

		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: 0055061 Facility Name: Westmont Manor Hlth Rhb Address: 512 East Ogden Ave Westmont 60559 County: Dupage Telephone Number: (630) 323-4400 Fax #: (630) 323-4583 HFS ID Number: Date of Initial License for Current Owners: 10/1/2018 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:

Facility Name & ID Number Westmont Manor Hlth Rhb

0055061 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	<u>149</u>	Skilled (SNF)	<u>149</u>	<u>54,534</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>149</u>	TOTALS	<u>149</u>	<u>54,534</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,563</u>	<u>1,449</u>	<u>10,559</u>	<u>27,571</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,563</u>	<u>1,449</u>	<u>10,559</u>	<u>27,571</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.56%

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

None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/1/2018

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/1/2018 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 149 and days of care provided 4,328

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ 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 **Westmont Manor Hlth Rhb** # **0055061** 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	263,959	53,581	28,034	345,574		345,574	487	346,061			1
2	Food Purchase		194,442		194,442		194,442	(84)	194,358			2
3	Housekeeping	111,934	22,966		134,900		134,900	893	135,793			3
4	Laundry	63,613	10,013		73,626		73,626		73,626			4
5	Heat and Other Utilities			180,090	180,090		180,090	(15,827)	164,263			5
6	Maintenance	48,978		203,242	252,220		252,220	(8,527)	243,693			6
7	Other (specify):*							2,431	2,431			7
8	TOTAL General Services	488,484	281,002	411,366	1,180,852		1,180,852	(20,627)	1,160,225			8
	B. Health Care and Programs											
9	Medical Director			3,535	3,535		3,535		3,535			9
10	Nursing and Medical Records	1,950,194	328,819	1,546,080	3,825,093		3,825,093	20,138	3,845,231			10
10a	Therapy	53,250		30,220	83,470		83,470		83,470			10a
11	Activities	153,227	3,076		156,303		156,303		156,303			11
12	Social Services	170,902	127	32,013	203,042		203,042	10,422	213,464			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							18,781	18,781			15
16	TOTAL Health Care and Programs	2,327,573	332,022	1,611,848	4,271,443		4,271,443	49,341	4,320,784			16
	C. General Administration											
17	Administrative	88,049			88,049		88,049	77,655	165,704			17
18	Directors Fees											18
19	Professional Services			443,288	443,288	(13,340)	429,948	(301,077)	128,871			19
20	Dues, Fees, Subscriptions & Promotions			233,253	233,253		233,253	(11,564)	221,689			20
21	Clerical & General Office Expenses	140,234	12,268	279,939	432,441		432,441	(127,967)	304,474			21
22	Employee Benefits & Payroll Taxes			614,311	614,311		614,311	(37,250)	577,061			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,343	6,343		6,343	(5,842)	501			24
25	Other Admin. Staff Transportation			2,122	2,122		2,122	452	2,574			25
26	Insurance-Prop.Liab.Malpractice			495,424	495,424		495,424	1,236	496,660			26
27	Other (specify):*							31,220	31,220			27
28	TOTAL General Administration	228,283	12,268	2,074,680	2,315,231	(13,340)	2,301,891	(373,137)	1,928,754			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,044,340	625,292	4,097,894	7,767,526	(13,340)	7,754,186	(344,423)	7,409,763			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			23,168	23,168		23,168	300,777	323,945			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			67,546	67,546		67,546	356,504	424,050			32
33	Real Estate Taxes			114,589	114,589	13,340	127,929	3,426	131,355			33
34	Rent-Facility & Grounds			336,000	336,000		336,000	(336,000)				34
35	Rent-Equipment & Vehicles			2,514	2,514		2,514	165	2,679			35
36	Other (specify):*											36
37	TOTAL Ownership			543,817	543,817	13,340	557,157	324,872	882,029			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	703,530	331,205	13,925	1,048,660		1,048,660	(11,635)	1,037,025			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			238,117	238,117		238,117		238,117			42
43	Other (specify):*			30,144	30,144		30,144	(30,144)				43
44	TOTAL Special Cost Centers	703,530	331,205	282,186	1,316,921		1,316,921	(41,779)	1,275,142			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,747,870	956,497	4,923,897	9,628,264		9,628,264	(61,330)	9,566,934			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	(16,793)	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	(252,715)	30		9
10	Interest and Other Investment Income	(457)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(101)	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				19
20	Contributions	(250)	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	(208,543)	21		24
25	Fund Raising, Advertising and Promotional	(11,736)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(47,105)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (537,700)		\$	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)	476,370		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 476,370		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (61,330)		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	Vending Income	\$ (49)	02	1
2	Misc. Income	(1,790)	21	2
3	Jury Duty Income	(17)	10	3
4	Theft Loss	(959)	21	4
5	Colletion Expense	(8,059)	21	5
6	Marketing Consultant	(30,144)	43	6
7	Building Company - Misc. Admin. Expenses	(91)	21	7
8	Building Company - Amortization	(8,856)	36	8
9	Capitalized R&M	(16,571)	06	9
10	Prior Year R&M	(3,363)	06	10
11	Real Estate Tax - Remove Entry relating to Prior Owner	36,067	33	11
12	Chamber of Commerce Dues	(1,809)	20	12
13	Prior Year Seminar	(6,343)	24	13
14	Non-Allowable Legal	(5,121)	19	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
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28				28
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31				31
32				32
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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	(47,105)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westmont Manor Hlth Rhb

0055061

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			90	397								487	1
2	Food Purchase	(150)		66									(84)	2
3	Housekeeping			788	105								893	3
4	Laundry													4
5	Heat and Other Utilities	(16,793)		863	103								(15,827)	5
6	Maintenance	(19,934)		11,303	104								(8,527)	6
7	Other (specify):*			2,373	58								2,431	7
8	TOTAL General Services	(36,877)		15,483	767								(20,627)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)			23,076	(2,921)							20,138	10
10a	Therapy													10a
11	Activities													11
12	Social Services				10,422								10,422	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				18,781								18,781	15
16	TOTAL Health Care and Programs	(17)			52,279	(2,921)							49,341	16
	C. General Administration													
17	Administrative			11,282	66,373								77,655	17
18	Directors Fees													18
19	Professional Services	(5,121)		(182,434)	(113,522)								(301,077)	19
20	Fees, Subscriptions & Promotions	(13,795)		1,469	762								(11,564)	20
21	Clerical & General Office Expenses	(219,442)	91	56,721	34,663								(127,967)	21
22	Employee Benefits & Payroll Taxes			(37,250)									(37,250)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(6,343)		240	261								(5,842)	24
25	Other Admin. Staff Transportation			452									452	25
26	Insurance-Prop.Liab.Malpractice			968	268								1,236	26
27	Other (specify):*			16,604	14,616								31,220	27
28	TOTAL General Administration	(244,701)	91	(131,948)	3,421								(373,137)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(281,595)	91	(116,465)	56,467	(2,921)							(344,423)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westmont Manor Hlth Rhb # 0055061 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(252,715)	551,877	1,519	96								300,777	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(457)	351,445	5,429	87								356,504	32
33	Real Estate Taxes	36,067	(36,067)	3,022	404								3,426	33
34	Rent-Facility & Grounds		(336,000)										(336,000)	34
35	Rent-Equipment & Vehicles			165									165	35
36	Other (specify):*	(8,856)	8,856											36
37	TOTAL Ownership	(225,961)	540,111	10,135	587								324,872	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(11,635)							(11,635)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(30,144)											(30,144)	43
44	TOTAL Special Cost Centers	(30,144)				(11,635)							(41,779)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(537,700)	540,202	(106,330)	57,054	(14,556)							(61,330)	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	Rent	\$ 336,000	Paradox Westmont Property, LLC		\$	(336,000)	1
2	V	33	Real Estate Tax	114,589	Paradox Westmont Property, LLC		78,522	(36,067)	2
3	V	21	Misc. Admin. Expenses		Paradox Westmont Property, LLC		91	91	3
4	V	30	Depreciation		Paradox Westmont Property, LLC		551,877	551,877	4
5	V	36	Amortization		Paradox Westmont Property, LLC		8,856	8,856	5
6	V	32	Interest		Paradox Westmont Property, LLC		351,445	351,445	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 450,589			\$ 990,791	\$ * 540,202	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	ATIED ASSOCIATES, LLC	99.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		PARADOX WESTMONT PROPE	WESTMONT	BUILDING COMPANY	1
2	B & Z GRANDCHILDREN TRUST	1.00%	BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	DES PLAINES	PHARMACY	7
8			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				8
9			MAJOR HOSPITAL DYER	DYER, IN				9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				21
22			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				22
23			ST. JAMES WELLNESS REHAB VILLAS	CRETE				23
24			THE ESTATES OF HYDE PARK	CHICAGO				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				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
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23								23
24								24
25								25
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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.

☒ X

 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	01	Dietary	\$	Extended Care Consulting, LLC		\$ 90	\$ 90	15
16	V	02	Food		Extended Care Consulting, LLC		66	66	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		788	788	17
18	V	05	Utilities		Extended Care Consulting, LLC		863	863	18
19	V	06	Maintenance		Extended Care Consulting, LLC		1,719	1,719	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	185,946	Extended Care Consulting, LLC		3,512	(182,434)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		1,469	1,469	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		7,735	7,735	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		240	240	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		452	452	25
26	V	26	Insurance		Extended Care Consulting, LLC		968	968	26
27	V	30	Depreciation		Extended Care Consulting, LLC		1,519	1,519	27
28	V	32	Interest		Extended Care Consulting, LLC		5,429	5,429	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		3,022	3,022	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		165	165	30
31	V	06	Maintenance Salaries	3,430	Extended Care Consulting, LLC		13,014	9,584	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		2,373	2,373	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		11,282	11,282	33
34	V	21	Office and Clerical Salaries	30,776	Extended Care Consulting, LLC		79,762	48,986	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		16,604	16,604	35
36	V	22	Employee Benefits	37,250	Extended Care Consulting, LLC			(37,250)	36
37	V								37
38	V								38
39	Total			\$ 257,402			\$ 151,072	\$ * (106,330)	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	1	Dietary Salary	\$	Extended Care Clinical, LLC		\$ 397	\$ 397	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		105	105	16
17	V	5	Utilities		Extended Care Clinical, LLC		103	103	17
18	V	6	Maintenance		Extended Care Clinical, LLC		104	104	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		58	58	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		22,494	22,494	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		582	582	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		10,422	10,422	22
23	V	15	Emp. Ben. - Direct Alloc.		Extended Care Clinical, LLC		13,943	13,943	23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		4,838	4,838	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		66,373	66,373	25
26	V	19	Professional Fees	114,444	Extended Care Clinical, LLC		922	(113,522)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC				27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		762	762	28
29	V	21	Office Salary		Extended Care Clinical, LLC		33,078	33,078	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		1,585	1,585	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		261	261	31
32	V	26	Insurance		Extended Care Clinical, LLC		268	268	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		14,616	14,616	33
34	V	30	Depreciation		Extended Care Clinical, LLC		96	96	34
35	V	32	Interest		Extended Care Clinical, LLC		87	87	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		404	404	36
37	V								37
38	V								38
39	Total			\$ 114,444			\$ 171,498	\$ * 57,054	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	10	Nursing and Medical Records	\$ 31,253	MAC Rx, LLC		\$ 28,333	\$ (2,921)	15
16	V	39	Ancillary	124,493	MAC Rx, LLC		112,858	(11,635)	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			\$ 155,746			\$ 141,191	\$ * (14,556)	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.

YESNO

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)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Westmont Manor Hlth Rhb # 0055061 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 Westmont Manor Hlth Rhb# 0055061

Report Period Beginning:

01/01/20Ending: 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

Extended Care Consulting, LLC

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

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	01	Dietary	Patient Days	1,219,947	38	\$ 3,992	\$ 27,571	\$ 90	1
2	02	Food	Patient Days	1,219,947	38	2,910	27,571	66	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856	27,571	788	3
4	05	Utilities	Patient Days	1,219,947	38	38,173	27,571	863	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040	27,571	1,719	5
6	17	Administrative	Patient Days	1,219,947	38		27,571		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408	27,571	3,512	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998	27,571	1,469	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251	27,571	7,735	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602	27,571	240	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988	27,571	452	11
12	26	Insurance	Patient Days	1,219,947	38	42,836	27,571	968	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209	27,571	1,519	13
14	32	Interest	Patient Days	1,219,947	38	240,208	27,571	5,429	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701	27,571	3,022	15
16	35	Rent - Equipment	Patient Days	1,219,947	38	7,304	27,571	165	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	27,571	13,014	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021	27,571	2,373	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	27,571	11,282	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	27,571	79,762	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685	27,571	16,604	21
22									22
23									23
24									24
25	TOTALS				\$ 6,684,506	\$ 4,604,325		\$ 151,072	25

Facility Name & ID Number Westmont Manor Hlth Rhb # 0055061 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 Extended Care Clinical, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	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	Dietary Salary	Patient Days	603,308	20	\$ 8,692	\$ 8,692	27,571	\$ 397	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		27,571	105	2
3	5	Utilities	Patient Days	603,308	20	2,264		27,571	103	3
4	6	Maintenance	Patient Days	603,308	20	2,283		27,571	104	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		27,571	58	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	27,571	22,494	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		27,571	582	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	27,571	10,422	8
9	15	Emp. Ben. - Direct Alloc.	Direct Allocation		4	44,957			13,943	9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		27,571	4,838	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	27,571	66,373	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		27,571	922	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220				13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		27,571	762	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	27,571	33,078	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		27,571	1,585	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		27,571	261	17
18	26	Insurance	Patient Days	603,308	20	5,874		27,571	268	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		27,571	14,616	19
20	30	Depreciation	Patient Days	603,308	20	2,099		27,571	96	20
21	32	Interest	Patient Days	603,308	20	1,914		27,571	87	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		27,571	404	22
23										23
24										24
25	TOTALS					\$ 3,507,824	\$ 2,905,144		\$ 171,498	25

Facility Name & ID Number Westmont Manor Hlth Rhb # 0055061 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 MAC Rx, LLC
Street Address 2307 S. Mount Prospect Road
City / State / Zip Code Des Plaines, IL 60018
Phone Number (224)220-2700
Fax Number (224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			\$	\$		\$ 28,333	1
2	39	Ancillary	Direct Allocation						112,858	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					\$	\$		\$ 141,191	25

Facility Name & ID Number Westmont Manor Hlth Rhb # 0055061 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
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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 Westmont Manor Hlth Rhb # 0055061 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
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18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Westmont Manor Hlth Rhb # 0055061 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
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18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Westmont Manor Hlth Rhb # 0055061 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
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18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Westmont Manor Hlth Rhb # 0055061 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
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12										12
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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 Westmont Manor Hlth Rhb # 0055061 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
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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	Huntington Bank		X	Mortgage			\$	5,743,709			\$	351,445	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Midcap		X	Line of Credit				3,484,068				67,546	6
7													7
8													8
9	TOTAL Facility Related						\$	9,227,777			\$	418,991	9
	B. Non-Facility Related*												
10	Interest Income		X									(457)	10
11	Alloc from Extended Care Consulting											5,429	11
12	Alloc from Extended Care Clinical											87	12
13													13
14	TOTAL Non-Facility Related						\$				\$	5,059	14
15	TOTALS (line 9+line14)						\$	9,227,777			\$	424,050	15

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westmont Manor Hlth Rhb COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0055061

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. 09-03-207-014	Long Term Care Property	\$ 115,409.04	\$ 115,409.04
2. See Attached	Alloc from Extended Care Consulting	\$ 197,162.69	\$ 3,021.67
3. See Attached	Alloc from Extended Care Clinical	\$ 197,162.69	\$ 403.74
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 509,734.42	\$ 118,834.45

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.

FACILITY NAME Westmont Manor Hlth Rhb COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0055061

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

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.

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 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.

Page 10B

A. Square Feet: 40,294

B. General Construction Type: ExteriorMasonryFrameSteelNumber of Stories1

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		2018	\$ 767,489	1
2	Allocated from Care Center Building			14,246	2
3	TOTALS			\$ 781,735	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	149		2018	1977	\$ 5,396,671	\$ 551,877	35	\$ 154,191	\$ (397,686)	\$ 308,382	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 Westmont Manor Hlth Rhb

0055061

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			\$	\$		\$	\$	\$	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
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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)		70,858	1,099		1,099		50,001	68
69	Financial Statement Depreciation			23,168			(23,168)		69
70	TOTAL (lines 4 thru 69)		\$ 5,467,529	\$ 576,144		\$ 155,290	\$ (420,854)	\$ 358,383	70

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

Facility Name & ID Number Westmont Manor Hlth Rhb

0055061

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		\$ 5,467,529	\$ 576,144		\$ 155,290	\$ (420,854)	\$ 358,383	1
2	Wifi And Main Mdf Cabling	2018	10,351		20	518	518	1,036	2
3	Storage Tank For Hot Water Heater	2019	22,075		20	1,104	1,104	2,208	3
4	Air Condition Unit (10 Ton)	2019	17,895		20	895	895	1,790	4
5	Dialysis Wing-Concrete/Drywall Patching, Paint,Plumbing	2019	70,902		20	3,545	3,545	7,090	5
6	Walk-In Cooler - New Motor Assembly & Contactor	2019	2,945		20	147	147	294	6
7	Boiler - New Circulating Pump Motor & Coupler	2019	5,624		20	281	281	562	7
8	Walk-In Cooler - New Compressor & Press Control	2019	3,865		20	193	193	386	8
9	Install Call Lights On 1St & 2Nd Floors	2020	20,198		20	1,010	1,010	1,010	9
10	Repair Station Board Of The Nurse Call Light System	2020	4,466		20	223	223	223	10
11	New Call Lights-Rooms 129,131,133,135,137 And 2 Shower Rms	2020	4,105		20	205	205	205	11
12	Dig Up Floor In Pt Room, Replace Sewer Pipe, Recement Floor	2020	5,000		20	250	250	250	12
13	Replace Drywall In Car Port Ceiling & Paint	2020	3,000		20	150	150	150	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)		\$ 5,637,955	\$ 576,144		\$ 163,812	\$ (412,333)	\$ 373,587	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,637,955	\$ 576,144		\$ 163,812	\$ (412,333)	\$ 373,587	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,637,955	\$ 576,144		\$ 163,812	\$ (412,333)	\$ 373,587	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,637,955	\$ 576,144		\$ 163,812	\$ (412,333)	\$ 373,587	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,637,955	\$ 576,144		\$ 163,812	\$ (412,333)	\$ 373,587	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,637,955	\$ 576,144		\$ 163,812	\$ (412,333)	\$ 373,587	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
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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)		\$ 5,637,955	\$ 576,144		\$ 163,812	\$ (412,333)	\$ 373,587	34

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

Facility Name & ID Number Westmont Manor Hlth Rhb

0055061

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.

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
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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 Westmont Manor Hlth Rhb

0055061

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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	17,318	444	35	444		8,122	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	5,424	120	35	120		1,622	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,314	59	39	59		1,085	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	14,306		20			14,306	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	16,859		20			16,859	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	838		20			838	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	151	8	20	8		91	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,451	73	20	73		508	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	238	12	20	12		154	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	941	47	20	47		235	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	1,633	82	20	82		327	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	748	37	20	37		112	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	282	14	20	14		28	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	75	4	20	4		4	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2002	1,911		20			1,911	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2003	2,253		20			2,253	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2005	112		20			112	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2009	20	1	20	1		12	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2014	187	9	20	9		66	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2015	32	2	20	2		21	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2016	126	6	20	6		31	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2017	218	11	20	11		44	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2018	100	5	20	5		15	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2019	38	2	20	2		4	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2020	10	1	20	1		1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 67,586	\$ 936		\$ 936	\$	\$ 48,761	34

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

Facility Name & ID Number Westmont Manor Hlth Rhb

0055061

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		\$ 67,586	\$ 936		\$ 936	\$	\$ 48,761	1
2									2
3									3
4									4
5	Leasehold Improvements:								5
6	Allocated from Extended Care Consulting	2007	104	5	20	5		73	6
7	Allocated from Extended Care Consulting	2009	62	3	20	3		37	7
8	Allocated from Extended Care Consulting	2010	610	30	20	30		335	8
9	Allocated from Extended Care Consulting	2011	219	11	20	11		110	9
10	Allocated from Extended Care Consulting	2012	72	4	20	4		33	10
11	Allocated from Extended Care Consulting	2014	1,002	50	20	50		351	11
12	Allocated from Extended Care Consulting	2016	1,202	60	20	60		300	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)		\$ 70,858	\$ 1,099		\$ 1,099	\$	\$ 50,001	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	\$1,590,785	\$515	\$159,078	\$158,563	10	\$321,834	71
72	Current Year Purchases	10,547		1,055	1,055	10	1,055	72
73	Fully Depreciated Assets	69,495				10	69,495	73
74								74
75	TOTALS	\$1,670,827	\$515	\$160,133	\$159,618		\$392,384	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		Alloc. Extended Care Clinical	2012	\$2,348	\$	\$	\$	5	\$2,348
77		Alloc. Extended Care Consulting	2014	575				5	575
78									
79									
80	TOTALS			\$2,923	\$	\$	\$		\$2,923

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	8,093,441
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	576,660
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	323,945
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(252,715)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	768,895

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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								5
6								6
7	TOTAL				\$			7

**

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 2,679 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	39 - 01	hrs	\$ 212,435		\$	\$		\$ 212,435	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	91,804					91,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	399,291					399,291	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				146,563		146,563	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					13,925	184,642		198,567	13
14	TOTAL			\$ 703,530		\$ 13,925	\$ 331,205		\$ 1,048,660	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 71,598	\$ 71,598	1
2	Cash-Patient Deposits	39,216	39,216	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,087,653	4,087,653	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,065	97,065	6
7	Other Prepaid Expenses	2,503	2,503	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	2,923	58,923	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,300,958	\$ 4,356,958	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		767,489	13
14	Buildings, at Historical Cost		5,194,785	14
15	Leasehold Improvements, at Historical Cost	110,872	312,758	15
16	Equipment, at Historical Cost	86,067	1,626,729	16
17	Accumulated Depreciation (book methods)	(41,515)	(1,507,014)	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): See Attached	107,550	35,092	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 262,974	\$ 6,429,839	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,563,932	\$ 10,786,797	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 714,276	\$ 714,277	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,006	34,006	28
29	Short-Term Notes Payable	3,484,068	3,484,068	29
30	Accrued Salaries Payable	295,794	295,794	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,785	7,785	31
32	Accrued Real Estate Taxes(Sch.IX-B)	121,179	121,179	32
33	Accrued Interest Payable		31,018	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,287,353	1,287,353	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,944,461	\$ 5,975,480	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,743,709	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	450,900	537,195	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 450,900	\$ 6,280,904	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,395,361	\$ 12,256,384	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,831,429)	\$ (1,469,587)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,563,932	\$ 10,786,797	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,683,067)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,683,067)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(148,362)	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)	\$ (148,362)	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)	\$ (1,831,429)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Westmont Manor Hlth Rhb

0055061

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	\$ 8,107,641	1
2	Discounts and Allowances for all Levels	(2,825,155)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,282,486	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,903,869	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,903,869	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	589	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	177,840	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,252	19
20	Radiology and X-Ray	2,020	20
21	Other Medical Services	18,064	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 200,765	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	457	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 457	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,092,325	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,092,325	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,479,902	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,180,852	31
32	Health Care	4,271,443	32
33	General Administration	2,315,231	33
	B. Capital Expense		
34	Ownership	543,817	34
	C. Ancillary Expense		
35	Special Cost Centers	1,078,804	35
36	Provider Participation Fee	238,117	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,628,264	40
41	Income before Income Taxes (line 30 minus line 40)**	(148,362)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (148,362)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,387,743	44
45	Private Pay - Net Inpatient Revenue	466,404	45
46	Medicare - Net Inpatient Revenue	1,029,540	46
47	Other-(specify) Hospice	187,186	47
48	Other-(specify) Insurance	211,613	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,282,486	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	1,905	2,088	\$ 101,340	\$ 48.53	1
2	Assistant Director of Nursing	926	979	39,267	40.11	2
3	Registered Nurses	17,198	18,909	716,386	37.89	3
4	Licensed Practical Nurses	15,799	17,487	547,349	31.30	4
5	CNAs & Orderlies	26,208	28,345	502,970	17.74	5
6	CNA Trainees					6
7	Licensed Therapist	15,001	16,518	703,530	42.59	7
8	Rehab/Therapy Aides	1,433	1,802	53,250	29.55	8
9	Activity Director	1,784	1,927	37,764	19.60	9
10	Activity Assistants	3,777	4,266	60,668	14.22	10
11	Social Service Workers	6,023	6,719	170,902	25.44	11
12	Dietician					12
13	Food Service Supervisor	1,179	1,526	32,150	21.07	13
14	Head Cook	4,931	5,237	94,134	17.97	14
15	Cook Helpers/Assistants	9,988	10,854	137,675	12.68	15
16	Dishwashers					16
17	Maintenance Workers	1,682	1,810	48,978	27.06	17
18	Housekeepers	7,913	8,689	111,934	12.88	18
19	Laundry	4,271	4,582	63,613	13.88	19
20	Administrator	1,728	1,834	88,049	48.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,197	1,350	33,556	24.86	23
24	Clerical	5,433	5,865	106,678	18.19	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	1,917	2,236	42,882	19.18	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	3,722	4,148	54,795	13.21	33
34	TOTAL (lines 1 - 33)	134,015	147,171	\$ 3,747,870 *	\$ 25.47	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	591	\$ 28,034	01-03	35
36	Medical Director	Monthly	3,535	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Per Visit	3,305	10-03	38
39	Pharmacist Consultant	Monthly	6,100	10-03	39
40	Physical Therapy Consultant	Monthly	29,189	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	146	10a-03	42
43	Speech Therapy Consultant	Per Visit	885	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	32,013	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	591	\$ 103,207		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,585	\$ 230,751	10-03	50
51	Licensed Practical Nurses	6,354	396,917	10-03	51
52	Certified Nurse Assistants/Aides	30,097	909,007	10-03	52
53	TOTAL (lines 50 - 52)	40,036	\$ 1,536,675		53

STATE OF ILLINOIS

Facility Name & ID NumberWestmont Manor Hlth Rhb# 0055061Report Period Beginning:01/01/20Ending:12/31/20Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Angela Noland	Administrator	0	\$ 87,881
Zakette Smith	Administrator	0	168
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 88,049

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	\$ 36,797
Midcap	Bank Audit	2,805
Pinnacle Quality	Customer Satisfaction	372
Red Eyed Moose Technologies	Software Support	3,040
Skidelsky & Associates	Real Estate Tax Appeal	13,330
GCHMO	Liason Service	1,800
US Dept of Homeland Security	Petition Non-immigrant Worker	2,920
Legat Architects	Architect	1,121
Navex Global	Ethics & Compliance	428
Ability Network	Medicare Billing Services	7,538
See Attached	Legal	10,838
See Supplemental Schedule		362,300
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 443,289

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 87,372
Unemployment Compensation Insurance	48,683
FICA Taxes	275,369
Employee Health Insurance	153,990
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Welfare	11,647
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	192,609
Health Care Worker Background Check (Indicate # of checks performed 198)	1,982
Patient Background Checks	
Dues & Subscriptions	17,093
Licenses & Fees	7,774
See Supplemental Schedule	2,231
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
See Supplemental Schedule	501
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 501

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>Westmont Manor Hlth Rhb</u>	STATE OF ILLINOIS # <u>0055061</u>	Report Period Beginning: <u>01/01/20</u>	Ending: <u>12/31/20</u>
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Page 22

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. N/A

(3) Did the nursing home make political contributions or payments to a political 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
10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,080 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 238,117
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No 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? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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