

		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>0055095</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>The Pearl of Rolling Meadows</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</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>4225 Kirchoff Road</u> <u>Rolling Meadows</u> <u>60008</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847)397-2400</u> Fax # <u>(847)397-2414</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>See Accountant's report Attached</u></td></tr><tr><td>(Firm Name & Address) <u>Mendel Schneider CPA & Associates</u> <u>4051 Old Orchard Rd, Skokie, IL 60076</u></td></tr><tr><td>(Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>See Accountant's report Attached</u>	(Firm Name & Address) <u>Mendel Schneider CPA & Associates</u> <u>4051 Old Orchard Rd, Skokie, IL 60076</u>	(Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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	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																								
Date of Initial License for Current Owners: <u>11/01/2018</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☒ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Mendel Schneider</u> Telephone Number: <u>(847)933-1274</u>																									
Email Address: _____																									

Facility Name & ID Number The Pearl of Rolling Meadows

0055095 Report Period Beginning: 01/01/2020 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>155</u>	Skilled (SNF)	<u>155</u>	<u>56,730</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>155</u>	TOTALS	<u>155</u>	<u>56,730</u>	7

B. Census-For the entire report period.					
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF	<u>27,061</u>	<u>3,262</u>	<u>11,123</u>	<u>41,446</u>
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	<u>27,061</u>	<u>3,262</u>	<u>11,123</u>	<u>41,446</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.06%

D. How many bed reserve days during this year were paid by the Department?
None (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 11/01/2018

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/01/2018 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 155 and days of care provided 10,187

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number The Pearl of Rolling Meadows # 0055095 Report Period Beginning: 01/01/2020 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		21,182	708,346	729,528		729,528		729,528			1
2	Food Purchase		17,502		17,502		17,502		17,502			2
3	Housekeeping	158,548	30,229	22,208	210,985		210,985		210,985			3
4	Laundry		1,260		1,260		1,260		1,260			4
5	Heat and Other Utilities			243,792	243,792		243,792		243,792			5
6	Maintenance	140,054	14,808	74,458	229,320		229,320		229,320			6
7	Other (specify):*											7
8	TOTAL General Services	298,602	84,981	1,048,804	1,432,387		1,432,387		1,432,387			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,208,687	345,682	103,501	3,657,870		3,657,870		3,657,870			10
10a	Therapy											10a
11	Activities	136,353	13,510		149,863		149,863		149,863			11
12	Social Services	69,490			69,490		69,490		69,490			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,414,530	359,192	103,501	3,877,223		3,877,223		3,877,223			16
	C. General Administration											
17	Administrative	86,022		250,000	336,022		336,022		336,022			17
18	Directors Fees											18
19	Professional Services			164,915	164,915		164,915		164,915			19
20	Dues, Fees, Subscriptions & Promotions			72,489	72,489		72,489	(21,930)	50,559			20
21	Clerical & General Office Expenses	522,020	35,529	391,418	948,967		948,967	(408)	948,559			21
22	Employee Benefits & Payroll Taxes			640,754	640,754		640,754		640,754			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			441,421	441,421		441,421		441,421			26
27	Other (specify):*											27
28	TOTAL General Administration	608,042	35,529	1,960,997	2,604,568		2,604,568	(22,338)	2,582,230			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,321,174	479,702	3,113,302	7,914,178		7,914,178	(22,338)	7,891,840			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			44,832	44,832		44,832	(28,873)	15,959			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,460	24,460		24,460	(11,391)	13,069			32
33	Real Estate Taxes			271,679	271,679		271,679		271,679			33
34	Rent-Facility & Grounds			881,074	881,074		881,074		881,074			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,222,045	1,222,045		1,222,045	(40,264)	1,181,781			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		379,467	968,254	1,347,721		1,347,721		1,347,721			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			274,837	274,837		274,837		274,837			42
43	Other (specify):* Bad Debt			322,162	322,162		322,162	(322,162)				43
44	TOTAL Special Cost Centers		379,467	1,565,253	1,944,720		1,944,720	(322,162)	1,622,558			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,321,174	859,169	5,900,600	11,080,943		11,080,943	(384,764)	10,696,179			45

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

	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	(28,873)	30		9
10	Interest and Other Investment Income	(11,391)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(408)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(322,162)	43		24
25	Fund Raising, Advertising and Promotional	(21,930)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (384,764)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (384,764)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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22				22
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27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Pearl of Rolling Meadows# 0055095

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(21,930)	0	0	0	0	0	0	0	0	0	0	(21,930)	20
21	Clerical & General Office Expenses	(408)	0	0	0	0	0	0	0	0	0	0	(408)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(22,338)	0	0	0	0	0	0	0	0	0	0	(22,338)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,338)	0	0	0	0	0	0	0	0	0	0	(22,338)	29

Summary B

12/31/2020

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 Supplemental		The Pearl At Naperville	Naperville			

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								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			\$			\$	\$ *	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Binyomin Halberstam	5.00%						1
2	BZ Halberstam	2.50%						2
3	Meyer Halberstam	1.25%						3
4	Yitzy Simcha	1.25%						4
5	Kushner IDF, LLC	3.75%						5
6	Gutnicki Marital Trust	6.25%						6
7	Sam Zeldes	6.25%						7
8	Meyer and Cheryl Magence	5.00%						8
9	Orsheva Enterprises, LLC	2.50%						9
10	Peter Huften	1.25%						10
11	Shlomo Rosenbaum	1.25%						11
12	Dinovitz Capital, LLC	1.25%						12
13	David Grinblatt	1.25%						13
14	Elan Magence	1.25%						14
15	Eitan Zeffren	60%						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eitan Zeffren	Owner	Management	60.00	260,304	30	60.00	Mgmt Fees	\$ 250,000	17-3	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	\$ 250,000		13

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

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

Facility Name & ID Number The Pearl of Rolling Meadows # 0055095 Report Period Beginning: 01/01/2020 Ending: 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
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CIBC		X	Working Capital								24,460	6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$ 24,460	9
	B. Non-Facility Related*												
10	Interest Income											(11,391)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ (11,391)	14
15	TOTALS (line 9+line14)						\$		\$			\$ 13,069	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		\$ 658,168	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.)		\$ 453,584	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (204,584)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 476,263	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.		\$ 271,679	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2015	8	
	2016	9	
	2017	10	
	2018	658,168	11
	2019	453,584	12
Accrual=1.05 x 453584			

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

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

NOTES:

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

FACILITY NAME The Pearl of Rolling Meadows COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055095

CONTACT PERSON REGARDING THIS REPORT Mendel Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

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

B. Real Estate Tax Cost Allocations

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.)

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: 38,523

B. General Construction Type: Exterior Masonry Frame Steel

Number of Stories 2

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: 15,641

2. Number of Years Over Which it is Being Amortized: 1

3. Current Period Amortization:

4. Dates Incurred: 01/01/2019

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Building of a new dialysis unit			2019	148,000		15	4,934	4,934	9,868
10	Cabling the facility Adding ethernet cables			2019	5,602		15	373	373	746
11	Replace fire panel			2019	1,851		15	123	123	246
12	Door repair back exit door			2019	1,466		15	98	98	196
13	Replace Ac motor and fan in kitchen			2019	4,190		15	279	279	558
14	Replace Sprinkler Heads in walk in cooler			2019	1,523		15	102	102	204
15	New Flooring in room 122 124			2019	1,701		15	113	113	226
16	Floor Coverings therapy gym			2019	1,120		15	75	75	150
17	Door repair fire Door			2019	1,026		15	68	68	136
18	Wall replacement in room 123 & 125			2019	2,600		15	173	173	346
19	rehang exhaust fan			2019	1,970		15	131	131	262
20	Replace Powersupply for door alarms			2019	2,931		15	195	195	390
21	Rebuild Domestic water Mixing Valve			2020	2,063		15	137	137	137
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	Financial Statement Depreciation					44,832			(44,832)	
35										35
36										36

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

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

See Page 12A, Line 70 for total

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 176,043	\$ 44,832		\$ 6,801	\$ (38,031)	\$ 13,465	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$64,086	\$	\$6,409	\$6,409	10	\$12,818	71
72	Current Year Purchases	27,482		2,749	2,749	10	2,749	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$91,568	\$	\$9,158	\$9,158		\$15,567	75

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

E. Summary of Care-Related Assets					1	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)				\$267,611	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$44,832	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$15,959	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$(28,873)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$29,032	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
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: BNF Paradox Holco
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐ YES

☐ NO
- If NO, see instructions.

		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:		155	11/1/18	\$ 881,074	10		3
4	Additions							4
5								5
6								6
7	TOTAL		155		\$ 881,074			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: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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.	12/31/2021	\$ 881,074
13.	12/31/2022	\$ 881,074
14.	12/31/2023	\$ 881,074

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)	\$			

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

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

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

12345678												
	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	\$		\$	322,226	\$		\$ 322,226	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs				157,598			157,598	2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	39-3	hrs				393,945			393,945	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					320,868		320,868	9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)											
10			hrs								10	
11	Academic Education	39-3	hrs								11	
12	Other (specify): <u>Dialysis</u>						94,485			94,485	12	
13	Other (specify): <u>Lab</u>	39-2						58,598		58,598	13	
14	TOTAL			\$		\$	968,254	\$	379,466	\$	1,347,720	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,771,489	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,672,146		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	384,146		6
7	Other Prepaid Expenses	10,032		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrows</u>	589,032		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,426,845	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	176,043		15
16	Equipment, at Historical Cost	91,568		16
17	Accumulated Depreciation (book methods)	(59,656)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	15,641		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(15,641)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	750,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 957,955	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,384,800	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,240,562	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,530,602		29
30	Accrued Salaries Payable	134,211		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	476,263		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,381,638	\$	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)	\$ 3,381,638	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,003,162	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,384,800	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,439,773	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,439,773	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,751,931	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	(1,188,542)	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)	\$ 2,563,389	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)	\$ 4,003,162	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Pearl of Rolling Meadows

0055095

Report Period Beginning: 01/01/2020

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	\$ 13,701,234	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,701,234	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,391	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,391	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Stimulus Income	1,074,541	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,074,541	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,787,166	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,432,387	31
32	Health Care	3,877,223	32
33	General Administration	2,558,860	33
	B. Capital Expense		
34	Ownership	1,222,045	34
	C. Ancillary Expense		
35	Special Cost Centers	1,669,883	35
36	Provider Participation Fee	274,837	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,035,235	40
41	Income before Income Taxes (line 30 minus line 40)**	3,751,931	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,751,931	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,183,110	44
45	Private Pay - Net Inpatient Revenue	1,115,043	45
46	Medicare - Net Inpatient Revenue	6,604,198	46
47	Other-(specify) Insurance Income	566,802	47
48	Other-(specify) Med B Income	232,081	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,701,234	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	2,024	2,080	\$ 110,594	\$ 53.17	1
2	Assistant Director of Nursing	1,904	2,080	61,003	29.33	2
3	Registered Nurses	25,687	28,233	1,006,948	35.67	3
4	Licensed Practical Nurses	25,318	27,175	832,123	30.62	4
5	CNAs & Orderlies	63,122	67,297	1,198,019	17.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,740	1,833	37,894	20.67	9
10	Activity Assistants	7,449	7,799	98,459	12.62	10
11	Social Service Workers	2,716	2,785	69,490	24.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,805	4,205	140,054	33.31	17
18	Housekeepers	11,339	12,283	158,548	12.91	18
19	Laundry					19
20	Administrator	2,032	2,080	86,022	41.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,642	18,755	522,020	27.83	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)	164,778	176,605	\$ 4,321,174 *	\$ 24.47	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				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	87,806	10-3	38
39	Pharmacist Consultant	Monthly	9,307	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	25	1,261	10-3	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)	25	\$ 98,374		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	190	5,128	10-3	52
53	TOTAL (lines 50 - 52)	190	\$ 5,128		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Eliyahu Grinblatt	Administrative	0	\$ 86,022
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 86,022
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Mendel Schneider	Accounting		\$ 9,500
Katz LLC	Accounting		7,227
PPG Retirement Plan	Retirement Consulting		738
Skidelsky & Associates	Legal		50,400
Stout	Legal		6,000
Stone Pogrund & Correy	Legal		5,678
Gutnicki LLP	Legal		7,463
LegalZoom	Legal		1,151
GCHMO	Case Management Consulting		31,050
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 119,207
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 55,768
Unemployment Compensation Insurance			34,287
FICA Taxes			330,570
Employee Health Insurance			220,129
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
TOTAL (agree to Schedule V, line 22, col.8)			\$ 640,754
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			\$ 1,990
Advertising: Employee Recruitment			22,117
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks	300		3,000
Misc License			3,331
Advertisng			21,930
Misc Dues and Subs			20,121
Less: Public Relations Expense			()
Non-allowable advertising			(21,930)
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 50,559
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			\$
TOTAL			\$

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- | | |
|---|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u>
If YES, give association name and amount. _____</p> <p>(3) Did the nursing home make political contributions or payments to a political 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</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>14,213</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>274,837</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>0</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? <u>100</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>No</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 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> |
|---|---|