

		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>0049353</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Manorcare of Palos Hts West</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/2019</u> to <u>05/31/2020</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>11860 Southwest Hwy</u> <u>Palos Heights</u> <u>60463</u> Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(708) 361-4555</u> Fax # <u>(708) 361-3777</u>																																																	
HFS ID Number: _____																																																	
Date of Initial License for Current Owners: <u>04/15/1996</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Martin D. Allen</u></td></tr><tr><td>(Title) <u>Director</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Martin D. Allen</u>	(Title) <u>Director</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>																																			
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	(Telephone) <u>()</u> Fax # <u>()</u>																																																
Type of Ownership:																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td>_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County			☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.		_____			☐	Limited Liability Co.		_____			☐	Trust		_____			☐	Other _____		_____
☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL																																												
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		☐	Trust		_____																																												
		☐	Other _____		_____																																												
IRS Exemption Code <u>501(c)(3)</u>																																																	
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE																																															
Name: <u>A. Dean Shipman</u>		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES																																															
Telephone Number: <u>(419) 254-7841</u>		201 S. Grand Avenue East																																															
Email Address: _____		Springfield, IL 62763-0001																																															
		Phone # (217) 782-1630																																															

Facility Name & ID Number Manorcare of Palos Hts West

0049353 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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>130</u>	Skilled (SNF)	<u>130</u>	<u>47,580</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>130</u>	TOTALS	<u>130</u>	<u>47,580</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>17,789</u>	<u>2,016</u>	<u>17,443</u>	<u>37,248</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,789</u>	<u>2,016</u>	<u>17,443</u>	<u>37,248</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.28%

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 04/15/1996

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/25/2018 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 130 and days of care provided 9,665

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 5/31
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare of Palos Hts West # 0049353 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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	411,377	38,942	47	450,366		450,366		450,366			1
2	Food Purchase		267,305		267,305		267,305	(98)	267,207			2
3	Housekeeping	243,813	27,004	852	271,669		271,669		271,669			3
4	Laundry	34,663	29,035		63,698		63,698		63,698			4
5	Heat and Other Utilities			204,174	204,174	3,381	207,555		207,555			5
6	Maintenance	52,247	14,325	167,530	234,102		234,102		234,102			6
7	Other (specify):* Security & Waste			15,124	15,124		15,124		15,124			7
8	TOTAL General Services	742,100	376,611	387,727	1,506,438	3,381	1,509,819	(98)	1,509,721			8
	B. Health Care and Programs											
9	Medical Director			22,770	22,770		22,770		22,770			9
10	Nursing and Medical Records	4,028,067	337,909	119,253	4,485,229	155	4,485,384		4,485,384			10
10a	Therapy	1,464,880	13,017	11,952	1,489,849		1,489,849		1,489,849			10a
11	Activities	85,483	2,367	2,228	90,078		90,078	(20)	90,058			11
12	Social Services	160,231	720		160,951		160,951		160,951			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,738,661	354,013	156,203	6,248,877	155	6,249,032	(20)	6,249,012			16
	C. General Administration											
17	Administrative	111,610		460,276	571,886	(82,301)	489,585		489,585			17
18	Directors Fees											18
19	Professional Services			63,544	63,544		63,544	(63,544)				19
20	Dues, Fees, Subscriptions & Promotions			94,493	94,493		94,493	(22,448)	72,045			20
21	Clerical & General Office Expenses	405,415	72,550	619,879	1,097,844		1,097,844	(499,730)	598,114			21
22	Employee Benefits & Payroll Taxes			1,090,306	1,090,306	58,474	1,148,780		1,148,780			22
23	Inservice Training & Education			4,172	4,172		4,172		4,172			23
24	Travel and Seminar			10,097	10,097		10,097		10,097			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,039,046	1,039,046		1,039,046		1,039,046			26
27	Other (specify):*											27
28	TOTAL General Administration	517,025	72,550	3,381,813	3,971,388	(23,827)	3,947,561	(585,722)	3,361,839			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,997,786	803,174	3,925,743	11,726,703	(20,291)	11,706,412	(585,840)	11,120,572			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			339,779	339,779	24,030	363,809		363,809			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(6,380)	(6,380)	(3,739)	(10,119)		(10,119)			32
33	Real Estate Taxes			479,096	479,096		479,096		479,096			33
34	Rent-Facility & Grounds			856,044	856,044		856,044	(856,044)				34
35	Rent-Equipment & Vehicles			77,025	77,025		77,025		77,025			35
36	Other (specify):*											36
37	TOTAL Ownership			1,745,564	1,745,564	20,291	1,765,855	(856,044)	909,811			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			46	46		46		46			38
39	Ancillary Service Centers		468,764	137	468,901		468,901		468,901			39
40	Barber and Beauty Shops			6,644	6,644		6,644		6,644			40
41	Coffee and Gift Shops	2,096			2,096		2,096		2,096			41
42	Provider Participation Fee			223,236	223,236		223,236		223,236			42
43	Other (specify):* IV Therapy		93,511	95,979	189,490		189,490		189,490			43
44	TOTAL Special Cost Centers	2,096	562,275	326,042	890,413		890,413		890,413			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,999,882	1,365,449	5,997,349	14,362,680		14,362,680	(1,441,884)	12,920,796			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(98)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(13)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(26)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(26,300)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(498,546)	21		24
25	Fund Raising, Advertising and Promotional	(22,448)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(894,381)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,441,884)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,441,884)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exeptional Care Program		X			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	Activity Income	\$ (20)	11	1
2	Misc. Income		21	2
3	Vending Income	(1,073)	21	3
4	Donations Revenue		21	4
5	Accounting/Collection Fees	(37,244)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest		32	8
9	WT Rent Expense	(856,044)	34	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(894,381)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Home Health Care	Toledo	Nursing Staff

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	See	Home Office Allocation	\$ 460,276	HCR Manor Care Services, LLC	0.00%	\$ 460,276	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	6,999,883	Heartland Employment Services, LLC	0.00%	6,999,883		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 7,460,159			\$ 7,460,159	\$ *	14

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

Facility Name & ID Number

Manorcare of Palos Hts West

0049353

Report Period Beginning:

06/01/2019

Ending:

05/31/2020

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			Heartland of Galesburg IL, LLC	Galesburg				1
2			Heartland of Henry IL, LLC	Henry				2
3			Heartland of Macomb IL, LLC	Macomb				3
4			Heartland of Moline IL, LLC	Moline				4
5			Manor Care at Arlington Heights	Arlington Heights				5
6			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				6
7			Manor Care of Hinsdale IL, LLC	Hinsdale				7
8			Manor Care of Homewood IL, LLC	Homewood				8
9			Manor Care of Libertyville IL, LLC	Libertyville				9
10			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				10
11			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				11
12			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				12
13			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Arden Courts of Geneva IL, LLC	Geneva				14
15			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				15
16			Arden Courts of Northbrook IL, LLC	Northbrook				16
17			Arden Courts of Palos Heights IL, LLC	Palos Heights				17
18			Arden Courts of South Holland IL, LLC	South Holland				18
19								19
20								20
21								21
22								22
23								23
24	Martin D. Allen	BOD						24
25	Lynne Davis	BOD						25
26	Kathryn S. Hoops	BOD						26
27	Thomas Kile	BOD						27
28	Patricia McCormick	BOD						28
29	Rami Ubaydi	BOD						29
30								30

Facility Name & ID Number Manorcare of Palos Hts West # 0049353 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Manorcare of Palos Hts West# 0049353

Report Period Beginning:

06/01/2019Ending: 5/31/2020

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 ☐

Name of Related Organization

HCR Manor Care Services LLC

Street Address

333 North Summit Street

City / State / Zip Code

Toledo, OH 43604-2617

Phone Number

(419) 252-5500

Fax Number

(419) 254-5495

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	\$ 709,073	\$ 0	12,571,737	\$ 3,381	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs		0	12,571,737	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	12,571,737	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	32,137	0	12,571,737	152	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	454	0	12,571,737	3	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	12,571,737	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	57,708,481	23,053	12,571,737	275,149	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	7,841,321	0	12,571,737	46,677	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs	2,818,405	0	12,571,737	56,149	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	5,631,859	35,913,957	12,571,737	26,852	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	5,312,192	1,179,502	12,571,737	31,622	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs		0	12,571,737	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	4,013,110	0	12,571,737	19,134	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	822,456	0	12,571,737	4,896	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	12,571,737	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	2,636,740,077		(782,905)		12,571,737	(3,733)	22
23	32	Directly Assigned Interest	Not Allocated			(8,038)			(6)	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,182,124				24
25	TOTALS					\$ 118,280,668	\$ 37,116,512		\$ 460,276	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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Home Office Pooled and Directly Assigned Interest Expense											(3,739)	6
7	Interest Income / Interest Expense											(6,380)	7
8													8
9	TOTAL Facility Related						\$					\$ (10,119)	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$ (10,119)	15

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

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

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

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.		\$	412,339	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.)				\$	474,416	2
3. Under or (over) accrual (line 2 minus line 1).				\$	62,077	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	425,855	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.)				\$	10,268	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 \$ (19,105) For 2016 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(19,105)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	479,095	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2015	392,088	8			
	2016	398,279	9			
	2017	449,510	10			
	2018	465,579	11			
	2019	481,358	12			
Line 2: \$412,339 = \$218,348.29 for 2nd half 2018+ \$256,068.20 for 1st half 2019						
Line 4: \$425,855= \$225,289.50 for 2nd half 2019 + \$200,565.83 estimate for 1st half 2020						
Line 5: \$10,268= \$229.25 for Objection FY 17; \$4776.00 for Objection FY 18; \$5,262.31 for Complaint FY 2020						
Line 6: \$(19,105) = \$19,104.55 refund for FY 16						
				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 Manorcare of Palos Hts West COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049353

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>23-24-300-341-0000</u>	<u>See Attached</u>	\$ <u>481,357.80</u>	\$ <u>481,357.80</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>481,357.80</u></u>	\$ <u><u>481,357.80</u></u>

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,757

B. General Construction Type: ExteriorMasonryFrameSteelNumber of Stories2

C. Does the Operating Entity?

☐ (a) Own the Facility☒ (b) Rent from a Related Organization.☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment☐ (b) Rent equipment from a Related Organization.☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	124,110	1996	\$ 705,000	1
2					2
3	TOTALS	124,110		\$ 705,000	3

Facility Name & ID Number Manorcare of Palos Hts West

0049353

Report Period Beginning:

06/01/2019

Ending:

05/31/2020

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	130			1996	\$ 5,345,094	\$ 133,627		\$ 133,627	\$	\$ 3,219,620
5										
6										
7										
8										
	Improvement Type**									
9	Current Year Depreciation					143,914		143,914		2,260,211
10				1996	398,017					
11				1997	165,442					
12				1998	67,765					
13				1999	27,686					
14				2000	74,134					
15				2001	129,144					
16	VINYL WALLCOVERING & BORDERS			2002	1,250					
17	CARPET, VINYL WALLCOVERING & BORDERS			2002	64,471					
18	FLOORING IN PUBIC RESTROOM			2003	2,125					
19	WALLCOVERING & PAINTING			2003	9,129					
20	DOORS			2003	3,109					
21	WINDOW TREATMENTS			2003	2,527					
22	CONSTRUCTION DEPT. COST & INTEREST			2004	12,658					
23	Adjust Cap Audit FY 19 - remove OH and interest				(12,658)					
24	WALLCOVERING & PAINTING			2004	39,469					
25	TV ANTENNA JACKS & COAX WIRING			2004	3,140					
26	DOORS			2004	1,020					
27	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization				(1,020)					
28	Sealcoat & Restripe Parking Lot			2004	2,280					
29	Renov. - General Overhead & Interest			2004	3,752					
30	Adjust Cap Audit FY 19 - remove OH and interest			2004	(3,752)					
31	Renov. - Painting			2004	35,265					
32	Renov. - Wallcovering & Corner Guards			2004	6,697					
33	Renov. - Carpentry			2004	4,180					
34	Dorrs			2004	4,483					
35	Ceramic Tile			2005	2,990					
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 Manorcare of Palos Hts West

0049353

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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	
37	Wallcovering & Painting	2005	\$ 8,452	\$		\$	\$		37
38	Carpet	2005	5,362						38
39	FABRICS / CURTAINS	2005	3,914						39
40	FABRICS / CURTAINS	2005	1,150						40
41	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization		(1,150)						41
42	Shower Floors	2005	9,945						42
43	Ceramic Tile / Bathrooms	2005	10,800						43
44	Painting	2005	3,859						44
45	1 new Rated Door	2005	1,260						45
46	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization		(1,260)						46
47	electrical work	2006	904						47
48	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization		(904)						48
49	drywall / access panels	2006	1,044						49
50	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization		(1,044)						50
51	12 doors	2006	4,495						51
52	4 simplex locks	2007	2,128						52
53	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization		(2,128)						53
54	Renov - General overhead & interest	2007	29,772						54
55	Adjust Cap Audit FY 19 - remove OH and interest		(29,772)						55
56	Renov - Carpentry & Subcontr	2007	8,370						56
57	Renov - resilient flooring	2007	88,568						57
58	Renov - Carpeting & Pads	2007	10,156						58
59	Renov - Wallcovering	2007	110,905						59
60	renov - basic electrical	2007	8,735						60
61	electrical for lighting	2007	1,692						61
62	3 roof top units	2007	29,952						62
63	Consulting for PT Expansion	2008	4,847						63
64	Bathroom floor and toilets	2007	7,106						64
65	door frame and flooring	2008	4,542						65
66	fire doors	2008	6,260						66
67	fire dampers	2009	12,600						67
68	Renov - Arch & engineering cost	2009	2,479						68
69	Renov - resilient flooring	2009	885						69
70	TOTAL (lines 4 thru 69)		\$ 6,732,321	\$ 277,541		\$ 277,541	\$	\$ 5,479,831	70

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

Facility Name & ID Number Manorcare of Palos Hts West

0049353

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 6,732,321	\$ 277,541		\$ 277,541		\$ 5,479,831	1
2	Renov - Wallcovering	2009	7,534						2
3	Renov - General overhead & interest	2009	9,308						3
4	Adjust Cap Audit FY 19 - remove OH and interest		(9,308)						4
5	Renov -Interest on Const	2009	868						5
6	Adjust Cap Audit FY 19 - remove interest		(868)						6
7	Renov - Carpentry & Subcontr	2009	69,237						7
8	Renov - Carpentry & Subcontr	2009	41,772						8
9	UL-263 Ceiling	2009	4,540						9
10	2 rooftop replacements	2009	25,017						10
11	water heater	2009	845						11
12	water heater	2009	1,293						12
13	water heater	2009	13,500						13
14	10tib RTU	2010	16,604						14
15	Install PTAC	2010	1,661						15
16	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization		(1,661)						16
17	flooring	2010	3,078						17
18	Parking lot paving	2009	13,669						18
19	flooring, 2nd flr dining	2010	6,420						19
20	curbs & flash in roof deck	2010	2,300						20
21	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization		(2,300)						21
22	air vent grills	2010	13,475						22
23	carpeting	2010	2,633						23
24	frt carpeting	2010	161						24
25	3000 make up air unit	2010	26,578						25
26	additional air vent grills	2011	5,995						26
27	roof ventilator	2011	2,764						27
28	kitchen ceiling fans	2011	8,870						28
29	floor and wall tile 2 restrooms	2011	12,877						29
30	carpet install in Admin	2011	2,867						30
31	pave parking lot	2010	6,986						31
32	doors and frames in corridors	2011	49,214						32
33	Adjust Cap Audit FY 19 - remove OH and interest		(2,914)						33
34	TOTAL (lines 1 thru 33)		\$ 7,065,336	\$ 277,541		\$ 277,541		\$ 5,479,831	34

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

Facility Name & ID Number Manorcare of Palos Hts West

0049353

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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 12B, Carried Forward		\$ 7,065,336	\$ 277,541		\$ 277,541		\$ 5,479,831	1
2	Renov - Fire Damper upgrade in bldg	2011	51,784						2
3	Adjust Cap Audit FY 19 - remove OH and interest		(2,184)						3
4	Renov - Basic Electrical for fire damper upgrade	2011	1,804						4
5	2000 sq. ft. of lower roof	2011	8,360						5
6	4 fire rated access hatch	2011	9,870						6
7	Renov - Carpentry 1st & 2nd floor offices & copier rooms	2011	36,225						7
8	Renov - Carpeting 1st & 2nd floor offices & copier rooms	2011	313						8
9	Renov - Wallcovering 1st & 2nd floor offices & copier rooms	2011	1,895						9
10	Revov - Basic Electrical 1st & 2nd floor offices & copier rooms	2011	4,802						10
11	HM door at electrical room	2011	2,410						11
12	3 sets of exterior HM door	2011	22,905						12
13	countertop for 2nd flr nourishment	2012	3,055						13
14	3 insinkerators	2012	10,317						14
15	Roofing membrane - main roof	2012	8,424						15
16	hot water heater	2012	17,985						16
17	vinyl flooring 14 baths on 2nd floor	2012	11,862						17
18	Concrete sidewalk -perimeter of facility	2012	9,920						18
19	Electrical panel -kitchen	2012	1,665						19
20	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization		(1,665)						20
21	Fusible links in 80 fire dampers	2012	10,025						21
22	Bathroom flooring in 19 resident rooms on 2nd floor	2012	16,485						22
23	Ceiling mounted heater in lobby	2013	3,680						23
24	Parking lot overlay	2013	8,121						24
25	Roofing	2013	8,658						25
26	Elevator door	2014	5,400						26
27	Electrical-admin, HR, 1st flr DON ofcs. Med rms	2014	5,380						27
28	Parking Exp - Asphalt paving	2014	41,730						28
29	Parking Exp - Landscaping & Grading and Exterior Signs	2014	203,362						29
30	Parking Exp - Concrete Paving	2014	72,432						30
31	Parking Exp - Permanent Fencing	2014	11,294						31
32	COMPRESSOR MOTOR	2015	2,606						32
33	Door restrictors-(3) elevator	2015	4,050						33
34	TOTAL (lines 1 thru 33)		\$ 7,658,306	\$ 277,541		\$ 277,541		\$ 5,479,831	34

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

Facility Name & ID Number Manorcare of Palos Hts West

0049353

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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 12C, Carried Forward		\$ 7,658,306	\$ 277,541		\$ 277,541		\$ 5,479,831	1
2	EZ path devices (8) @ smoke alarm walls above fire drs	2014	13,767						2
3	Electrical to emer circuits: Admin, admissions, BOM Ofcs & corridor shower rm/toilet area, front corridor btwn DON & HR,								3
4	1st flr lounge & corridor btwn rms 101-116	2014	3,693						4
5	ROOF UPGRADE	2014	6,408						5
6	WATER HEATER	2015	21,736						6
7	Wallcovering internet café	2015	1,260						7
8	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization		(1,260)						8
9	Parking Exp - Carpentry/Subcontr	2014	25,137						9
10	Parking Exp - Basic Electrical	2014	136,249						10
11	Parking Exp -Fire Sprinkler System	2014	7,704						11
12									12
13	CARPET FREIGHT	2015	440						13
14	Adjust Cap Audit FY 19 - remove due to not meeting min for capitalization		(440)						14
15	Life Safety Circuit Corrections to elec panel 1st flr elec rm	2015	5,737						15
16	Fire stop ductwrk @ smoke wall @ 1st flr PT & by rm 102	2015	3,460						16
17	Engineering consulting for parking lot improvements	2015	3,500						17
18	Carpeting 1st floor hallways and lobby	2015	11,959						18
19	Carpet Freight for 1st flr hallways & lobby	2015	737						19
20									20
21	Hot Water Expansion Tank in Boiler room	2015	2,968						21
22	Shower Valves (6) for 1st & 2nd floor showers	2015	3,499						22
23	Carpet all corridors on first floor	2015	12,105						23
24									24
25	Interior Renovation consisting of the following:								25
26	Resilient Flooring	2015	5,828						26
27	Aluminum Windows	2015	4,694						27
28	Carpeting & Wallcovering	2015	162,942						28
29	Adjust Cap Audit FY 19 - adjust to actual 159007 rather than filed 162942		(3,935)						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,086,494	\$ 277,541		\$ 277,541		\$ 5,479,831	34

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

Facility Name & ID Number Manorcare of Palos Hts West

0049353

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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

1	2	3 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 12D, Carried Forward		\$ 8,086,494	\$ 277,541		\$ 277,541	\$	\$ 5,479,831	1
2	Firestopping at 1st flr staiwell & 1st flr smoke wall by rm 119	2016	7,733						2
3	Hot Water Heater for Kitchen	2016	23,459						3
4	RTU #4 -dripping into 2nd flr offices	2016	3,111						4
5									5
6	Heat Exchanger for RTU for lobby area	2017	3,100						6
7									7
8	Transformer - Main Electric room	2017	5,525						8
9	Fusible Links (128) for fire dampers	2017	3,840						9
10	Smoke Dampers (4)	2018	2,911						10
11	Water Heater - Boiler room	2018	21,451						11
12	Electrical -Steam Table - Kitchen	2018	2,928						12
13	Sealcoat & Stripe parking lot	2017	3,598						13
14									14
15	Valves for Plumbing	2018	3,450						15
16									16
17	Fired Alarm	2020	9,632						17
18	Fire Alarm	2020	5,760						18
19	Two Five Ton Compressors	2018	5,321						19
20	Heat Timer Mixing Valve	2020	4,735						20
21	Recirculation pump	2019	2,814						21
22	Replace Heat Exchanger Rooftop Unit 1	2020	2,725						22
23	Install floor sink	2019	2,686						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)		\$ 8,201,273	\$ 277,541		\$ 277,541	\$	\$ 5,479,831	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 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 12E, Carried Forward		\$ 8,201,273	\$ 277,541		\$ 277,541	\$	\$ 5,479,831	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,201,273	\$ 277,541		\$ 277,541	\$	\$ 5,479,831	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	\$ 2,775,229	\$ 62,238	\$ 62,238	\$		\$ 2,606,566	71
72	Current Year Purchases	49,957						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			24,030	24,030			74
75	TOTALS	\$ 2,825,186	\$ 62,238	\$ 86,268	\$ 24,030		\$ 2,606,566	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	11,731,459
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	339,779
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	363,809
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	24,030
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	8,086,397

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	CIP	\$
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:
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:	N/A			\$			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: *

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	\$

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$77,025 Description: 02 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

C. Vehicle Rental (See instructions.)

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	7245 hrs	\$ 326,102		\$	2,511	7,245	\$ 328,613	1
2	Licensed Speech and Language Development Therapist	10a	3101 hrs	139,593			1,666	3,101	141,259	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	6040 hrs	271,841			8,840	6,040	280,681	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				468,764		468,764	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Inhal Therapy</u>	10a, 3	689	31,020				689	31,020	12
13	Other (specify): <u>X-Ray & Lab I IV</u>	43, 2 & 3				95,979	93,511		189,490	13
14	TOTAL			\$ 768,556		\$ 95,979	\$ 575,292	17,075	\$ 1,439,827	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,650	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (599,054))	615,475		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,187		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 622,312	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	705,000		13
14	Buildings, at Historical Cost	8,201,273		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,825,186		16
17	Accumulated Depreciation (book methods)	(8,086,397)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): OMIT	195,204		22
23	Other(specify): CIP			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,840,266	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,462,578	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 190,679	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	578,462		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,917		31
32	Accrued Real Estate Taxes(Sch.IX-B)	425,855		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	90,196		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,290,109	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,290,109	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,172,469	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,462,578	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,639,002	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,639,002	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(302,746)	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)	\$ (302,746)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(163,787)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (163,787)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,172,469	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Palos Hts West

0049353

Report Period Beginning: 06/01/2019

Ending: 05/31/2020

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	\$ 14,351,784	1
2	Discounts and Allowances for all Levels	(6,926,275)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,425,509	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,553,744	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,553,744	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,073	12
13	Barber and Beauty Care	7,006	13
14	Non-Patient Meals	98	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,020,472	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	77,401	19
20	Radiology and X-Ray	79,893	20
21	Other Medical Services	106,999	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,292,942	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Discount</u>	787,739	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 787,739	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,059,934	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,506,438	31
32	Health Care	6,248,877	32
33	General Administration	3,971,388	33
	B. Capital Expense		
34	Ownership	1,745,564	34
	C. Ancillary Expense		
35	Special Cost Centers	667,177	35
36	Provider Participation Fee	223,236	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,362,680	40
41	Income before Income Taxes (line 30 minus line 40)**	(302,746)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (302,746)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,348,365	44
45	Private Pay - Net Inpatient Revenue	867,551	45
46	Medicare - Net Inpatient Revenue	2,141,292	46
47	Other-(specify) <u>Hospice</u>	501,864	47
48	Other-(specify) <u>Insurance</u>	566,437	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,425,509	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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	2,051	2,200	\$ 116,297	\$ 52.86	1
2	Assistant Director of Nursing	2,886	3,096	127,354	41.14	2
3	Registered Nurses	52,863	56,691	2,064,235	36.41	3
4	Licensed Practical Nurses	14,998	16,084	441,021	27.42	4
5	CNAs & Orderlies	74,310	79,830	1,252,239	15.69	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	20,073	21,428	964,468	45.01	7
8	Rehab/Therapy Aides	13,387	14,290	500,412	35.02	8
9	Activity Director	5,408	5,780	85,483	14.79	9
10	Activity Assistants					10
11	Social Service Workers	5,918	6,333	160,231	25.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,930	25,631	411,377	16.05	15
16	Dishwashers					16
17	Maintenance Workers	2,438	2,595	52,247	20.13	17
18	Housekeepers	16,409	17,488	243,813	13.94	18
19	Laundry	2,423	2,603	34,663	13.32	19
20	Administrator	2,080	2,080	111,610	53.66	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,119	18,368	405,415	22.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,736	1,851	26,921	14.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	154	166	2,096	12.63	33
34	TOTAL (lines 1 - 33)	258,183	276,514	\$ 6,999,882 *	\$ 25.31	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		\$		35
36	Medical Director	Monthly	22,770	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				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)		\$ 22,770		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	479	\$ 29,230	10, 3	50
51	Licensed Practical Nurses	141	6,346	10, 3	51
52	Certified Nurse Assistants/Aides	1,480	45,887	10, 3	52
53	TOTAL (lines 50 - 52)	2,100	\$ 81,463		53

Facility Name & ID Number

Manorcare of Palos Hts West

STATE OF ILLINOIS

0049353

Report Period Beginning:

06/01/2019

Page 21

Ending: 05/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Katherine Gillman	Administrator	0	\$ 111,610
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 111,610

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	\$ 460,276
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 460,276

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	\$ 26,300
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.		
Various	Collections	37,244
AR Collection Costs were adjusted off via Page 5A, Lines 6 & 7, therefore, no detail schedule is attached.		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 63,544

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 107,749
Unemployment Compensation Insurance	16,808
FICA Taxes	506,950
Employee Health Insurance	392,988
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	42,822
Appreciation, Oth Benefits & Mktg Adj	8,367
Tuition Program	7,589
SMSP Match	
Employee Uniforms	7,033
Home Office Allocation	58,474
TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,148,780

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

Description	Line #	Amount
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	41,713
Health Care Worker Background Check (Indicate # of checks performed 381)	8,008
Patient Background Checks 402	4,020
Dues & Subscriptions	16,204
Association Dues	
Advertising	20,108
Other Licenses and Permits	4,484
Less: Non-Allowable Association Dues	(2,384)
Less: Public Relations Expense	()
Non-allowable advertising	(20,108)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 72,045

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	10,097
Includes travel expense to the Home Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 10,097

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA \$4,174 & AHCA \$1,945
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 63,705 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? YES
If YES, give effective date of lease. 7/28/18
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 223,236
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 98
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NO
Attach invoices and a summary of services for all architect and appraisal fees.