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: 0055657

Facility Name: ALLURE OF MT CARROLL

Address: 1006 NORTH LAWDEN RD (Number) | MOUNT CARROLL (City) | 61053 (Zip Code)

County: CARROLL

Telephone Number: 815-244-7150 **Fax #** 815-244-3127

HFS ID Number:

Date of Initial License for Current Owners: 07/01/19

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: AARON MAUER **Telephone Number:** 773-747-4506
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) 5/28/2021 (Date)
(Type or Print Name) Leo LaFranco
(Title) CFO

Paid Preparer

(Signed) 5/27/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM ASSOCIATES, INC, 5683 NORTH LINCOLN AVE
(Telephone) 773-747-4506 Fax # 773-747-4725

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,352	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	72	TOTALS	72	26,352	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,889	7,144	561	14,594	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,889	7,144	561	14,594	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.38%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 07/01/2019

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/2019 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 2,338

Medicare Intermediary Noridian Administrative Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	208,712	14,153	13,344	236,209		236,209		236,209			1
2	Food Purchase		90,726		90,726		90,726	(246)	90,480			2
3	Housekeeping	58,252	7,914		66,166		66,166		66,166			3
4	Laundry	33,994	2,562		36,556		36,556		36,556			4
5	Heat and Other Utilities			121,842	121,842		121,842	1	121,843			5
6	Maintenance	56,777	22,145	8,814	87,736		87,736		87,736			6
7	Other (specify):*											7
8	TOTAL General Services	357,735	137,500	144,000	639,235		639,235	(245)	638,990			8
	B. Health Care and Programs											
9	Medical Director			2,200	2,200		2,200		2,200			9
10	Nursing and Medical Records	1,406,772	79,778	68,903	1,555,453		1,555,453		1,555,453			10
10a	Therapy			309,446	309,446		309,446		309,446			10a
11	Activities	89,521	5,901		95,422		95,422		95,422			11
12	Social Services	37,700		2,941	40,641		40,641		40,641			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Rx Consultant			2,455	2,455		2,455		2,455			15
16	TOTAL Health Care and Programs	1,533,993	85,679	385,945	2,005,617		2,005,617		2,005,617			16
	C. General Administration											
17	Administrative	139,491			139,491		139,491	5,630	145,121			17
18	Directors Fees											18
19	Professional Services			298,548	298,548		298,548	234,322	532,870			19
20	Dues, Fees, Subscriptions & Promotions			13,713	13,713		13,713	2,377	16,090			20
21	Clerical & General Office Expenses	110,394	55,588	66,507	232,489		232,489	(242,196)	(9,707)			21
22	Employee Benefits & Payroll Taxes			361,736	361,736		361,736	22,678	384,414			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,458	6,458		6,458	3,196	9,654			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			76,047	76,047		76,047		76,047			26
27	Other (specify):*											27
28	TOTAL General Administration	249,885	55,588	823,009	1,128,482		1,128,482	26,006	1,154,488			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,141,613	278,767	1,352,954	3,773,334		3,773,334	25,761	3,799,095			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.

Facility Name & ID Number ALLURE OF MT CARROLL #0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			14,640	14,640		14,640	94,963	109,603			30
31	Amortization of Pre-Op. & Org.							7,737	7,737			31
32	Interest			1,940	1,940		1,940	39,419	41,359			32
33	Real Estate Taxes			38,995	38,995		38,995		38,995			33
34	Rent-Facility & Grounds			133,224	133,224		133,224	(81,347)	51,877			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			188,799	188,799		188,799	60,772	249,571			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		84,959		84,959		84,959		84,959			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			123,392	123,392		123,392		123,392			42
43	Other (specify):* **Bad Debt**			52,019	52,019		52,019	(52,018)	1			43
44	**TOTAL Special Cost Centers**		84,959	175,411	260,370		260,370	(52,018)	208,352			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,141,613	363,726	1,717,164	4,222,503		4,222,503	34,515	4,257,018			45

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

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Reference	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	(713,487)	30		9
10	Interest and Other Investment Income	(1,586)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,333)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,018)	43		24
25	Fund Raising, Advertising and Promotional	(19,879)	21		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	(246)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (790,549)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	825,064	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 825,064		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 34,515		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

ALLURE OF MT CARROLL

ID# 0055657

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income Food	$ (246)	2	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(246)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(246)	0	0	0	0	0	0	0	0	0	0	(246)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1	0	0	0	0	0	0	0	0	0	1	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(246)	1	0	0	0	0	0	0	0	0	0	(245)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	5,630	0	0	0	0	0	0	0	0	0	5,630	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	209,682	24,640	0	0	0	0	0	0	0	0	234,322	19
20	Fees, Subscriptions & Promotions	0	2,377	0	0	0	0	0	0	0	0	0	2,377	20
21	Clerical & General Office Expenses	(23,212)	(218,984)	0	0	0	0	0	0	0	0	0	(242,196)	21
22	Employee Benefits & Payroll Taxes	0	22,678	0	0	0	0	0	0	0	0	0	22,678	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,196	0	0	0	0	0	0	0	0	0	3,196	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(23,212)	24,578	24,640	0	0	0	0	0	0	0	0	26,006	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,458)	24,579	24,640	0	0	0	0	0	0	0	0	25,761	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 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	(713,487)	886	807,564	0	0	0	0	0	0	0	0	94,963	30
31	Amortization of Pre-Op. & Org.	0	0	7,737	0	0	0	0	0	0	0	0	7,737	31
32	Interest	(1,586)	0	41,005	0	0	0	0	0	0	0	0	39,419	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(81,347)	0	0	0	0	0	0	0	0	0	(81,347)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(715,073)	(80,461)	856,306	0	0	0	0	0	0	0	0	60,772	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(52,018)	0	0	0	0	0	0	0	0	0	0	(52,018)	43
44	TOTAL Special Cost Centers	(52,018)	0	0	0	0	0	0	0	0	0	0	(52,018)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(790,549)	(55,882)	880,946	0	0	0	0	0	0	0	0	34,515	45

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

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
MICHAEL NUDELL	34	ALLURE OF PROPHETSTOWN	PROPHETSTOWN	ALLURE Healthcare S	CHICAGO	MGMT COMPANY
JEREMY GOLDBERG	33	ALLURE OF GENESEO	GENESEO	Mt Carrol Property	CHICAGO	
MEYER OSEROFF	33	ALLURE OF Lake Storey	Gelesburg			
		ALLURE OF Galesburg	Galesburg			
		ALLURE OF Moline	Moline			

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Management Fees	$ 231,043	ALLURE Healthcare Services		$	$ (231,043)	1
2	V	5	Heat and Other Utilities		ALLURE Healthcare Services		1	1	2
3	V	17	Administrative		ALLURE Healthcare Services		5,630	5,630	3
4	V	19	Professional Services		ALLURE Healthcare Services		209,682	209,682	4
5	V	20	Dues, Fees, Subscriptions & Promotions		ALLURE Healthcare Services		2,377	2,377	5
6	V	21	Clerical & General Office Expenses		ALLURE Healthcare Services		12,059	12,059	6
7	V	22	Employee Benefits & Payroll Taxes		ALLURE Healthcare Services		22,678	22,678	7
8	V	24	Travel and Seminar		ALLURE Healthcare Services		3,196	3,196	8
9	V	30	Depreciation		ALLURE Healthcare Services		886	886	9
10	V	34	Rent-Facility & Grounds		ALLURE Healthcare Services		4,243	4,243	10
11	V	34	Rent	85,590	Mt Carrol Property			(85,590)	11
12	V								12
13	V								13
14	Total			$ 316,633			$ 260,752	$ * (55,882)	14

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

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	Mt Carrol Property		$ 24,640	$ 24,640	15
16	V	31	Ammoritzation		Mt Carrol Property		7,737	7,737	16
17	V	30	Depreciation		Mt Carrol Property		807,564	807,564	17
18	V	32	Interest		Mt Carrol Property		41,005	41,005	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			$			$ 880,946	$ * 880,946	39

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

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
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								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 ALLURE OF MT CARROLL # 0055657 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 [X]

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 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						$	$		$	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 ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	CIBC		X	Mortgage	Various	7/1/2020	$ 2,257,716	$ 2,236,116	6/30/2025	4.7500	$ 41,005	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,257,716	$ 2,236,116			$ 41,005	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,257,716	$ 2,236,116			$ 41,005	15

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

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

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

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	21,189	2
3. Under or (over) accrual (line 2 minus line 1).	$	21,189	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	17,806	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	38,995	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015		8
2016		9
2017		10
2018		11
2019		12

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALLURE OF MT CARROLL COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0055657

CONTACT PERSON REGARDING THIS REPORT AARON MAUER

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-08-01-100-005		$ 21,189.20	$ 21,189.20
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 21,189.20	$ 21,189.20

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach 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 provide copies of their original **second installment** tax bill.

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,848 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (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? [X] (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		2020	1970	$ 1,370,492	$ 33,673	39	$ 17,570	$ (16,103)	$ 33,673	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REPLACEMENT OF WEIL-MCLAIN ULTRA 230 HEAT EXCHANGE			2020	3,190	37	39	41	4	37	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 ALLURE OF MT CARROLL # 0055657 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
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)		$ 1,373,682	$ 33,710		$ 17,611	$ (16,099)	$ 33,710	70

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

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 43,808	$ 14,603	$ 14,603	$ (0)	3	$ 23,365	71
72	Current Year Purchases	773,891	773,891	77,389	(696,502)	5	773,891	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 817,699	$ 788,494	$ 91,992	$ (696,502)		$ 797,256	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 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)	$ 2,191,381	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 822,204	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 109,603	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (712,601)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 830,966	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MT CARROLL PROPERTY LLC

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. [X] 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:	1970	72	07/01/19	$ 47,634	10		3
4	Additions							4
5								5
6								6
7	TOTAL		72		$ 47,634 **			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: [X] YES [ ] NO Terms: 2,083,333 *

10. Effective dates of current rental agreement:
Beginning 07/01/19
Ending 07/01/29

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   - [X] 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	1,827	$ 214,105	$	1,827	$ 214,105	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		322	11,296		322	11,296	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,826	84,045		2,826	84,045	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				78,413		78,413	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					885		885	12
13	Other (specify): Lab	39-2					5,661		5,661	13
14	TOTAL			$	4,975	$ 309,446	$ 84,959	4,975	$ 394,405	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.

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 734,906	$ 747,102	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	313,995	328,062	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,028	26,028	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,074,929	$ 1,101,192	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		1,370,492	14
15	Leasehold Improvements, at Historical Cost	3,190	3,190	15
16	Equipment, at Historical Cost	43,808	817,699	16
17	Accumulated Depreciation (book methods)	(23,402)	(830,966)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		38,685	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(7,737)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Replacement Reserve	16,703	16,703	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 40,299	$ 1,508,066	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,115,228	$ 2,609,258	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 244,771	$ 247,171	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,538	131,538	30
31	Accrued Taxes Payable (excluding real estate taxes)	115,255	115,255	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	PPP Loan	383,815	383,815	36
37	Intercompany Loan		90,700	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 875,379	$ 968,479	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,236,116	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)**	$	$ 2,236,116	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 875,379	$ 3,204,595	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 239,849	$ (595,337)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,115,228	$ 2,609,258	48

***(See instructions.)**

Facility Name & ID Number ALLURE OF MT CARROLL # 0055657 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (156,484)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (156,484)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	751,042	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	(404,710)	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)**	$ 346,332	17
	B. Transfers (Itemize):		
18	**Paid in Capital**	50,000	18
19	**Round**	1	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 50,001	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 239,849	24 *

*** This must agree with page 17, line 47.**

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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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,332,181	1
2	Discounts and Allowances for all Levels	(44,122)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,288,059	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	147,948	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 147,948	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	469,876	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	37,770	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,314	19
20	Radiology and X-Ray	546	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 510,506	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,586	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,586	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		25,446	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 25,446	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,973,545	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	639,235	31
32	Health Care	2,005,617	32
33	General Administration	1,128,482	33
	B. Capital Expense		
34	Ownership	188,799	34
	C. Ancillary Expense		
35	Special Cost Centers	260,370	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,222,503	40
41	**Income before Income Taxes (line 30 minus line 40)****	751,042	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 751,042	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,140,949	44
45	Private Pay - Net Inpatient Revenue	1,577,180	45
46	Medicare - Net Inpatient Revenue	1,258,117	46
47	Other-(specify) Insurance	311,813	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,288,059	49

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

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	720	720	$ 67,847	$ 94.23	1
2	Assistant Director of Nursing	152	160	14,746	92.16	2
3	Registered Nurses	11,783	12,628	472,438	37.41	3
4	Licensed Practical Nurses	4,388	4,928	170,722	34.64	4
5	CNAs & Orderlies	35,689	37,717	661,739	17.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,980	5,392	89,135	16.53	10
11	Social Service Workers	1,108	1,217	37,700	30.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,954	15,275	208,712	13.66	15
16	Dishwashers					16
17	Maintenance Workers	2,657	2,808	57,163	20.36	17
18	Housekeepers	4,246	4,631	58,252	12.58	18
19	Laundry	2,429	2,599	33,994	13.08	19
20	Administrator	880	880	139,491	158.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,216	3,414	110,394	32.34	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	84	96	934	9.73	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	8	32	18,346	573.31	33
34	TOTAL (lines 1 - 33)	86,294	92,497	$ 2,141,613 *	$ 23.15	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 13,344	1-3	35
36	Medical Director	Monthly	2,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	21,828	10-3	38
39	Pharmacist Consultant	Monthly	2,455	15-3	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	Monthly	2,941	12-3	45
46	Other(specify) MDS	Monthly	4,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 47,268		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 400	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	238	38,374	10-3	52
53	TOTAL (lines 50 - 52)	238	$ 38,774		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Emily Dykstra	Administrator	0	111,398
Tammy Olson	Administrator	0	28,093
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 139,491

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
GCHMO	Professional fees	$ 30,517
August Mack	Professional fees	4,000
Personnel Planners	Professional fees	900
Madison Specs	Professional fees	4,850
MTS Consulting	Professional fees	1,365
LECTRONICS, INC	Professional fees	45
Cheryl Swan	Professional fees	713
Other Professionla fees	Professional fees	65
See Professional Fees Sheet	Total	256,093
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 298,548

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,413
Unemployment Compensation Insurance	29,212
FICA Taxes	144,313
Employee Health Insurance	145,050
Employee Meals	67
Illinois Municipal Retirement Fund (IMRF)*	
Background Checks	696
Employee Other benefits	16,162
Pension	19,500
TOTAL (agree to Schedule V, line 22, col.8)	$ 384,414

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	$ 2,247
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Illinois Healthcare council	8,496
Secretart of State	75
Clia Lab	180
IL department of Rev	648
Other dues and subs	4,444
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,090

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	9,159
Seminar Expense	
Education & Seminars	495
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,654

* Attach copy of IMRF notifications

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
GCHMO	Professional fees	$ 30,517
August Mack	Professional fees	4,000
Personnel Planners	Professional fees	900
Madison Specs	Professional fees	4,850
MTS Consulting	Professional fees	1,365
LECTRONICS, INC	Professional fees	45
Cheryl Swan	Professional fees	713
Other Professionla fees	Professional fees	65
GGM	Accounting Fees	14,500
Allan Goodman	Accounting Fees	550
Mendel Scheneider	Accounting Fees	5,000
Allure Healthcare	Management fees	231,043
Steve Scher	Legal	5,000
See Professional Fees Sheet		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 298,548

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $4,371**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,779** 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. $ **123,392**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** 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? **0**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees