

		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>0054999</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Springs at Monarch Landing</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																																																	
Address: <u>2308 N Route 59</u> <u>Naperville</u> <u>60563</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Dupage</u>																																																			
Telephone Number: <u>630-330-1181</u> Fax # <u>630-300-1386</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>05/01/1980</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 _____				
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		☒	Limited Liability Co.																																																
		☐	Trust																																																
		☐	Other _____																																																
IRS Exemption Code _____																																																			
In the event there are further questions about this report, please contact:																																																			
Name: <u>Beth Shaw</u>																																																			
Telephone Number: <u>314-295-1469</u>																																																			
Email Address: _____																																																			
		Officer or Administrator of Provider																																																	
		(Signed) _____ (Date) _____																																																	
		(Type or Print Name) <u>Richarde Nolden</u>																																																	
		(Title) <u>Administrator</u>																																																	
		Paid Preparer																																																	
		(Signed) _____ (Date) _____																																																	
		(Print Name and Title) <u>Beth Shaw</u> <u>Healthcare Consulting Senior</u>																																																	
		(Firm Name & Address) <u>Mueller Prost LC</u>																																																	
		(Telephone) <u>314.295.1469</u> Fax # <u>314.889.8798</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																																																	

Facility Name & ID Number Springs at Monarch Landing

0054999 Report Period Beginning: 1/1/20 Ending: 12/31/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>96</u>	Skilled (SNF)	<u>96</u>	<u>35,136</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>96</u>	TOTALS	<u>96</u>	<u>35,136</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>1,385</u>	<u>18,147</u>	<u>7,135</u>	<u>26,667</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>1,385</u>	<u>18,147</u>	<u>7,135</u>	<u>26,667</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.90%

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)

Adult Day Care

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 10/19/2014

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 96 and days of care provided 5,633

Medicare Intermediary National Government Services (Anthem)

IV. ACCOUNTING BASIS

ACCUAL ☒ 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 Springs at Monarch Landing # 0054999 Report Period Beginning: 1/1/20 Ending: 12/31/20

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	284,387	1,762	1,098	287,247		287,247		287,247			1
2	Food Purchase		116,986		116,986		116,986		116,986			2
3	Housekeeping	350,409	107,906	198,260	656,575		656,575	(27)	656,548			3
4	Laundry											4
5	Heat and Other Utilities											5
6	Maintenance	102,376	13,743	40,452	156,571		156,571	(177)	156,394			6
7	Other (specify):*											7
8	TOTAL General Services	737,172	240,397	239,810	1,217,379		1,217,379	(204)	1,217,175			8
	B. Health Care and Programs											
9	Medical Director			23,913	23,913		23,913		23,913			9
10	Nursing and Medical Records	4,698,914	399,057	268,131	5,366,102		5,366,102	(2,664)	5,363,438			10
10a	Therapy			877,310	877,310		877,310		877,310			10a
11	Activities	131,173		5,300	136,473		136,473	(516)	135,957			11
12	Social Services	151,978	960		152,938		152,938		152,938			12
13	CNA Training	42,639			42,639		42,639		42,639			13
14	Program Transportation											14
15	Other (specify):*			687,807	687,807		687,807		687,807			15
16	TOTAL Health Care and Programs	5,024,704	400,017	1,862,461	7,287,182		7,287,182	(3,180)	7,284,002			16
	C. General Administration											
17	Administrative	39,056	66,852	3,242	109,150		109,150	(719)	108,431			17
18	Directors Fees											18
19	Professional Services			8,074	8,074		8,074		8,074			19
20	Dues, Fees, Subscriptions & Promotions			34,862	34,862		34,862	(34,147)	715			20
21	Clerical & General Office Expenses	218,647		226,324	444,971		444,971	(2,380)	442,591			21
22	Employee Benefits & Payroll Taxes			1,407,972	1,407,972		1,407,972		1,407,972			22
23	Inservice Training & Education			1,511	1,511		1,511		1,511			23
24	Travel and Seminar			2,049	2,049		2,049	(2,049)				24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*			6,826	6,826		6,826		6,826			27
28	TOTAL General Administration	257,703	66,852	1,690,860	2,015,415		2,015,415	(39,295)	1,976,120			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,019,579	707,266	3,793,131	10,519,976		10,519,976	(42,679)	10,477,297			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			4,095,712	4,095,712		4,095,712	(3,841,473)	254,239			30
31	Amortization of Pre-Op. & Org.			29,464	29,464		29,464	(29,464)				31
32	Interest			105,502	105,502		105,502		105,502			32
33	Real Estate Taxes			66,306	66,306		66,306		66,306			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,854	8,854		8,854		8,854			35
36	Other (specify):*			39,074	39,074		39,074		39,074			36
37	TOTAL Ownership			4,344,912	4,344,912		4,344,912	(3,870,937)	473,975			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	770			770		770		770			41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	770			770		770		770			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,020,349	707,266	8,138,043	14,865,658		14,865,658	(3,913,616)	10,952,042			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(719)	17		4
5	Telephone, TV & Radio in Resident Rooms	(2,664)	10		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,500)	30		9
10	Interest and Other Investment Income				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	(3,839,973)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(103)	21		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	167	21		24
25	Fund Raising, Advertising and Promotional	(34,147)	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	(40,558)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,919,497)		\$	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))	\$ (3,919,497)		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	Housekeeping	\$ (27)	3	1
2	Wellness	(516)	11	2
3	Transportation	(2,049)	24	3
4	Amortization	(29,464)	31	4
5	Misc. Expense	(2,444)	21	5
6	Maintenance	(177)	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				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	(34,677)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Springs at Monarch Landing

0054999

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(27)	0	0	0	0	0	0	0	0	0	0	(27)	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	(177)	0	0	0	0	0	0	0	0	0	0	(177)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(204)	0	0	0	0	0	0	0	0	0	0	(204)	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	(2,664)	0	0	0	0	0	0	0	0	0	0	(2,664)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(516)	0	0	0	0	0	0	0	0	0	0	(516)	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	(3,180)	0	0	0	0	0	0	0	0	0	0	(3,180)	16
	C. General Administration													
17	Administrative	(719)	0	0	0	0	0	0	0	0	0	0	(719)	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	(34,147)	0	0	0	0	0	0	0	0	0	0	(34,147)	20
21	Clerical & General Office Expenses	(2,380)	0	0	0	0	0	0	0	0	0	0	(2,380)	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	(2,049)	0	0	0	0	0	0	0	0	0	0	(2,049)	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	(39,295)	0	0	0	0	0	0	0	0	0	0	(39,295)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,679)	0	0	0	0	0	0	0	0	0	0	(42,679)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Springs at Monarch Landing # 0054999 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(3,841,473)	0	0	0	0	0	0	0	0	0	0	(3,841,473)	30
31	Amortization of Pre-Op. & Org.	(29,464)	0	0	0	0	0	0	0	0	0	0	(29,464)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,870,937)	0	0	0	0	0	0	0	0	0	0	(3,870,937)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,913,616)	0	0	0	0	0	0	0	0	0	0	(3,913,616)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

X 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			\$			\$	\$	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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 Springs at Monarch Landing # 0054999 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

FACILITY NAME Springs at Monarch Landing COUNTY Dupage
FACILITY IDPH LICENSE NUMBER 0054999
CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler
TELEPHONE 847-374-0400 FAX #: 847-374-0420

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.

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

A. Square Feet: 45,443

B. General Construction Type: Exterior Frame

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).

Independent Living 364 Units

Assisted Living 28 Units

Adult Day Care

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

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	Land	45,443	2018	\$ 9,700,000	1
2					2
3	TOTALS	45,443		\$ 9,700,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	120		2018	2019	\$ 7,738,140	\$ 211,801	25 to 40	\$ 211,801	\$	\$ 496,385
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,738,140	\$ 211,801		\$ 211,801	\$	\$ 496,385	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	\$312,196	\$43,669	\$42,169	\$(1,500)	5 to 10	\$94,131	71
72	Current Year Purchases	45,414	9,333	9,333		3 to 10	9,333	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$357,610	\$53,002	\$51,502	\$(1,500)		\$103,464	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	Vehicle	2018	2018	\$1,344	\$269	\$269			\$649	76
77										77
78										78
79										79
80	TOTALS			\$1,344	\$269	\$269			\$649	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$17,797,094	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$265,072	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$263,572	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(1,500)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$600,498	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	Building	\$116,191,366	\$3,180,246	\$7,453,446	86
87	Equipment	4,687,753	633,163	1,413,406	87
88	Vehicle	20,175	26,564	9,752	88
89					89
90					90
91	TOTALS	\$120,899,294	\$3,839,973	\$8,876,604	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95			95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: _____*

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

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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.
- (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.

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	

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

		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1		
2	Licensed Speech and Language Development Therapist		hrs							2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist		hrs							4		
5	Physician Care		visits							5		
6	Dental Care		visits							6		
7	Work Related Program		hrs							7		
8	Habilitation		hrs							8		
9	Pharmacy		# of prescrpts							9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Other (specify):									12		
13	Other (specify):									13		
14	TOTAL			\$		\$	\$		\$	14		

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,933,040	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,098,991		3
4	Supply Inventory (priced at)	97,974		4
5	Short-Term Investments			5
6	Prepaid Insurance	391,110		6
7	Other Prepaid Expenses	29,387		7
8	Accounts Receivable (owners or related parties)	26,602		8
9	Other(specify):	640,035		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,217,139	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,700,000		13
14	Buildings, at Historical Cost	117,435,307		14
15	Leasehold Improvements, at Historical Cost	6,494,198		15
16	Equipment, at Historical Cost	5,021,467		16
17	Accumulated Depreciation (book methods)	(9,467,769)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	4,346,075		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,081,120)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	94,201		22
23	Other(specify):	1,500		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 132,543,859	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 142,760,998	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,544,859	\$	26
27	Officer's Accounts Payable	132,750		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	544,991		29
30	Accrued Salaries Payable	470,994		30
31	Accrued Taxes Payable (excluding real estate taxes)	582,763		31
32	Accrued Real Estate Taxes(Sch.IX-B)	336,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Derivative Instrument /Wait list & Deposits</u>	1,818,457		36
37	<u>Accrued Expenses</u>	2,173,790		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,604,604	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	29,277,005		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Attrition</u>	110,423,264		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 139,700,269	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 147,304,873	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,543,875)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 142,760,998	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,671,638	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,671,638	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,215,513)	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)	\$ (6,215,513)	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)	\$ (4,543,875)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Springs at Monarch Landing

0054999

Report Period Beginning: 1/1/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,580,669	1
2	Discounts and Allowances for all Levels	(153,596)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,427,073	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,880,239	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,880,239	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	(43,854)	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	719	14
15	Telephone, Television and Radio	2,664	15
16	Rental of Facility Space		16
17	Sale of Drugs	267,120	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	63,001	20
21	Other Medical Services	386,216	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 675,866	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	394,433	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 394,433	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Independent & Assisted Living</u>	15,578,990	28
28a	<u>Other Income</u>	1,154,563	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,733,553	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 28,111,164	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,217,379	31
32	Health Care	7,287,182	32
33	General Administration	2,015,415	33
	B. Capital Expense		
34	Ownership	4,344,912	34
	C. Ancillary Expense		
35	Special Cost Centers	770	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	<u>Assisted Living</u>	4,020,613	37
38	<u>Independent Living</u>	15,304,810	38
39	<u>Marketing</u>	135,596	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 34,326,677	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,215,513)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,215,513)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 283,162	44
45	Private Pay - Net Inpatient Revenue	4,111,354	45
46	Medicare - Net Inpatient Revenue	1,781,613	46
47	Other-(specify) <u>Managed Care</u>	417,865	47
48	Other-(specify) <u>Hospice</u>	1,833,080	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,427,074	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	5,688	5,688	\$ 358,070	\$ 62.95	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	26,397	26,397	1,267,047	48.00	3
4	Licensed Practical Nurses	26,684	26,684	836,544	31.35	4
5	CNAs & Orderlies	94,907	94,907	1,723,430	18.16	5
6	CNA Trainees			0		6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	15,658	15,658	378,453	24.17	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	5,537	5,537	151,978	27.45	11
12	Dietician	2,422	2,422	39,547	16.33	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0		0		14
15	Cook Helpers/Assistants	25,482	25,482	416,115	16.33	15
16	Dishwashers	0		0		16
17	Maintenance Workers	4,934	4,934	102,376	20.75	17
18	Housekeepers	19,368	19,368	310,862	16.05	18
19	Laundry	0		0		19
20	Administrator	0	0	0		20
21	Assistant Administrator	0		0		21
22	Other Administrative	0		0		22
23	Office Manager	0		0		23
24	Clerical	15,484	15,484	251,151	16.22	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	10,737	10,737	184,776	17.21	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	253,298	253,298	\$ 6,020,349 *	\$ 23.77	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				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)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	237	\$ 13,451	10-3	50
51	Licensed Practical Nurses	51	2,672	10-3	51
52	Certified Nurse Assistants/Aides	1,110	28,825	10-3	52
53	TOTAL (lines 50 - 52)	1,397	\$ 44,948		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
			\$
Debrorah Hedlund	Biller	0	39,056
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 39,056
B. Administrative - Other			
Description			Amount
Uniforms & Training			\$ 3,242
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 3,242
C. Professional Services			
Vendor/Payee	Type		Amount
Journal entry (no vendor)	Cost Report accrual		\$ 6,242
Edward Clancy PC	Legal Fees		498
OnShift, Inc	3rd Party IT Services		1,335
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 8,074
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 126,318
Unemployment Compensation Insurance			25,945
FICA Taxes			447,283
Employee Health Insurance			758,641
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401K Expense			49,934
Employee Benefit			(148)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,407,972
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			
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks			
License			
Dues & Subscription			715
Marketing			
Less: Public Relations Expense			()
Non-allowable advertising			()
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 715
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:

(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. Leading Age Illinois

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

(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?

N/a

(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?

10 Years

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

\$ 0

Line N/a

(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?

No

If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement?

X

YES

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.

N/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 180,320

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.

\$ 0

Has any meal income been offset against related costs?

Yes

Indicate the amount. \$ 719

(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. \$ N/a

c. What percent of all travel expense relates to transportation of nurses and patients?

Ln 14

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

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.

\$ N/a

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name: Beers, Hammerman, Cohen & Berger PC

(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.

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