		FOR BHF USE				

LL1

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.

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

I. IDPH License ID Number: 0055640

Facility Name: ALLURE OF PROPHETSTOWN

Address: 310 MOSHER DRIVE (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: 825-537-5175 Fax # 825-537-2628

HFS ID Number:

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

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code
- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 CHICAGO, IL 60659
(Telephone) 773-747-4506 EXT 601 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 PROPHETSTOWN # 0055640 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	70	Skilled (SNF)	70	25,620	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	70	TOTALS	70	25,620	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	7,036	6,106	389	13,531	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,036	6,106	389	13,531	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.81%

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 07/01/19

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/19 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 70 and days of care provided 2,288

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 PROPHETSTOWN # 0055640 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	168,701	18,039	4,152	190,892		190,892		190,892			1
2	Food Purchase		89,332		89,332		89,332		89,332			2
3	Housekeeping	83,941	11,764		95,705		95,705		95,705			3
4	Laundry	26,942	7,511		34,453		34,453		34,453			4
5	Heat and Other Utilities			144,852	144,852		144,852	(7,290)	137,562			5
6	Maintenance	98,679	44,921	20,006	163,606		163,606	(1,526)	162,080			6
7	Other (specify):*											7
8	TOTAL General Services	378,263	171,567	169,010	718,840		718,840	(8,816)	710,024			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,035,719	86,927	81,564	1,204,210		1,204,210	(37)	1,204,173			10
10a	Therapy			307,913	307,913		307,913		307,913			10a
11	Activities	77,445	4,592		82,037		82,037		82,037			11
12	Social Services			1,690	1,690		1,690		1,690			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			2,541	2,541		2,541		2,541			15
16	TOTAL Health Care and Programs	1,113,164	91,519	406,908	1,611,591		1,611,591	(37)	1,611,554			16
	C. General Administration											
17	Administrative	72,733			72,733		72,733	4,922	77,655			17
18	Directors Fees											18
19	Professional Services			271,940	271,940		271,940	203,323	475,263			19
20	Dues, Fees, Subscriptions & Promotions			17,074	17,074		17,074	1,939	19,013			20
21	Clerical & General Office Expenses	117,352	70,081	72,030	259,463		259,463	(218,557)	40,906			21
22	Employee Benefits & Payroll Taxes			261,030	261,030		261,030	19,825	280,855			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,394	11,394		11,394	2,794	14,188			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,342	79,342		79,342	(1,713)	77,629			26
27	Other (specify):*											27
28	TOTAL General Administration	190,085	70,081	712,810	972,976		972,976	12,533	985,509			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,681,512	333,167	1,288,728	3,303,407		3,303,407	3,680	3,307,087			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 PROPHETSTOWN #0055640 **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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			31,499	31,499		31,499	25,513	57,012			30
31	Amortization of Pre-Op. & Org.							5,840	5,840			31
32	Interest			52	52		52	24,052	24,104			32
33	Real Estate Taxes			9,933	9,933		9,933		9,933			33
34	Rent-Facility & Grounds			77,435	77,435		77,435	(55,290)	22,145			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			118,919	118,919		118,919	114	119,033			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			(821)	(821)		(821)	(800)	(1,621)			38
39	Ancillary Service Centers		74,085		74,085		74,085		74,085			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,409	116,409		116,409		116,409			42
43	Other (specify):* **Bad Debt**			63,576	63,576		63,576	(63,576)				43
44	**TOTAL Special Cost Centers**		74,085	179,164	253,249		253,249	(64,376)	188,873			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,681,512	407,252	1,586,811	3,675,575		3,675,575	(60,582)	3,614,993			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 PROPHETSTOWN # 0055640 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	(346,355)	30		9
10	Interest and Other Investment Income	(3,285)	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	(1,506)	21		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	(63,576)	43		24
25	Fund Raising, Advertising and Promotional	(17,143)	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	(13,770)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (448,968)		$	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	388,385	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 388,385		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (60,583)		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

STATE OF ILLINOIS

ALLURE OF PROPHETSTOWN

ID# 0055640

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income Garage fees	$ (3,816)	5	1
2	Misc income Medical Records	(37)	10	2
3	Misc income Transportation	(800)	38	3
4	Independent Living Expenses	(139)	20	4
5	Independent Living Expenses	(287)	21	5
6	Independent Living Expenses	(1,713)	26	6
7	Independent Living Expenses	(1,939)	34	7
8	Independent Living Expenses	(3,475)	5	8
9	Independent Living Expenses	(402)	6	9
10	Independent Living Expenses	(38)	21	10
11	Independent Living Expenses	(1,124)	6	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**	(13,770)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 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	0	0	0	0	0	0	0	0	0	0	0	0	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	(7,291)	1	0	0	0	0	0	0	0	0	0	(7,290)	5
6	Maintenance	(1,526)	0	0	0	0	0	0	0	0	0	0	(1,526)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,817)	1	0	0	0	0	0	0	0	0	0	(8,816)	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	(37)	0	0	0	0	0	0	0	0	0	0	(37)	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**	(37)	0	0	0	0	0	0	0	0	0	0	(37)	16
	C. General Administration													
17	Administrative	0	4,922	0	0	0	0	0	0	0	0	0	4,922	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	183,302	20,021	0	0	0	0	0	0	0	0	203,323	19
20	Fees, Subscriptions & Promotions	(139)	2,078	0	0	0	0	0	0	0	0	0	1,939	20
21	Clerical & General Office Expenses	(22,307)	(196,250)	0	0	0	0	0	0	0	0	0	(218,557)	21
22	Employee Benefits & Payroll Taxes	0	19,825	0	0	0	0	0	0	0	0	0	19,825	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,794	0	0	0	0	0	0	0	0	0	2,794	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(1,713)	0	0	0	0	0	0	0	0	0	0	(1,713)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(24,159)	16,671	20,021	0	0	0	0	0	0	0	0	12,533	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,013)	16,672	20,021	0	0	0	0	0	0	0	0	3,680	29

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 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 D. Ownership	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)	
30	Depreciation	(346,355)	775	371,093	0	0	0	0	0	0	0	0	25,513	30
31	Amortization of Pre-Op. & Org.	0	0	5,840	0	0	0	0	0	0	0	0	5,840	31
32	Interest	(3,285)	0	27,337	0	0	0	0	0	0	0	0	24,052	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,939)	(53,351)	0	0	0	0	0	0	0	0	0	(55,290)	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**	(351,579)	(52,576)	404,269	0	0	0	0	0	0	0	0	114	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(800)	0	0	0	0	0	0	0	0	0	0	(800)	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):*	(63,576)	0	0	0	0	0	0	0	0	0	0	(63,576)	43
44	**TOTAL Special Cost Centers**	(64,376)	0	0	0	0	0	0	0	0	0	0	(64,376)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(448,968)	(35,905)	424,290	0	0	0	0	0	0	0	0	(60,582)	45

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 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 GENESEO LLC	GENESEO	ALLURE Healthcare S	CHICAGO	MGMT COMPANY
JEREMY GOLDBERG	33	ALLURE OF PROPHETSTOWN LLC	PROPHETSTOWN	Prophetstown Property	CHICAGO	
MEYER OSEROFF	33	ALLURE OF Lake Storey	Galesburg			
		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	$ 206,792	ALLURE Healthcare Services		$	$ (206,792)	1
2	V	5	Heat and Other Utilities		ALLURE Healthcare Services		1	1	2
3	V	17	Administrative		ALLURE Healthcare Services		4,922	4,922	3
4	V	19	Professional Services		ALLURE Healthcare Services		183,302	183,302	4
5	V	20	Dues, Fees, Subscriptions & Promotions		ALLURE Healthcare Services		2,078	2,078	5
6	V	21	Clerical & General Office Expenses		ALLURE Healthcare Services		10,542	10,542	6
7	V	22	Employee Benefits & Payroll Taxes		ALLURE Healthcare Services		19,825	19,825	7
8	V	24	Travel and Seminar		ALLURE Healthcare Services		2,794	2,794	8
9	V	30	Depreciation		ALLURE Healthcare Services		775	775	9
10	V	34	Rent-Facility & Grounds		ALLURE Healthcare Services		3,709	3,709	10
11	V	34	Rent	57,060	Prophetstwonw Property			(57,060)	11
12	V								12
13	V								13
14	Total			$ 263,852			$ 227,947	$ * (35,905)	14

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

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 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	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	19	Professional Services	$	Prophetstwonw Property		$ 20,021	$ 20,021	15
16	V	31	Ammoritzation		Prophetstwonw Property		5,840	5,840	16
17	V	30	Depreciation		Prophetstwonw Property		371,093	371,093	17
18	V	32	Interest		Prophetstwonw Property		27,337	27,337	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			$			$ 424,290	$ * 424,290	39

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

STATE OF ILLINOIS

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 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 PROPHETSTOWN # 0055640 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 PROPHETSTOWN # 0055640 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 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 PROPHETSTOWN # 0055640 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	$41,737.00	7/1/2020	$ 1,505,144	$ 1,490,744	6/30/2025	4.7500	$ 27,337	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$41,737.00		$ 1,505,144	$ 1,490,744			$ 27,337	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,505,144	$ 1,490,744			$ 27,337	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NA 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 PROPHETSTOWN # 0055640 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line	Description	Amount	
1.	Real Estate Tax accrual used on 2019 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.)	$ 7,539	2
3.	Under or (over) accrual (line 2 minus line 1).	$ 7,539	3
4.	Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 2,394	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.	$ 9,933	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 PROPHETSTOWN COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0055640

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)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	15-33-151-011		$ 5,653.74	$ 5,653.74
2.	15-33-151-013		$ 1,885.44	$ 1,885.44
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 7,539.18	$ 7,539.18

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.

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 PROPHETSTOWN # 0055640 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	70		2020	1967	$ 711,091	$ 25,711	39	$ 9,117	$ (16,594)	$ 25,711	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NEW FLOORING IN rooms 301,305,302,304,310,314 on the third floor 30			2020	9,904	9,904	39	127	(9,777)	9,904	9
10	NEW FLOORING IN Rooms 200,208,210 on second floor 200 hall			2020	3,104	3,104	39	40	(3,064)	3,104	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 PROPHETSTOWN # 0055640 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)		$ 724,099	$ 38,719		$ 9,283	$ (29,436)	$ 38,719	70

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

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 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	$ 37,804	$ 12,601	$ 12,601	$ 0	3	$ 20,162	71
72	Current Year Purchases	351,271	351,271	35,127	(316,144)	5	351,271	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 389,075	$ 363,872	$ 47,728	$ (316,144)		$ 371,433	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)	$ 1,113,174	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 402,591	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,012	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (345,579)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 410,152	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 PROPHETSTOWN # 0055640 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: PROPHETSTOWN 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:	1967	70	07/01/19	$ 20,375	10		3
4	Additions							4
5								5
6								6
7	TOTAL		70		$ 20,375 **			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 PROPHETSTOWN # 0055640 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	$	1,723	$ 212,132	$	1,723	$ 212,132	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		180	5,027		180	5,027	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,266	90,754		2,266	90,754	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				66,028		66,028	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					1,041		1,041	12
13	Other (specify): Lab	39-2					7,017		7,017	13
14	TOTAL			$	4,169	$ 307,913	$ 74,086	4,169	$ 381,999	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 PROPHETSTOWN # 0055640 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	$ 813,627	$ 844,128	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	686,516	688,701	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,870	28,870	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)**	$ 1,529,013	$ 1,561,699	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		1,046,429	14
15	Leasehold Improvements, at Historical Cost	13,008	13,008	15
16	Equipment, at Historical Cost	43,694	389,076	16
17	Accumulated Depreciation (book methods)	(39,060)	(410,153)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		29,201	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(5,840)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Replacement reserve	11,151	11,151	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 28,793	$ 1,172,872	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,557,806	$ 2,734,571	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 294,311	$ 296,711	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,777	21,777	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,404	84,404	30
31	Accrued Taxes Payable (excluding real estate taxes)	77,844	77,844	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	307,294	307,294	36
37	Intercompany Loan		129,478	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 785,630	$ 917,508	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,490,744	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)**	$	$ 1,490,744	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 785,630	$ 2,408,252	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 772,176	$ 326,319	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,557,806	$ 2,734,571	48

*(See instructions.)

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 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**	$ 195,240	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 195,240	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	950,149	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	(518,211)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Roudning	(2)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 431,936	17
	B. Transfers (Itemize):		
18	Paid In Capital	145,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 145,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 772,176	24 *

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

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,994,330	1
2	Discounts and Allowances for all Levels	(48,190)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,946,140	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	167,979	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 167,979	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	452,565	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	43,158	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	575	19
20	Radiology and X-Ray	980	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 497,278	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,285	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,285	26
	E. Other Revenue (specify):** **		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a		11,042	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,042	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,625,724	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	718,840	31
32	Health Care	1,611,591	32
33	General Administration	972,976	33
	B. Capital Expense		
34	Ownership	118,919	34
	C. Ancillary Expense		
35	Special Cost Centers	253,249	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)***	$ 3,675,575	40
41	**Income before Income Taxes (line 30 minus line 40)****	950,149	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 950,149	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,088,353	44
45	Private Pay - Net Inpatient Revenue	1,185,691	45
46	Medicare - Net Inpatient Revenue	1,287,060	46
47	Other-(specify) Insurance	385,036	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,946,140	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.**

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,352	1,360	$ 98,282	$ 72.27	1
2	Assistant Director of Nursing	880	880	38,673	43.95	2
3	Registered Nurses	5,509	5,905	248,878	42.15	3
4	Licensed Practical Nurses	6,589	6,802	235,891	34.68	4
5	CNAs & Orderlies	20,872	21,878	391,607	17.90	5
6	CNA Trainees	104	107		0.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,317	4,559	76,451	16.77	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,946	12,336	168,701	13.68	15
16	Dishwashers					16
17	Maintenance Workers	5,444	5,711	99,673	17.45	17
18	Housekeepers	5,946	6,328	83,942	13.27	18
19	Laundry	2,238	2,340	26,942	11.51	19
20	Administrator	1,280	1,280	72,733	56.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,683	5,056	118,596	23.46	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					31
32	Other Health Care(specify)					32
33	Other(specify) MDS	1,638	1,706	21,143	12.39	33
34	TOTAL (lines 1 - 33)	72,798	76,248	$ 1,681,512 *	$ 22.05	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 4,152	1-3	35
36	Medical Director	Monthly	13,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	14,213	10-3	38
39	Pharmacist Consultant	Monthly	2,541	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	1,690	12-3	45
46	Other(specify) MDS	Monthly	4,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 40,296		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	74	$ 8,740	10-3	50
51	Licensed Practical Nurses	8	25,459	10-3	51
52	Certified Nurse Assistants/Aides	940	28,652	10-3	52
53	TOTAL (lines 50 - 52)	1,022	$ 62,851		53

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Letha M Dolph	Administrator	0	13,203
Cherish La Marche	Administrator	0	58,469
Tannis Tyler	Administrator	0	1,061
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,733

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
Mendel Schneider	Accounting Fees	$ 6,000
Alan Goodman	Accounting Fees	550
GGM	Accounting Fees	14,500
Allure Healthcare Services	Management Fees	206,792
Steve Scher	Legal Fees	5,000
Fuchs and Roselli	Legal Fees	200
MEYER MAGENCE	Legal Fees	150
SKIDELSKY & ASSOCIATES	Legal Fees	875
See Professional Fees Sheet	Total	37,873
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 271,940

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,884
Unemployment Compensation Insurance	28,792
FICA Taxes	125,098
Employee Health Insurance	73,995
Employee Meals	59
Illinois Municipal Retirement Fund (IMRF)*	
Pension	6,525
Employee Other benefits	15,225
Background Checks	278
TOTAL (agree to Schedule V, line 22, col.8)	$ 280,856

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,694
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Illinois Health Care	7,420
Secretary of State	153
Whiteside county health dept	330
Other Dues	8,416
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,013

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	13,546
Seminar Expense	
Education & Seminars	643
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,189

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
GCHMO	Professional Fees	24,117
August Mack	Professional Fees	4,000
PERSONAL PLANNERS	Professional Fees	975
Madison Specs	Professional Fees	4,850
MTS Consulting	Professional Fees	1,570
CJL Consulting	Professional Fees	1,536
Other Professional fees	Professional Fees	825
See Professional Fees Sheet		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 37,873

Facility Name & ID Number ALLURE OF PROPHETSTOWN # 0055640 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 $3,435**

(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?

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,159** 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. $ **116,409**
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? **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 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