYS	296,074	9	66,584	27,076	6,089	2
3	10	NURSE CONSULTANT	PATIENT DAYS	296,074	9	116,092	27,076	10,617	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	296,074	9	31,579	27,076	2,888	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	296,074	9	19,254	27,076	1,761	5
6	21	CLERICAL & GENERAL - SALAR	PATIENT DAYS	296,074	9	791,573	791,573	72,389	6
7	21	CLERICAL & GENERAL-OTHER	PATIENT DAYS	296,074	9	241,939	27,076	22,125	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	296,074	9	2,520	27,076	230	8
9	25	AUTO EXPENSE	PATIENT DAYS	296,074	9	25,044	27,076	2,290	9
10	26	INSURANCE	PATIENT DAYS	296,074	9	31,289	27,076	2,861	10
11	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	296,074	9	595,611	27,076	54,469	11
12	30	DEPRECIATION	PATIENT DAYS	296,074	9	11,374	27,076	1,040	12
13	32	INTEREST	PATIENT DAYS	296,074	9	21,081	27,076	1,928	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	296,074	9	39,621	27,076	3,623	14
15	35	AUTO RENTAL	PATIENT DAYS	296,074	9	93,680	27,076	8,567	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	296,074	9	2,605	27,076	238	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,100,553	\$ 791,573	\$ 192,094	25

Facility Name & ID Number GROSSE POINTE MANOR# 0045203

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

DYNAMIC HEALTH CARE CONSULTANTS

Street Address

3359 W MAIN STREET

City / State / Zip Code

SKOKIE, IL 60076

Phone Number

(847) 679-8219

Fax Number

(847) 679-7377

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	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	5	\$ 58,624	\$ 58,624		1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	9	250,000	250,000	4	23,563
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	5	250,000	250,000		
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	3	127,500	127,500		
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	5	9	21,541	21,541	1	2,154
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	230,000	230,000		
7	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	6	3	21,541	21,541		
8	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	1	69,011	69,011		
9	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	5	168,022	168,022		
10	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000		
11	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	5	132,015	132,015		
12	17	ADMIN COMP - CONTROLLER-N	WGHTD AVG HOURS	40	9	114,916	114,916	5	13,876
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	95,871	95,871	5	11,576
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	40	9	72,080	72,080	3	6,001
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					\$ 1,623,121	\$ 1,623,121		\$ 57,170

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	CAMBRIDGE REAL ESTATE		X	MORTGAGE	\$19,769.95	10/30/12	\$ 5,100,000	\$ 4,352,228	11/1/47	3.0500	\$ 134,188	1
2				LOAN COSTS	W/O OVER LOAN		43,516	33,361			1,243	2
3												3
4												4
5												5
	Working Capital											
6	MN FINANCIAL	X		WORKING CAPITAL						PRIME+	5,684	6
7												7
8	MGMT ALLOCATION										1,928	8
9	TOTAL Facility Related				\$19,769.95		\$ 5,143,516	\$ 4,385,589			\$ 143,043	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 5,143,516	\$ 4,385,589			\$ 143,043	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,954 Line # 36

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

** 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.	\$	279,970	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.)			\$	293,956	2
3. Under or (over) accrual (line 2 minus line 1).			\$	13,983	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	300,000	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.			\$	313,983	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	235,229	8		
	2016	249,707	9		
	2017	280,914	10		
	2018	274,573	11		
	2019	293,956	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 GROSSE POINTE MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045203

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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. 10-31-205-030-0000	NURSING HOME	\$ 93,390.59	\$ 93,390.59
2. 10-31-205-031-0000	NURSING HOME	\$ 196,941.97	\$ 196,941.97
3.		\$	\$
4.		\$	\$
5. 10-23-404-059-0000	DYNAMIC HEALTHCARE	\$ 36,915.77	\$ 3,623.00
6.	ALLOCATION	\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 327,248.33	\$ 293,955.56

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.)

C. Tax Bills

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

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

A. Square Feet:

B. General Construction Type:

Exterior

BRICK

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).

N/A

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	FACILITY		2001	\$ 573,648	1
2					2
3	TOTALS			\$ 573,648	3

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

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	BOOK DEPRECIATION		16,491			(16,491)		65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 4,750,713	\$ 183,565		\$ 123,729	\$ (59,836)	\$ 2,497,960	70

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

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	
1	Totals from Page 12A, Carried Forward		\$ 4,750,713	\$ 183,565		\$ 123,729	\$ (59,836)	\$ 2,497,960	1
2	Electrical	2014	2,596		20	130	130	653	2
3	Electrical	2014	2,818		20	141	141	679	3
4	Security system	2014	2,730		20	137	137	1,809	4
5	Gaskets and bolts	2014	5,055		20	253	253	4,045	5
6	Fire alarm equipment	2014	6,759		20	338	338	5,407	6
7	Window Treatements	2014	2,807		20	140	140	2,244	7
8	Window Treatements	2014	10,815		20	541	541	8,473	8
9	New stair modifications	2014	15,400		20	770	770	3,544	9
10	Electrical repair	2015	10,570		20	529	529	2,292	10
11	Furnish/install new solid state starter on elevator	2015	3,895		20	195	195	826	11
12	Amp transfer switch for emergency lighting	2015	3,958		20	198	198	839	12
13	Elevator work	2016	4,350		20	218	218	892	13
14	Fire alarm work	2016	2,719		20	136	136	1,405	14
15	Smoke detectors	2016	3,882		20	194	194	2,005	15
16	Elevator work	2016	4,350		20	218	218	882	16
17	Install new power unit/keyswitch on elevator 1	2017	36,805		20	1,840	1,840	6,572	17
18	Fire alarm system - replace simplex mapnet board	2017	3,153		20	158	158	534	18
19	Repiping - rooms 205/207, boiler and radiator service	2017	4,632		20	232	232	795	19
20	Emergency fire panel circuit - core drilling 1st 2nd floor	2017	2,632		20	132	132	446	20
21	16 position annunciator panel - 2nd floor nurses station	2017	4,372		20	219	219	719	21
22	Replace dock doors, install wiring, electric strikes	2017	17,772		20	889	889	2,921	22
23	Wall repair in kithcen behind stove	2017	3,311		20	1,656	1,656	5,063	23
24	Domestic hot water system pump repair	2017	4,032		20	202	202	808	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,910,126	\$ 183,565		\$ 133,195	\$ (50,370)	\$ 2,551,813	34

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

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,910,126	\$ 183,565		\$ 133,195	\$ (50,370)	\$ 2,551,813	1
2	<u>Building Company</u>								2
3									3
4									4
5									5
6									6
7									7
8	<u>Leasehold Improvements:</u>								8
9	<u>Hvac system pipes</u>	2008	13,550		20	678	678	8,135	9
10	<u>Carpeting</u>	2009	2,657		20	133	133	1,596	10
11	<u>Security camera</u>	2009	3,128		20	156	156	1,873	11
12	<u>Sprinkler heads</u>	2009	7,930		20	397	397	4,763	12
13	<u>Acrylic shower heads</u>	2010	27,144		20	1,357	1,357	14,927	13
14	<u>Phone system</u>	2010	3,764		20	188	188	2,068	14
15	<u>Hot water exchange</u>	2010	15,356		20	768	768	8,448	15
16	<u>Smoke detectors/dampners</u>	2010	4,237		20	212	212	2,332	16
17	<u>Hot water line</u>	2010	33,945		20	1,697	1,697	18,667	17
18	<u>Walk in cooler</u>	2011	115,337		20	5,767	5,767	57,670	18
19	<u>Delay egress alarm syatem</u>	2011	70,878		20	3,544	3,544	35,440	19
20	<u>Delay egress alarm syatem</u>	2011	4,850		20	243	243	2,430	20
21	<u>Vinyl floors</u>	2011	4,151		20	208	208	2,452	21
22	<u>Compressor for ac system</u>	2011	29,584		20	1,479	1,479	14,790	22
23	<u>2 doors/frames for medication rooms</u>	2011	4,690		20	235	235	2,350	23
24	<u>porcelain flooring in 1st floor lobby</u>	2011	22,991		20	1,150	1,150	8,616	24
25	<u>Wooden baseboards in 1st floor lobby</u>	2013	2,577		20	129	129	1,032	25
26	<u>2 exterior building signs (affixed in the building)</u>	2013	19,413		20	971	971	7,150	26
27	<u>Vinyl flooring in 6 resident rooms</u>	2013	3,081		20	172	172	1,376	27
28	<u>Quarry tile flooring in the dishwashing area of kitchen</u>	2013	2,993		20	150	150	1,200	28
29	<u>Fire sprinklers</u>	2013	12,359		20	618	618	4,445	29
30	<u>Exterior lights on building</u>	2013	3,370		20	169	169	1,317	30
31	<u>Ac coolong tower</u>	2013	39,123		20	1,956	1,956	13,734	31
32	<u>Parking lot</u>	2013	5,502		20	275	275	2,108	32
33	<u>Therapy room install new cove base, vct, sheet vinyl, pvt</u>	2016	18,890		20	944	944	4,720	33
34	TOTAL (lines 1 thru 33)		\$ 5,381,626	\$ 183,565		\$ 156,791	\$ (26,774)	\$ 2,775,452	34

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

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	
1	Totals from Page 12C, Carried Forward		\$ 5,381,626	\$ 183,565		\$ 156,791	\$ (26,774)	\$ 2,775,452	1
2	Lighting Signage, evac, signs, new drywall in resident rooms	2016	11,238		20	562	562	2,810	2
3	Vestibule and lobby lighting, elevator flooring, wallcovering, light	2016	242,696		20	12,135	12,135	60,675	3
4	1st floor corridor and seating, wallcovering, signage, corner guards								4
5	2nd floor corridor, resident rooms, cove base, flooring, handrails								5
6	2nd floor corridor, resident bathroom flooring, roller shades, cove bases								6
7	plumbing tile, millwork, grab bars, towel bars, wall mount sink								7
8	3rd floor corridor, resident bathrooms, carpet, tile, millwork								8
9	handrails, bumperguards, upholstered cornice, cove base								9
10	wallcovering and paint 1st, 2nd, 3rd floors/corridors/resident rooms								10
11	chiller	2018	99,830		39	853	853	2,559	11
12	Replace Front Door Install Trip Charge	2019	5,055		10	337	337	674	12
13	Air Condition repair	2019	11,535		10	769	769	1,538	13
14	Repiped Kitchen Water Lines	2019	14,928		10	995	995	1,990	14
15	Installed New Colling Tower Motor	2019	3,203		10	160	160	320	15
16	Installed 3 New Security Cameras	2019	3,173		10	159	159	318	16
17	New Floor -second, third floor east and west wings, fourth floor	2019	6,135		10	256	256	512	17
18	lobby								18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,779,419	\$ 183,565		\$ 173,017	\$ (10,548)	\$ 2,846,848	34

**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	\$ 228,046	\$ 19,221	\$ 20,566	\$ 1,345	10	\$ 167,337	71
72	Current Year Purchases	18,432	3,686	922	(2,764)	10	922	72
73	Fully Depreciated Assets	138,887					138,857	73
74	RELATED PARTY			347	347			74
75	TOTALS	\$ 385,365	\$ 22,907	\$ 21,835	\$ (1,072)		\$ 307,116	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		2005 TOYOTA RAV 4	2006	\$ 18,500	\$	\$	\$		\$ 18,500
77									
78									
79									
80	TOTALS			\$ 18,500	\$	\$	\$		\$ 18,500

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)			\$ 6,756,932	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 206,472	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 194,852	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ (11,620)	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 3,172,464	

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: N/A RELATED PARTY
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? YES NO
16. Rental Amount for movable equipment: \$ 5,677 Description: SCHEDULE ATTACHED
(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	FACILITY	2019 HYUNDAI TUSCON	\$	\$ 4,247	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,247	21

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

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

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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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	39-3	hrs	\$		\$ 212,337	\$		\$ 212,337	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			56,213			56,213	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			215,003			215,003	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				79,411		79,411	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY								0	
	Other (specify): RENTALS	39-2					30,299		30,299	13
14	TOTAL			\$		\$ 483,553	\$ 109,710		\$ 593,263	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	\$ 874,223	\$ 900,019	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 354,457)	2,999,302	2,999,302	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	123,110	143,655	6
7	Other Prepaid Expenses	5,195	5,195	7
8	Accounts Receivable (owners or related parties)	10,000	20,000	8
9	Other(specify): <u>ESCROWS</u>		296,420	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,011,830	\$ 4,364,591	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		573,648	13
14	Buildings, at Historical Cost		3,862,200	14
15	Leasehold Improvements, at Historical Cost	478,210	1,258,157	15
16	Equipment, at Historical Cost	403,865	994,414	16
17	Accumulated Depreciation (book methods)	(575,902)	(3,446,668)	17
18	Deferred Charges	152,210	400,631	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Security deposit</u>	19,580	19,580	22
23	Other(specify): <u>LOAN COSTS</u>		33,362	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 477,963	\$ 3,695,324	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,489,793	\$ 8,059,915	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 838,701	\$ 892,462	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		105,970	29
30	Accrued Salaries Payable	286,230	286,230	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,409	4,409	31
32	Accrued Real Estate Taxes(Sch.IX-B)		300,000	32
33	Accrued Interest Payable		11,062	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO OTHERS</u>	800,443	800,443	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,929,783	\$ 2,400,576	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,246,258	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)	\$	\$ 4,246,258	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,929,783	\$ 6,646,834	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,560,010	\$ 1,413,081	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,489,793	\$ 8,059,915	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,331,659	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,331,659	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	678,351	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	(450,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 228,351	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)	\$ 2,560,010	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 8,130,010	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,130,010	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,692	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 283,692	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***	1,186	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,186	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STIMULUS PAYMENT	824,313	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 824,313	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,239,201	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,628,060	31
32	Health Care	3,132,688	32
33	General Administration	2,320,950	33
	B. Capital Expense		
34	Ownership	689,608	34
	C. Ancillary Expense		
35	Special Cost Centers	593,263	35
36	Provider Participation Fee	196,281	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,560,850	40
41	Income before Income Taxes (line 30 minus line 40)**	678,351	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 678,351	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,912,512	44
45	Private Pay - Net Inpatient Revenue	439,857	45
46	Medicare - Net Inpatient Revenue	2,777,641	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,130,010	49

**TAX RETURN

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

PREPARED ON
CASH BASIS** Does this agree with taxable income (loss) per Federal Income
Tax Return? NO** 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	2,720	3,300	\$ 167,971	\$ 50.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,818	16,305	547,741	33.59	3
4	Licensed Practical Nurses	13,277	14,409	487,857	33.86	4
5	CNAs & Orderlies	63,647	69,153	1,486,488	21.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,247	7,124	147,750	20.74	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,422	1,813	37,910	20.91	13
14	Head Cook	8,507	9,220	167,096	18.12	14
15	Cook Helpers/Assistants	26,469	28,446	443,084	15.58	15
16	Dishwashers					16
17	Maintenance Workers	5,230	5,730	131,235	22.90	17
18	Housekeepers	13,139	14,204	234,400	16.50	18
19	Laundry	1,978	2,177	43,660	20.06	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,489	10,608	256,768	24.21	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)	166,943	182,489	\$ 4,151,960 *	\$ 22.75	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	M	\$ 9,623	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,177	10-3	37
38	Nurse Consultant	T	2,370	10-3	38
39	Pharmacist Consultant	H	2,345	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,515		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	91	\$ 4,530	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides	15	387	10-3	52
53	TOTAL (lines 50 - 52)	106	\$ 4,917		53

Facility Name & ID Number		GROSSE POINTE MANOR		STATE OF ILLINOIS		# 0045203		Report Period Beginning:		1/1/2020		Page 21		Ending: 12/31/2020	
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function		Ownership %		Amount		Description		Amount		Description		Amount	
						\$		Workers' Compensation Insurance		\$ 96,123		IDPH License Fee		\$ 1,990	
								Unemployment Compensation Insurance		12,737		Advertising: Employee Recruitment		32,178	
								FICA Taxes		313,282		Health Care Worker Background Check		33	
								Employee Health Insurance		238,400		(Indicate # of checks performed 2)			
								Employee Meals		30,104		Patient Background Checks		101 1,010	
								Illinois Municipal Retirement Fund (IMRF)*				TRUST/FRANCHISE/CONTRIB/ETC		11,823	
								EMPLOYEE BENEFITS - OTHER		3,046		MARKETING/ADV/PROMO		28,433	
										0		LICENSES/DUES/SUBSCRIPTIONS		40,764	
										0		MGMT CO ALLOC		1,761	
										0		TRUST/FRANCHISE/CONTRIB/ETC		(11,823)	
												Less: Public Relations Expense		(0)	
												Non-allowable advertising		(28,433)	
												Yellow page advertising		(0)	
TOTAL (agree to Schedule V, line 17, col. 1)						\$		TOTAL (agree to Schedule V, line 22, col.8)		\$ 693,692		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 77,736	
(List each licensed administrator separately.)															
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**							
Description				Description		Line #		Amount		Description		Amount			
SHERRY MAUER MANAGEMENT FEES								\$		Out-of-State Travel		\$			
										In-State Travel					
												13			
										MGMT CO ALLOC		230			
										Seminar Expense					
												0			
										Entertainment Expense		()			
										(agree to Sch. V, line 24, col. 8)					
TOTAL (agree to Schedule V, line 17, col. 3)								\$		TOTAL		\$ 243			
(Attach a copy of any management service agreement)															
C. Professional Services															
Vendor/Payee		Type		Amount											
				\$											
SEE ATTACHED SCHEDULE				128,106											
TOTAL (agree to Schedule V, line 19, column 3)				\$ 128,106											
(For legal fee disclosure, see page 39 of instructions)															
				* Attach copy of IMRF notifications								**See instructions.			

**GROSSE POINTE MANOR
SCHEDULE - LEGAL
12/31/2020**

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
11/15/2019	BAKER DONELSON	PRIVACY & SECURITY MATTERS	1,726
12/16/2019	BAKER DONELSON	PRIVACY & SECURITY MATTERS	125
1/1/2020	MUCH SHELIST, P.C.	GENERAL COUNSELING - 2019 SERVICE	1,170
2/29/2020	NEAL, GERBER, & EISENBER LLP	LABOR & EMPLOYMENT	551
4/14/2020	NEAL, GERBER, & EISENBER LLP	LABOR & EMPLOYMENT	275
4/30/2020	NEAL, GERBER, & EISENBER LLP	LABOR & EMPLOYMENT	3,404
5/31/2020	NEAL, GERBER, & EISENBER LLP	LABOR & EMPLOYMENT	5,735
6/30/2020	NEAL, GERBER, & EISENBER LLP	LABOR & EMPLOYMENT	220
2/29/2020	POLSINELLI PC	FEBRUARY 2020 IDPH SURVEY	2,906
5/26/2020	POLSINELLI PC	FEBRUARY 2020 IDPH SURVEY	1,785
5/31/2020	POLSINELLI PC	FEBRUARY 2020 IDPH SURVEY	105
6/30/2020	POLSINELLI PC	GENERAL MATTER	2,500
7/20/2020	POLSINELLI PC	FEBRUARY 2020 IDPH SURVEY	788
9/30/2020	POLSINELLI PC	GENERAL MATTER	275
2/13/2020	STOUT RISUS ROSS, INC.	R/E APPRAISAL	5,525
6/1/2020	YURI RUTMAN	LEGAL GUARDIANSHIP	1,200
TOTAL LEGAL FEES			----- 28,289 =====

XX. GENERAL INFORMATION:

- | | |
|--|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>YES</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>YES</u>
If YES, give association name and amount. <u>IL HEALTH CARE COUNCIL-\$38,863</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action 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>10 YR</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>27,629</u> Line <u>10-2</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. <u>NO</u></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>196,281</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>30,232</u> Has any meal income been offset against related costs? <u>N/A</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>5%</u>
d. Have vehicle usage logs been maintained? <u>NO</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>NO</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>YES</u>
g. Does the facility transport residents to and from day training? <u>NO</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></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> |
|--|--|