

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0054171

Facility Name: Thornton Heights Terrace

Address: 160 West 10th Street Chicago Heights 60411
Number City Zip Code

County: Cook

Telephone Number: (708) 754-2220 Fax # (708) 754-9311

HFS ID Number:

Date of Initial License for Current Owners: 12/18/1995

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) 05/05/2021 (Date)
* Subject to the attached Accountants' Consulting Report
(Print Name and Title) Steven N. Lavenda, CPA Partner
(Firm Name & Address) Marcum, LLP 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Thornton Heights Terrace

0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

N/A

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		Skilled (SNF)					1
2		Skilled Pediatric (SNF/PED)					2
3	216	Intermediate (ICF)		216	79,056		3
4		Intermediate/DD					4
5		Sheltered Care (SC)					5
6		ICF/DD 16 or Less					6
7	216	TOTALS		216	79,056		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					8
9	SNF/PED					9
10	ICF	65,623	91	196	65,910	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	65,623	91	196	65,910	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.37%

D. How many bed reserve days during this year were paid by the Department? 69 (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 X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 06/01/1994

J. Was the facility purchased or leased after January 1, 1978? YES X Date 06/01/1994 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

MODIFIED ACCRUAL X CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020 * All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	332,218	50,145	9,143	391,506		391,506		391,506			1
2	Food Purchase		560,121		560,121	(29,426)	530,695	(8)	530,687			2
3	Housekeeping	212,032	62,846		274,878		274,878		274,878			3
4	Laundry	30,169	6,100		36,269		36,269		36,269			4
5	Heat and Other Utilities			182,437	182,437		182,437	(1,258)	181,179			5
6	Maintenance	225,979	12,734	268,945	507,658		507,658	(37,869)	469,789			6
7	Other (specify):*											7
8	TOTAL General Services	800,398	691,946	460,525	1,952,869	(29,426)	1,923,443	(39,135)	1,884,308			8
	B. Health Care and Programs											
9	Medical Director			2,700	2,700		2,700		2,700			9
10	Nursing and Medical Records	1,601,805	114,880	149,639	1,866,324		1,866,324	(3,592)	1,862,732			10
10a	Therapy											10a
11	Activities	62,256	21,663		83,919		83,919		83,919			11
12	Social Services	1,100,450		55,969	1,156,419		1,156,419		1,156,419			12
13	CNA Training											13
14	Program Transportation			1,570	1,570		1,570		1,570			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,764,511	136,543	209,878	3,110,932		3,110,932	(3,592)	3,107,340			16
	C. General Administration											
17	Administrative	482,642		895,402	1,378,044		1,378,044	(808,253)	569,791			17
18	Directors Fees											18
19	Professional Services			104,563	104,563	(22,510)	82,053	(764)	81,289			19
20	Dues, Fees, Subscriptions & Promotions			105,598	105,598		105,598	(54,464)	51,134			20
21	Clerical & General Office Expenses	222,620	3,809	69,690	296,119		296,119	(29,401)	266,718			21
22	Employee Benefits & Payroll Taxes			805,869	805,869	29,426	835,295		835,295			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,853	4,853		4,853		4,853			24
25	Other Admin. Staff Transportation			2,352	2,352		2,352		2,352			25
26	Insurance-Prop.Liab.Malpractice			157,095	157,095		157,095	248	157,343			26
27	Other (specify):*							1,689	1,689			27
28	TOTAL General Administration	705,262	3,809	2,145,422	2,854,493	6,916	2,861,409	(890,945)	1,970,464			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,270,171	832,298	2,815,825	7,918,294	(22,510)	7,895,784	(933,672)	6,962,112			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			66,434	66,434		66,434	16,636	83,070			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							21,301	21,301			32
33	Real Estate Taxes			569,957	569,957	22,510	592,467	7,989	600,456			33
34	Rent-Facility & Grounds			417,896	417,896		417,896	(399,143)	18,753			34
35	Rent-Equipment & Vehicles			8,474	8,474		8,474		8,474			35
36	Other (specify):*											36
37	TOTAL Ownership			1,062,761	1,062,761	22,510	1,085,271	(353,217)	732,054			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											41
42	Provider Participation Fee											42
43	Other (specify):*	326,397		2,095	328,492		328,492	(328,492)				43
44	TOTAL Special Cost Centers	326,397		2,095	328,492		328,492	(328,492)				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,596,568	832,298	3,880,681	9,309,547		9,309,547	(1,615,381)	7,694,166			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,666)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(26,983)	30		9
10	Interest and Other Investment Income	(11,787)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	02		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				18
19	Entertainment	(43)	21		19
20	Contributions	(36,680)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,477)	21		24
25	Fund Raising, Advertising and Promotional				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	(429,410)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (514,054)		\$	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)	(1,101,327)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,101,327)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,615,381)		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	Capitalized R&M	\$ (43,361)	06	1
2	Bank Charges	(15,274)	21	2
3	Misc Income	(855)	21	3
4	Patient Clothing	(555)	10	4
5	Resident Stipend	(3,037)	10	5
6	Marketing	(2,095)	43	6
7	Meals	(6,759)	21	7
8	Bldg Co - Accounting Fees	(6,077)	19	8
9	Bldg Co - IL Replacement Taxes	(3,898)	21	9
10	Bldg Co - License & Fees	(75)	20	10
11	Bldg Co - Political Contribution	(4,500)	20	11
12	Additional R&M	2,399	06	12
13	PAC Dues	(17,857)	20	13
14	Non Allowable Legal Fees	(1,069)	19	14
15	Non Allowable Compensation	(326,397)	43	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	(429,410)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(8)											(8)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,666)		1,408									(1,258)	5
6	Maintenance	(40,962)		3,093									(37,869)	6
7	Other (specify):*													7
8	TOTAL General Services	(43,636)		4,501									(39,135)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,592)											(3,592)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(3,592)											(3,592)	16
	C. General Administration													
17	Administrative					(808,253)							(808,253)	17
18	Directors Fees													18
19	Professional Services	(7,146)	6,077	305									(764)	19
20	Fees, Subscriptions & Promotions	(59,112)	4,575	73									(54,464)	20
21	Clerical & General Office Expenses	(33,306)	3,898	7									(29,401)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			248									248	26
27	Other (specify):*					1,689							1,689	27
28	TOTAL General Administration	(99,564)	14,550	633		(806,564)							(890,945)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(146,792)	14,550	5,134		(806,564)							(933,672)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(26,983)	43,619										16,636	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(11,787)	33,687		(599)								21,301	32
33	Real Estate Taxes			7,989									7,989	33
34	Rent-Facility & Grounds		(384,000)	(15,143)									(399,143)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(38,770)	(306,694)	(7,154)	(599)								(353,217)	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													41
42	Provider Participation Fee													42
43	Other (specify):*	(328,492)											(328,492)	43
44	TOTAL Special Cost Centers	(328,492)											(328,492)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(514,054)	(292,144)	(2,020)	(599)	(806,564)							(1,615,381)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 384,000	Thornton Heights Associates		\$	(384,000)	1
2	V	19	Accounting Fees		Thornton Heights Associates		6,077	6,077	2
3	V	30	Depreciation		Thornton Heights Associates		43,619	43,619	3
4	V	21	IL Replacement Taxes		Thornton Heights Associates		3,898	3,898	4
5	V	32	Interest Expense		Thornton Heights Associates		33,687	33,687	5
6	V	20	License & Fees		Thornton Heights Associates		75	75	6
7	V	20	Political Contribution		Thornton Heights Associates		4,500	4,500	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 384,000			\$ 91,856	\$ * (292,144)	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	DAVID AND MIRAL SIMCHA	4.12%	BARTON SENIOR RESIDENCES (SLF)	ZION	THORNTON HEIGHTS ASSOCIATION	NORTHFIELD	BUILDING CO.	1
2	ELISA SHLOFROCK-ZUSMAN	22.43%	CENTRAL PLAZA	CHICAGO	BARTON HEALTHCARE	NORTHFIELD	BOND ISSUE CO.	2
3	GARY WEINTRAUB	14.14%	CLAYTON RESIDENTIAL HOME, INC.	CHICAGO	BARTON MANAGEMENT	NORTHFIELD	BOOKEEPING	3
4	JOHN SHLOFROCK	15.35%	SHARON HEALTH CARE WOODS, INC.	PEORIA	REDWOOD MANAGEMENT	NORTHFIELD	MANAGEMENT CO.	4
5	MARLA COQUILLETTE	11.07%	RUSH BARTON (SLF)	CHICAGO				5
6	MICHAEL AND SARALEY RAITZIK	8.25%	SHARON HEALTH CARE ELMS, INC.	PEORIA				6
7	PETER AND SHARON PETERS	11.07%	SHARON HEALTH CARE PINES, INC.	PEORIA				7
8	RICHARD DEAN DUROS DECL. OF TRUST	6.79%	SHARON HEALTH CARE WILLOWS, INC.	PEORIA				8
9	SUZANNE A. KOENIG	5.54%						9
10	YEHUDIS LEVOVITZ	1.24%						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

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)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Barton Management Inc.		\$ 1,408	\$ 1,408	15
16	V	6	Repairs & Maintenance		Barton Management Inc.		3,093	3,093	16
17	V	19	Professional Fees		Barton Management Inc.		305	305	17
18	V	20	Dues, Licenses, Fees		Barton Management Inc.		73	73	18
19	V	21	Clerical & General		Barton Management Inc.		7	7	19
20	V	26	Insurance		Barton Management Inc.		248	248	20
21	V	33	Real Estate Taxes		Barton Management Inc.		7,989	7,989	21
22	V	34	Rent Office Space		Barton Management Inc.		15,157	15,157	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	Rent	30,300	Barton Management Inc.			(30,300)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 30,300			\$ 28,280	\$ * (2,020)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	INTEREST		BARTON HEALTHCARE LLC		33,088	\$ 33,088	15
16	V								16
17	V								17
18	V								18
19	V	32	Interest	33,687	BARTON HEALTHCARE LLC			(33,687)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 33,687			\$ 33,088	\$ * (599)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	895,402	Redwood Management			\$ (895,402)	15
16	V								16
17	V	17	Salary - J. Shlofrock		Redwood Management		20,161	20,161	17
18	V	27	Payroll Taxes - J. Shlofrock		Redwood Management		1,689	1,689	18
19	V								19
20	V	17	Management Fee - S. Aron		Redwood Management		66,988	66,988	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 895,402			\$ 88,838	\$ * (806,564)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	John Shlofrock	Shareholder	Administrative	15.35%	See Attached	5.00	11.90%	Salary All. Sal	\$ 59,182	17-1, 17-3	1
2	Gary Weintraub	Shareholder	Legal	14.14%	See Attached	6.00	14.29%	Salary	38,993	17-1	2
3	Rick Duros	COO	Administrative	N/A	See Attached	6.50	14.61%	Salary	78,042	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 176,217		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 Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Barton Management Inc.
Street Address 465 Cental Ave.
City / State / Zip Code Northfield, IL 60093
Phone Number (847) 441-8200
Fax Number (847) 441-0800

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Available Days	501,818	8	\$ 8,697	\$	81,252	\$ 1,408	1
2	6	Repairs & Maintenance	Available Days	501,818	8	19,103		81,252	3,093	2
3	19	Professional Fees	Available Days	501,818	8	1,885		81,252	305	3
4	20	Dues, Licenses, Fees	Available Days	501,818	8	450		81,252	73	4
5	21	Clerical & General	Available Days	501,818	8	41		81,252	7	5
6	26	Insurance	Available Days	501,818	8	1,534		81,252	248	6
7	33	Real Estate Taxes	Available Days	501,818	8	49,340		81,252	7,989	7
8	34	Rent Office Space	Available Days	501,818	8	93,608		81,252	15,157	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					\$ 174,658	\$		\$ 28,280	25

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Barton Healthcare LLC
Street Address 465 Central Ave.
City / State / Zip Code Northfield, IL 60093
Phone Number (847) 441-8200
Fax Number (847) 441-0800

	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	32	INTEREST	Note Receivable	8,937,500	7	282,973		1,045,048	33,088	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					\$ 282,973	\$		\$ 33,088	25

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Redwood Management
Street Address 465 Central Ave. ,Suite 100
City / State / Zip Code Northfield, IL. 60093
Phone Number (847) 441-8200
Fax Number (847) 441-0800

	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	17	Salary - J. Shlofrock	Average Hours Worked	31	5	125,000	125,000	5	20,161	1
2	27	Payroll Taxes - J. Shlofrock	Average Hours Worked	31	5	10,472		5	1,689	2
3										3
4	17	Management Fee - S. Aron	Average Hours Worked	23	5	220,103		7	66,988	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					\$ 355,575	\$ 125,000		\$ 88,838	25

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Thornton Heights Terrace # 0054171 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Barton Healthcare, LLC		X	Mortgage			\$	1,045,048			\$	33,088	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	1,045,048			\$	33,088	9
	B. Non-Facility Related*												
10	Interest Income		X									(11,787)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(11,787)	14
15	TOTALS (line 9+line14)						\$	1,045,048			\$	21,301	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	540,936	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.)				\$	847,933	2
3. Under or (over) accrual (line 2 minus line 1).				\$	306,997	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	270,950	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.)				\$	22,510	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 \$ 56,585 For 2017 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.				\$	600,457	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	434,749	8		
		2016	439,730	9		
		2017	492,481	10		
		2018	515,177	11		
		2019	541,899	12		
2020 Accrual = \$541,899 x 1.05 = \$568,994 - \$298,045 prepaid 2020 tax = \$270,950						
Payment of 1st Installment 2021 made in December 2020.						
Allocated from Barton Management \$7,989						

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

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Thornton Heights Terrace COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054171

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 32-20-205-011-0000	Long Term Property Care	\$ 541,899.12	\$ 541,899.12
2. 05-09-112-017-0000	Allocated from Barton Mgmt	\$ 98,680.58	\$ 7,988.95
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 640,579.70	\$ 549,888.07

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Thornton Heights Terrace COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0054171
CONTACT PERSON REGARDING THIS REPORT Steven Lavenda
TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 51,085

B. General Construction Type: Exterior Frame Number of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 266,529	1
2					2
3	TOTALS			\$ 266,529	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	216			1977	\$ 3,982,306	\$ 43,619	35	\$	(43,619)	\$ 3,982,306
5										
6										
7										
8										
	Improvement Type**									
9	Various		1980	5,767		20				5,767
10	Various		1981	13,000		20				13,000
11	Various		1985	7,018		20				7,018
12	Various		1986	13,102		20				13,102
13	Various		1987	899		20				899
14	Various		1989	9,106		20				8,339
15	Various		1990	4,093		20	73	73		4,022
16	Various		1991	24,882		20	568	568		23,685
17	Various		1992	10,189		20				9,459
18	Various		1993	80,557		20				79,494
19	Various		1994	75,510		20				75,497
20	Various		1995	56,341		20				56,319
21	Various		1996	27,338		20				27,329
22	Various		1997	33,349		20				33,344
23	Various		1998	52,793		20				52,789
24	Various		1999	84,044		20	3	3		84,043
25	Various		2000	33,473		20	1,071	1,071		33,473
26	Various		2001	144,503		20	3,705	3,705		72,951
27	Various		2002	35,180		20				35,180
28	Various		2003	139,471		20	3,286	3,286		132,352
29	Various		2004	71,450		20				71,450
30	Various		2005	357,706		20				357,706
31	Various		2006	192,624		20	6,589	6,589		110,690
32	Various		2007	71,471		20				71,471
33	Various		2008	106,933		20				106,933
34	Various		2009	175,629		20	3,184	3,184		164,349
35	Various		2010	38,017		20	1,372	1,372		32,921
36	Various		2011	23,231		20	1,576			22,619

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 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	Various	2012	\$ 31,396	\$	20	\$ 3,140	\$ 3,140	\$ 27,808	37
38	Various	2013	155,151		20	15,045	15,045	113,134	38
39	Various	2014	100,904		20	4,129	4,129	22,560	39
40	Various	2015	18,069		20	903	903	4,804	40
41	Various	2016	47,839		20	2,392	2,392	10,475	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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			66,434			(66,434)		69
70	TOTAL (lines 4 thru 69)		\$ 6,223,341	\$ 110,053		\$ 47,035	\$ (64,594)	\$ 5,867,288	70

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

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,223,341	\$ 110,053		\$ 47,035	\$ (63,018)	\$ 5,867,288	1
2	Installed Metal Door & Frame - 3Rd Floor Short Hall Stairs	2017	3,183		20	159	159	584	2
3	Remove & Replace Circulation Pump - Pump Room	2017	6,716		20	336	336	1,315	3
4	Demolished, Removed Old Boiler; Installed New Boiler - Boiler Room	2017	38,332		20	1,917	1,917	6,069	4
5	Installed New Evaporator, Tsv, Lines 1 & Electric - Walk In Freezer	2017	2,772		20	139	139	485	5
6	Remove & Replace Concrete - Boiler Room	2017	6,000		20	300	300	1,050	6
7	A/C 8000Btu 115V Wall Heatcool (10)	2018	4,280		20	214	214	571	7
8	40 Cubicle Curtains	2018	7,038		20	352	352	880	8
9	8 Pcs. Baseboard Heat Covers	2018	3,506		20	175	175	438	9
10	First Floor Air Handler	2018	4,684		20	234	234	703	10
11	Replace Bricks & Fix Window Sill	2019	3,200		20	160	160	320	11
12	Flooring (Carpet)	2019	63,947		20	3,197	3,197	6,128	12
13	Remodeling Supplies	2019	1,990		20	100	100	174	13
14	Remodeling Supplies	2019	3,811		20	191	191	318	14
15	Passenger Elevator Hydraulic Replacement & Emergency Repairs	2019	44,860		20	2,243	2,243	3,738	15
16	Installation Of Smoke Detectors	2019	3,933		20	197	197	328	16
17	Air Conditioner 8000 Btu - Wall Unit	2019	3,411		20	171	171	270	17
18	Install Two New Grease Traps	2019	10,000		20	500	500	792	18
19	Installation Of New Wall Heads To Supply Heating & Cooling	2019	9,733		20	487	487	689	19
20	Install Area #1 Granite Counter Tops	2019	2,370		20	119	119	158	20
21	Remodeling Supplies	2019	3,345		20	167	167	209	21
22	Flooring For 5 Rooms (Carpet)	2019	5,655		20	283	283	353	22
23	Flooring Materials Only (2Bedrooms/Office)	2019	19,477		20	974	974	1,136	23
24	Flooring 3Rd Floor & Short Hall Ways, 1 Office & Stairs (Carpet)	2019	24,332		20	1,217	1,217	1,419	24
25	Flooring 2Nd Floor, Long & Short Hall Ways, Day Rm (Carpet)	2019	29,099		20	1,455	1,455	1,697	25
26	Hvac- 5 Mini-Split Systems, 15 Heads	2019	33,066		20	1,653	1,653	1,791	26
27	Remodeling Supplies	2019	8,333		20	417	417	451	27
28	Day Room Converted Into Office/North & South Stairwell Landin	2019	5,050		20	253	253	463	28
29	3Rd & 4Th Floor-Shower Rooms/Nursing Station/Day Room & Of	2019	40,550		20	2,028	2,028	3,693	29
30	Shower Rooms/Nursing Station/Day Room & Office-Floor/Walls/I	2019	28,888		20	1,444	1,444	1,714	30
31	Tuckpointing And Replace Bricks	2019	13,800		20	690	690	978	31
32	Installation Of New Breaker, Circuits & Wiring In Basement	2019	3,280		20	164	164	328	32
33	Chilled Water Valve Actuator Replacement In 1st Floor.	2019	2,560		20	128	128	256	33
34	TOTAL (lines 1 thru 33)		\$ 6,664,543	\$ 110,053		\$ 69,095	\$ (40,958)	\$ 5,906,787	34

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

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,664,543	\$ 110,053		\$ 69,095	\$ (40,958)	\$ 5,906,787	1
2	Replacement Of Valve Actuator , Switch, And Thermostat	2019	3,954		20	198	198	562	2
3	Materials For Project (Carpeting)	2020	11,812		20	591	591	591	3
4	Upgrade Surveillance Systems	2020	3,380		20	169	169	169	4
5	Replace / Install Panic Bars	2020	4,879		20	244	244	244	5
6	Installation Of New Sprinkler Heads And New Smoke Detectors	2020	8,890		20	445	445	445	6
7	Convert 4 Bed Units Into 2 Bed, Flooring In Shower Rms, Stairwe	2020	28,936		20	1,447	1,447	1,447	7
8	Replace Ceiling Tiles In Dining Room	2020	3,136		20	157	157	157	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,729,531	\$ 110,053		\$ 72,345	\$ (37,708)	\$ 5,910,401	34

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

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,729,531	\$ 110,053		\$ 72,345	\$ (37,708)	\$ 5,910,401	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,729,531	\$ 110,053		\$ 72,345	\$ (37,708)	\$ 5,910,401	34

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

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,729,531	\$ 110,053		\$ 72,345	\$ (37,708)	\$ 5,910,401	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,729,531	\$ 110,053		\$ 72,345	\$ (37,708)	\$ 5,910,401	34

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

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$145,588	\$	\$6,405	\$6,405	10	\$114,783	71
72	Current Year Purchases	6,810		681	681	10	681	72
73	Fully Depreciated Assets	729,710				10	729,710	73
74								74
75	TOTALS	\$882,108	\$	\$7,086	\$7,086		\$845,173	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		1998 FORD VAN	2001	\$13,217	\$	\$	\$	5	\$13,217	76
77		2006 FORD E350	2009	14,360				5	14,360	77
78		Multistate Transmissions	2011	2,751				5	2,751	78
79		See Attached		34,144		3,640	3,640		34,144	79
80	TOTALS			\$64,472	\$	\$3,640	\$3,640		\$64,472	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)	\$7,942,640	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$110,053	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$83,070	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(26,983)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,820,046	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				3,596			5
6	Allocated from Barton Management				15,157			6
7	TOTAL				\$18,753			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: \$8,474
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 2,827,887	\$ 3,939,230	1
2	Cash-Patient Deposits	189	189	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,046,930	1,046,930	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	169,601	169,601	6
7	Other Prepaid Expenses	53,714	53,714	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	29,780	29,780	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,128,101	\$ 5,239,444	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		266,529	13
14	Buildings, at Historical Cost		4,377,723	14
15	Leasehold Improvements, at Historical Cost	2,351,936	2,351,936	15
16	Equipment, at Historical Cost	804,829	2,647,883	16
17	Accumulated Depreciation (book methods)	(2,303,514)	(7,279,494)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 853,251	\$ 2,364,577	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,981,352	\$ 7,604,021	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,730,191	\$ 1,730,191	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	150,887	150,887	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	342,029	342,029	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,985	9,985	31
32	Accrued Real Estate Taxes(Sch.IX-B)	270,950	270,950	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		872,592	872,592	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,376,634	\$ 3,376,634	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,045,048	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		1,297,747		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,297,747	\$ 1,045,048	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,674,381	\$ 4,421,682	46
47	TOTAL EQUITY(page 18, line 24)	\$ 306,971	\$ 3,182,339	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,981,352	\$ 7,604,021	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,414,200	1
2	Restatements (describe):		2
3	State Replacement Tax	(8,168)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,406,032	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(49,061)	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	(1,050,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,099,061)	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)	\$ 306,971	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Thornton Heights Terrace

0054171

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,087,996	1
2	Discounts and Allowances for all Levels	(2,145,759)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,942,237	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***	11,787	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,787	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	306,462	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 306,462	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,260,486	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,952,869	31
32	Health Care	3,110,932	32
33	General Administration	2,854,493	33
	B. Capital Expense		
34	Ownership	1,062,761	34
	C. Ancillary Expense		
35	Special Cost Centers	328,492	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,309,547	40
41	Income before Income Taxes (line 30 minus line 40)**	(49,061)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (49,061)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,854,137	44
45	Private Pay - Net Inpatient Revenue	19,500	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) CASA	68,600	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,942,237	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** 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	2,480	2,600	\$ 165,098	\$ 63.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,319	2,415	70,847	29.34	3
4	Licensed Practical Nurses	18,974	20,438	560,323	27.42	4
5	CNAs & Orderlies	48,616	52,222	779,740	14.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,246	4,534	62,256	13.73	10
11	Social Service Workers	54,195	57,312	1,100,450	19.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,243	21,886	332,218	15.18	15
16	Dishwashers					16
17	Maintenance Workers	9,821	10,673	225,979	21.17	17
18	Housekeepers	14,837	15,565	212,032	13.62	18
19	Laundry	2,036	2,124	30,169	14.20	19
20	Administrator	2,080	2,080	128,839	61.94	20
21	Assistant Administrator	2,112	2,144	74,429	34.72	21
22	Other Administrative	4,336	4,336	279,374	64.43	22
23	Office Manager					23
24	Clerical	11,137	11,723	222,620	18.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,505	1,734	25,797	14.88	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	5,066	5,066	326,397	64.43	33
34	TOTAL (lines 1 - 33)	204,003	216,852	\$ 4,596,568 *	\$ 21.20	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	Monthly	\$ 9,143	01-03	35
36	Medical Director	Monthly	2,700	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	10-03	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	200	11,969	12-03	45
46	Other(specify)				46
47	Psychiatric Director	416	44,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	616	\$ 69,612		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	2,680	147,839	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,680	\$ 147,839		53

STATE OF ILLINOIS

Facility Name & ID Number

Thornton Heights Terrace

0054171

Report Period Beginning:

01/01/20

Ending:

12/31/20

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Kim Rogers

Administrator

0

\$ 128,839

Keegan Collier

Asst. Admin.

0

74,429

Arnie Kanter

Other Administrative

0

81,701

John Shlofrock

Other Administrative

15.35%

39,021

Rick Duros

Other Administrative

0

78,042

Gary Weintraub

Other Administrative

14.14%

38,993

See Supplemental Schedule

41,617

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 482,642

B. Administrative - Other

Description

Amount

Redwood Management - Management Fees

\$ 895,402

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 895,402

C. Professional Services

Vendor/Payee

Type

Amount

Personnel Planners

Unemployment Consultant

\$ 1,515

NJ Kimme & Co

Resident Consulting

8,109

Gigliotti Consulting

Healthcare Consulting

1,875

First Real Estate Services

Real Estate Appraisal

3,250

ProPay HR

Payroll Services

477

iSolved HCM Midwest, LLC

HR Consultant

3,158

Pension Performance

Pension Consultant

2,986

Marcum LLP

Accounting

14,575

Paychex

Payroll Processing

8,312

Barton Management

Acctg Software

13,031

See Attached

Legal

21,339

See Supplemental Schedule

25,937

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 104,564

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 43,188

Unemployment Compensation Insurance

24,998

FICA Taxes

351,637

Employee Health Insurance

258,607

Employee Meals

29,426

Illinois Municipal Retirement Fund (IMRF)*

401K Contribution

38,537

Employee Benefit

859

Union Pension Contrib

84,943

Christmas Expense

3,100

TOTAL (agree to Schedule V, line 22, col.8)

\$ 835,295

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

\$ 5,700

Advertising: Employee Recruitment

4,706

Health Care Worker Background Check

(Indicate # of checks performed 291)

2,917

Patient Background Checks

11

110

Dues & Subscriptions

10,950

Licenses & Fees

26,678

See Supplemental Schedule

73

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 51,134

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

4,853

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 4,853

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Thornton Heights Terrace	STATE OF ILLINOIS # 0054171	Report Period Beginning: 01/01/20	Ending: 12/31/20	Page 22
--	--	---	--------------------------------	----------------

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. Alliance for Living \$28,540

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ _____
 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? N/A

(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. \$ 29,426 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____

(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? 100% 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? N/A
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? No
 Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted 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. Yes
 Attach invoices and a summary of services for all architect and appraisal fees