

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0043364</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Torrence Place</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>4/1/2019</u> to <u>3/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>2601 223rd Street</u> <u>Sauk Village</u> <u>60411</u> Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(708) 758-7211</u> Fax # <u>(708) 758-1841</u>																																																	
HFS ID Number: _____																																																	
Date of Initial License for Current Owners: <u>11/27/93</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Lisa Winnett</u></td></tr><tr><td>(Title) <u>Director of Operations</u></td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Lisa Winnett</u>	(Title) <u>Director of Operations</u>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																				
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		☐	Other _____	☐	_____																																												
In the event there are further questions about this report, please contact:																																																	
Name: <u>Ron Wilson</u>		Telephone Number: <u>(309) 343-1550</u>																																															
Email Address: _____																																																	

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Torrence Place

0043364 Report Period Beginning: 4/1/2019 Ending: 3/31/20

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,586			5,586	13
14	TOTALS	5,586			5,586	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.39 %

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed reserve days during this year were paid by the Department? 42 (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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location? Date started 12/14/93

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 03/31/97 NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 3/31/20 Fiscal Year: 3/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Torrence Place # 0043364 Report Period Beginning: 4/1/2019 Ending: 3/31/20
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	35,125	3,115	1,294	39,534		39,534		39,534			1
2	Food Purchase		64,547		64,547		64,547		64,547			2
3	Housekeeping	18,336	6,319		24,655		24,655		24,655			3
4	Laundry		6,523		6,523		6,523		6,523			4
5	Heat and Other Utilities			17,064	17,064		17,064		17,064			5
6	Maintenance	18,225	6,151	30,174	54,550		54,550		54,550			6
7	Other (specify):*											7
8	TOTAL General Services	71,686	86,655	48,532	206,873		206,873		206,873			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	328,350	10,989	10,603	349,942		349,942		349,942			10
10a	Therapy											10a
11	Activities		2,732	398	3,130		3,130		3,130			11
12	Social Services											12
13	CNA Training	4,560			4,560		4,560		4,560			13
14	Program Transportation			7,322	7,322		7,322		7,322			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	332,910	13,721	19,523	366,154		366,154		366,154			16
	C. General Administration											
17	Administrative	20,485			20,485		20,485		20,485			17
18	Directors Fees											18
19	Professional Services			66,495	66,495		66,495		66,495			19
20	Dues, Fees, Subscriptions & Promotions			3,583	3,583		3,583	(232)	3,351			20
21	Clerical & General Office Expenses	52,798	3,150	7,070	63,018		63,018	4	63,022			21
22	Employee Benefits & Payroll Taxes			67,321	67,321		67,321		67,321			22
23	Inservice Training & Education			2,230	2,230		2,230		2,230			23
24	Travel and Seminar			77	77		77		77			24
25	Other Admin. Staff Transportation			3,100	3,100		3,100	1	3,101			25
26	Insurance-Prop.Liab.Malpractice			6,213	6,213		6,213		6,213			26
27	Other (specify):*											27
28	TOTAL General Administration	73,283	3,150	156,089	232,522		232,522	(227)	232,295			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	477,879	103,526	224,144	805,549		805,549	(227)	805,322			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			34,824	34,824		34,824		34,824			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			34,824	34,824		34,824		34,824			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			53,428	53,428		53,428		53,428			42
43	Other (specify):* Disallowed Costs			464	464		464	(464)				43
44	TOTAL Special Cost Centers			53,892	53,892		53,892	(464)	53,428			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	477,879	103,526	312,860	894,265		894,265	(691)	893,574			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(265)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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 See Page 5A	(464)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (729)		\$	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)	38		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 38		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (691)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Resident Vacations	\$ (464)	43	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(464)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Frances House, Inc.	100	Frances House, Inc. (FH)		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Residential Alternatives of Illinois, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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	20	Dues, Fees & Subscriptions	\$	Frances House, Inc.	100.00%	\$ 11	\$ 11	1
2	V	21	Clerical & General Office Exp		Frances House, Inc.	100.00%	4	4	2
3	V	25	Employee Training		Frances House, Inc.	100.00%	1	1	3
4	V	20	Dues, Fees & Subscriptions		Frances House, Inc. - Pioneer Concepts Facilities	100.00%	22	22	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 38	\$ * 38	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Torrence Place

0043364

Report Period Beginning:

4/1/2019

Ending:

3/31/20

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	Residential Alternatives of Illinois	100%	Hawthorne Inn of Danville	Danville				1
2	Residential Alternatives of Illinois	100%	Manor Court of Clinton	Clinton				2
3	Residential Alternatives of Illinois	100%	Manor Court of Freeport	Freeport				3
4	Residential Alternatives of Illinois	100%	Manor Court of Peoria	Peoria				4
5	Residential Alternatives of Illinois	100%	Manor Court of Peru	Peru				5
6	Residential Alternatives of Illinois	100%	Manor Court of Princeton	Princeton				6
7	Residential Alternatives of Illinois	100%			Hawthorne Inn of Freeport	Freeport, IL	Supportive Living Facility	7
8	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peoria	Peoria, IL	Assisted Living Facility	8
9	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peru	Peru, IL	Assisted Living Facility	9
10	Residential Alternatives of Illinois	100%			Liberty Estates of Geneseo	Geneseo, IL	Asst'd & Ind Living	10
11	Residential Alternatives of Illinois	100%			Liberty Estates of Streator	Streator, IL	Asst'd & Ind Living	11
12	Residential Alternatives of Illinois	100%			Liberty Estates of Danville	Danville, IL	Ind Living Facility	12
13	Residential Alternatives of Illinois	100%			Liberty Estates of Freeport	Freeport, IL	Ind Living Facility	13
14	Residential Alternatives of Illinois	100%			Liberty Estates of Peoria	Peoria, IL	Ind Living Facility	14
15	Residential Alternatives of Illinois	100%			Liberty Estates of Peru	Peru, IL	Ind Living Facility	15
16	Residential Alternatives of Illinois	100%	Windmill Manor	Coralville, IA				16
17	Residential Alternatives of Illinois	100%			Hawthorne Inn of Rochelle	Rochelle, IL	Assisted Living Facility	17
18	Frances House, Inc.	100%	Casa Willis	Sterling, IL	Woodburn	Sterling, IL	CILA	18
19	Frances House, Inc.	100%	Freeport Terrace	Freeport, IL				19
20	Frances House, Inc.	100%	Gordon Jones Terrace	Lanark, IL				20
21	Frances House, Inc.	100%	Hallam Terrace	Rockford, IL				21
22	Frances House, Inc.	100%	Hammett House	Sterling, IL				22
23	Frances House, Inc.	100%	Kanthak House	Ottawa, IL				23
24	Frances House, Inc.	100%	Olson Terrace	Rockford, IL				24
25	Frances House, Inc.	100%	Ridge Terrace	Freeport, IL				25
26	Frances House, Inc.	100%	Cantebury Place	Rockford, IL				26
27	Frances House, Inc.	100%	Glenwood Villa	Rockford, IL				27
28	Frances House, Inc.	100%	Rockton Court	Rockford, IL				28
29	Frances House, Inc.	100%	Rose House	Moline, IL				29
30	Frances House, Inc.	100%	Seborg Terrace	Rockford, IL				30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Torrence Place

0043364

Report Period Beginning:

4/1/2019

Ending:

3/31/20

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	Frances House, Inc.	100%	Smith Square	Moline, IL				1
2	Frances House, Inc.	100%	Stern Square	Sterling, IL				2
3	Frances House, Inc.	100%	Stouffer Terrace	Oregon, IL				3
4	Frances House, Inc.	100%	Lewis Terrace	North Chicago, IL				4
5	Frances House, Inc.	100%	Seymour Terrace	North Chicago, IL				5
6	Frances House, Inc.	100%	Waukegan Terrace	Waukegan, IL				6
7	Frances House, Inc.	100%	Pine Terrace	Waukegan, IL				7
8	Pioneer Concepts, Inc.	100%	Broadway Terrace	Chicago Heights, IL	Woodgate	Matteson	CILA	8
9	Pioneer Concepts, Inc.	100%	Carole Lane Terrace	Sauk Village, IL	Thornton	Thornton	CILA	9
10	Pioneer Concepts, Inc.	100%	Flossmoor Terrace	Flossmoor, IL				10
11	Pioneer Concepts, Inc.	100%	Ravisloe Terrace	Country Club Hills, IL				11
12	Pioneer Concepts, Inc.	100%	Spaulding Terrace	Markham, IL				12
13	Pioneer Concepts, Inc.	100%	Calumet City Terrace	Calumet City, IL				13
14	Pioneer Concepts, Inc.	100%	Dolton Terrace	Dolton, IL				14
15	Pioneer Concepts, Inc.	100%	Lynwood Terrace	Lynwood, IL				15
16	Pioneer Concepts, Inc.	100%	Holland Terrace	South Holland, IL				16
17	Pioneer Concepts, Inc.	100%	Matteson Court	Matteson, IL				17
18	Pioneer Concepts, Inc.	100%	Priarie House	Sauk Village, IL				18
19	Pioneer Concepts, Inc.	100%	Torrence Place	Sauk Village, IL				19
20	Pinnacle Opportunities	100%	Chambness Square	Bourbannais, IL	Gravlin Square	Bradley, IL	CILA	20
21	Pinnacle Opportunities	100%	Collins Square	Bradley, IL				21
22	Pinnacle Opportunities	100%	Dearborn Court	Kankakee, IL				22
23	Pinnacle Opportunities	100%	River Court	Kankakee, IL				23
24	Pinnacle Opportunities	100%	Station Court	Kankakee, IL				24
25	Pinnacle Opportunities	100%	Eagle Court	Kankakee, IL				25
26	Pinnacle Opportunities	100%	Kankakee Court	Kankakee, IL				26
27	Pinnacle Opportunities	100%	Roy Court	Bourbannais, IL				27
28	Pinnacle Opportunities	100%	Hunt Terrace	Kankakee, IL				28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Torrence Place # 0043364 Report Period Beginning: 4/1/2019 Ending: 3/31/20

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	See Attached Schedule 7A								\$ 0	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 3/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

FACILITY NAME Torrence Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0043364

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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

B. Real Estate Tax Cost Allocations

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

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.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

4,200

B. General Construction Type:

Exterior Brick

Frame Wood

Number of Stories

1

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		1997	\$ 29,906	1
2					2
3	TOTALS			\$ 29,906	3

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

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	16		1997	1993	\$ 590,406	\$ 23,616	25	\$ 23,616		\$ 545,142
5										
6										
7										
8										
	Improvement Type**									
9	Parking Lots, Sidewalks & Landscaping			1993	68,169		15			68,169
10	Retention Pond			1996	10,495		10			10,495
11	Roof Repairs & Carpet			2002	18,937		5-10 yrs			18,937
12	Congoleum			2004	1,207		10			1,207
13	Sprinkler System, Carpet			2006	26,134	798	5-25 yrs	798		17,559
14	Cabinets/Countertops			2008	3,584	239	15	239		2,867
15	Carpet			2008	16,715		5			16,715
16	Furnace			2010	2,575	258	10	258		2,425
17	Carpet - Living Room, Program Room, Office			2012	3,115		5			3,115
18	Concrete Drive/Sidewalks			2015	7,485	499	15	499		2,246
19	Bathroom-New Fixtures/Walls/Tile/Drain/Toilet/Shower			2016	40,050	3,337	12	3,337		13,628
20	Kitchen Remodel-Drywall/Counters/Sink/Paint			2016	11,990	999	12	999		3,664
21	Backyard Wooden Fence			2016	6,015	751	8	751		2,757
22	Replace Vinyl Tile - Activity Room and Hallway			2017	3,187	318	10	318		823
23	Replace Vinyl Tile - Living Room, Dining Room, Hallway			2019	5,396	540	10	540		629
24	Convert Sprinkler System to a Wet System			2020	14,700	102	12	102		102
25	LVT Flooring-Bedrooms/Halls/Lobby/Dining Room/Kitchen			2020	18,880	157	10	157		157
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Torrence Place

0043364

Report Period Beginning:

4/1/2019

Ending:

3/31/20

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			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 849,040	\$ 31,614		\$ 31,614	\$	\$ 710,637	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$45,718	\$2,516	\$2,516	\$	3-15 yrs	\$31,764	71
72	Current Year Purchases	9,992	694	694		12 yrs	694	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$55,710	\$3,210	\$3,210	\$		\$32,458	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	Pateint Care	2004 GMC G3500 Van	2005	\$38,500	\$	\$	\$	4	\$38,500	76
77										77
78										78
79										79
80	TOTALS			\$38,500	\$	\$	\$		\$38,500	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)	\$973,156	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$34,824	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$34,824	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$781,595	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Constr in Progress	\$4,013	92
93			93
94			94
95		\$4,013	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

N/A
N/A
9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: \$ 0 Description: N/A
(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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

☒

☐

☐

138

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)		4,560		4,560
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 4,560	\$	\$ 4,560
10	SUM OF line 9, col. 1 and 2 (e)	\$ 4,560			

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

(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.
SEE ACCOUNTANTS' PREPARATION REPORT

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

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.

SEE ACCOUNTANTS' PREPARATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,446,756	\$ 1,446,756	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 9,950)	20,247	20,247	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,476	5,476	6
7	Other Prepaid Expenses	662	662	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	2,210,191	2,210,191	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,683,332	\$ 3,683,332	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	29,906	29,906	13
14	Buildings, at Historical Cost	852,228	849,040	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	94,210	94,210	16
17	Accumulated Depreciation (book methods)	(781,595)	(781,595)	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 (spe Constr in Progress	4,013	4,013	22
23	Other(specify): <u>Unreal Gain (Loss) on Invest.</u>	6,064	6,064	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 204,826	\$ 201,638	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,888,158	\$ 3,884,970	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,022	\$ 29,022	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,245	27,245	30
31	Accrued Taxes Payable (excluding real estate taxes)	903	903	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	331	331	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 57,501	\$ 57,501	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 57,501	\$ 57,501	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,830,657	\$ 3,827,469	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,888,158	\$ 3,884,970	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,777,463	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,777,463	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	53,194	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 53,194	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)	\$ 3,830,657	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Torrence Place

0043364

Report Period Beginning: 4/1/2019

Ending:

3/31/20

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	\$ 942,849	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 942,849	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	4,560	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)	\$ 4,560	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 50	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 947,459	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	206,873	31
32	Health Care	366,154	32
33	General Administration	232,522	33
	B. Capital Expense		
34	Ownership	34,824	34
	C. Ancillary Expense		
35	Special Cost Centers	464	35
36	Provider Participation Fee	53,428	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 894,265	40
41	Income before Income Taxes (line 30 minus line 40)**	53,194	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 53,194	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 942,849	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 942,849	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	496	525	13,596	25.90	4
5	CNAs & Orderlies	19,615	20,500	284,760	13.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,405	2,593	35,125	13.55	15
16	Dishwashers					16
17	Maintenance Workers	1,109	1,129	18,225	16.14	17
18	Housekeepers	1,500	1,540	18,336	11.91	18
19	Laundry					19
20	Administrator	436	468	16,192	34.60	20
21	Assistant Administrator	250	274	4,293	15.67	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,587	3,587	52,798	14.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,136	2,208	34,554	15.65	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	31,534	32,824	\$ 477,879 *	\$ 14.56	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	\$ 1,294	L1, C3	35
36	Medical Director	Monthly	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	98	L10, C3	38
39	Pharmacist Consultant	Monthly	900	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	5,562	L10, C3	46
47	Psychological Consultant	Monthly	4,043	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,097		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number

Torrence Place

0043364

Report Period Beginning:

4/1/2019

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3/31/20

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Description		Amount		Description		Amount	
Angela Moore		Administrator	None	Workers' Compensation Insurance		\$ 4,829		IDPH License Fee		\$	
Chelsea Mumford		Administrator	None	Unemployment Compensation Insurance		(2,574)		Advertising: Employee Recruitment		2,241	
Juanita McFadden		Asst Administrator	None	FICA Taxes		34,756		Health Care Worker Background Check			
				Employee Health Insurance		23,619		(Indicate # of checks performed)			
				Employee Meals		1,847		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*							
				401k		1,921		Subscriptions		397	
				Other Employee Benefits		2,923		IHCA Dues		934	
								Other Licenses & Fees		11	
								Indirect costs		33	
								Less: Public Relations Expense		(265)	
								Non-allowable advertising		()	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,		\$ 67,321		TOTAL (agree to Sch. V,		\$ 3,351	
(List each licensed administrator separately.)			\$ 20,485	line 22, col.8)				line 20, col. 8)			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description		Amount		Description		Line #	Amount	Description		Amount	
N/A		\$		N/A			\$	Out-of-State Travel		\$	
TOTAL (agree to Schedule V, line 17, col. 3)		\$						In-State Travel			
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee		Type	Amount								
RFMS, Inc.		Administrative Services	\$ 33,990								
LTC Support Services, LLC		Support Services	28,224								
RSM US LLP		Accounting Services	3,232								
Templin Healthcare Accounting		Accounting Services	1,020								
Digital River Pacific		Computer Services	29								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 66,495	TOTAL			\$	Seminar Expense		77	
(For legal fee disclosure, see page 39 of instructions)								()			
								Entertainment Expense		()	
								(agree to Sch. V,			
								line 24, col. 8)		\$ 77	

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0043364

Report Period Beginning:

4/1/2019

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- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. 934 IHCA
- (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?
What was the average life used for new equipment added during this period? Yes
12 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. \$ 4,554 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? 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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period. \$ 53,428
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.

SEE ACCOUNTANTS' PREPARATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,847 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? None
- 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? Yes
Firm Name: RSM US LLP
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.