



Facility Name & ID Number The Austin Oasis

# 0055087 Report Period Beginning: 01/01/20 Ending: 12/31/20

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3	108	Intermediate (ICF)	108	39,528	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	79,056	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,633	2,633	8
9	SNF/PED					9
10	ICF	57,696	115	1,081	58,892	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,696	115	3,714	61,525	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 77.82%

**D. How many bed reserve days during this year were paid by the Department?**  
None (Do not include bed reserve days in Section B.)

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

**F. Does the facility maintain a daily midnight census?** Yes

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

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

**I. On what date did you start providing long term care at this location?**  
Date started 9/1/2018

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 9/1/2018 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 108 and days of care provided 2,633

Medicare Intermediary CGS Administrators

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  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 The Austin Oasis # 0055087 Report Period Beginning: 01/01/20 Ending: 12/31/20

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	412,610	47,006	17,866	477,482		477,482		477,482		1
2	Food Purchase		342,301		342,301	(16,196)	326,106	(6)	326,100		2
3	Housekeeping	513,796	85,111		598,907		598,907	4,735	603,642		3
4	Laundry	161,640	20,037	255	181,932		181,932		181,932		4
5	Heat and Other Utilities			288,610	288,610		288,610	(11,920)	276,690		5
6	Maintenance	156,263		108,423	264,686		264,686	(12,863)	251,823		6
7	Other (specify):*							3,484	3,484		7
8	<b>TOTAL General Services</b>	1,244,309	494,455	415,154	2,153,918	(16,196)	2,137,723	(16,570)	2,121,153		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,950	22,950		22,950		22,950		9
10	Nursing and Medical Records	3,208,573	230,876	270,538	3,709,987		3,709,987	(176,365)	3,533,622		10
10a	Therapy	59,629			59,629		59,629		59,629		10a
11	Activities	130,087	2,644	1,988	134,719		134,719		134,719		11
12	Social Services	248,345		4,602	252,947		252,947		252,947		12
13	CNA Training										13
14	Program Transportation			74	74		74		74		14
15	Other (specify):*							8,664	8,664		15
16	<b>TOTAL Health Care and Programs</b>	3,646,634	233,520	300,152	4,180,306		4,180,306	(167,701)	4,012,605		16
	<b>C. General Administration</b>										
17	Administrative	155,112		359,765	514,877		514,877	(223,500)	291,377		17
18	Directors Fees										18
19	Professional Services			887,341	887,341	(1,791)	885,550	(733,381)	152,169		19
20	Dues, Fees, Subscriptions & Promotions			60,263	60,263		60,263	(18,609)	41,655		20
21	Clerical & General Office Expenses	211,981		334,883	546,864		546,864	(18,982)	527,882		21
22	Employee Benefits & Payroll Taxes			795,247	795,247	16,196	811,443		811,443		22
23	Inservice Training & Education										23
24	Travel and Seminar							1,123	1,123		24
25	Other Admin. Staff Transportation			875	875		875	7,260	8,135		25
26	Insurance-Prop.Liab.Malpractice			512,043	512,043		512,043	5,985	518,028		26
27	Other (specify):*							67,615	67,615		27
28	<b>TOTAL General Administration</b>	367,093		2,950,417	3,317,510	14,404	3,331,914	(912,488)	2,419,426		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,258,036	727,975	3,665,723	9,651,734	(1,791)	9,649,943	(1,096,759)	8,553,183		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 &amp; ID Number

The Austin Oasis

#0055087

Report Period Beginning:

01/01/20

Ending:

12/31/20

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			9,402	9,402		9,402	15,953	25,355			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,439	26,439		26,439	6,569	33,008			32
33	Real Estate Taxes			375,000	375,000	1,791	376,791	(9,570)	367,221			33
34	Rent-Facility & Grounds			1,352,400	1,352,400		1,352,400	0	1,352,400			34
35	Rent-Equipment & Vehicles			845	845		845		845			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,764,086	1,764,086	1,791	1,765,877	12,952	1,778,829			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	77,063	84,207	431,503	592,773		592,773		592,773			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			491,687	491,687		491,687		491,687			42
43	Other (specify):*			23,850	23,850		23,850	(23,850)	(0)			43
44	<b>TOTAL Special Cost Centers</b>	77,063	84,207	947,040	1,108,310		1,108,310	(23,850)	1,084,460			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	5,335,099	812,182	6,376,849	12,524,130	(0)	12,524,130	(1,107,658)	11,416,472			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(14,977)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,953	30		9
10	Interest and Other Investment Income	(2,536)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,490)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(215,593)	21		24
25	Fund Raising, Advertising and Promotional	(1,285)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,729)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(159,064)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (380,727)		\$	30

**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	2	
		Amount	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)	(726,931)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (726,931)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,107,658)		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	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

The Austin Oasis

ID# 0055087

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Bank Charges	\$ (17,948)	21	1
2	Sequestration Expense	(47,998)	21	2
3	Miscellaneous Income	(3,525)	21	3
4	Marketing Expense	(1,050)	43	4
5	Capitalized R&M	(10,962)	06	5
6	PAC Dues	(17,520)	20	6
7	Prior Period Expense	(13,904)	21	7
8	Prior Period License Expense	(40)	20	8
9	Other Out of Period Professional Fees	(169)	19	9
10	Non-Allowable Legal	(23,772)	19	10
11	Business Seminar Refund	(750)	21	11
12	Real Estate Expense	(21,427)	33	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	<b>Total</b>	(159,064)		49



## STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Austin Oasis# 0055087

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(6)											(6)	2
3	Housekeeping			4,735									4,735	3
4	Laundry													4
5	Heat and Other Utilities	(14,977)		3,057									(11,920)	5
6	Maintenance	(10,962)		3,466		(5,367)							(12,863)	6
7	Other (specify):*					3,484							3,484	7
8	<b>TOTAL General Services</b>	<b>(25,945)</b>		<b>11,258</b>		<b>(1,883)</b>							<b>(16,570)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records					(176,365)							(176,365)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,664							8,664	15
16	<b>TOTAL Health Care and Programs</b>					<b>(167,701)</b>							<b>(167,701)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(270,572)		47,072							(223,500)	17
18	Directors Fees													18
19	Professional Services	(23,940)		(714,775)	1,838	3,497							(733,381)	19
20	Fees, Subscriptions & Promotions	(18,845)		127		109							(18,609)	20
21	Clerical & General Office Expenses	(302,937)		200,642		83,312							(18,982)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			901		222							1,123	24
25	Other Admin. Staff Transportation					7,260							7,260	25
26	Insurance-Prop.Liab.Malpractice			1,949		4,036							5,985	26
27	Other (specify):*			47,023		20,592							67,615	27
28	<b>TOTAL General Administration</b>	<b>(345,721)</b>		<b>(734,705)</b>	<b>1,838</b>	<b>166,100</b>							<b>(912,488)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(371,666)</b>		<b>(723,447)</b>	<b>1,838</b>	<b>(3,484)</b>							<b>(1,096,759)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Austin Oasis # 0055087 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	15,953											15,953	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,536)		7	2,622		6,476						6,569	32
33	Real Estate Taxes	(21,427)			3,018		8,839						(9,570)	33
34	Rent-Facility & Grounds			34,495	(14,942)		(19,553)						0	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(8,010)</b>		<b>34,501</b>	<b>(9,301)</b>		<b>(4,238)</b>						<b>12,952</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,050)				(22,800)							(23,850)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,050)</b>				<b>(22,800)</b>							<b>(23,850)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(380,727)</b>		<b>(688,946)</b>	<b>(7,464)</b>	<b>(26,284)</b>	<b>(4,238)</b>						<b>(1,107,658)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

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

**VII. RELATED PARTIES**

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SHIMON WEBSTER	29.63%	Center Home Hispanic Elderly	Chicago	Premier HC & Financial	Skokie	Consulting Co.	1
2	YERUCHOM LEVOVITZ	27.78%	Pine Crest Health Care	Hazel Crest	Premier HC Real Estate	Skokie	Building Co.	2
3	ATIED ASSOCIATES, LLC	33.33%	River View Rehab Center	Elgin	iCare Consulting	Skokie	Consulting Co.	3
4	JEFFREY WEBSTER	0.93%	Forest City Rehab & Nursing	Rockford	8131 Monticello Realty	Skokie	Building Company	4
5	ELI WEBSTER	0.46%	Rock River Health Care	Rockford	iCare Health Services Incorporated	Burlington, VT	Insurance	5
6	EZ \$ A LLC	0.46%	Park View Rehab Center	Chicago				6
7	KEVIN CHANKIN	4.63%	Prairie Oasis	South Holland				7
8	CTCAAR LLC	0.93%	Oak Park Oasis	Oak Park				8
9	CHAIM LEVOVITZ	0.93%						9
10	RALPH MEYER SHELDON KATZ	0.93%						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

The Austin Oasis

# 0055087

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		\$ 4,735	\$ 4,735
16	V	5 UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		3,057	3,057
17	V	6 REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		3,466	3,466
18	V	17 ADMINISTRATIVE SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		89,193	89,193
19	V	19 PROFESSIONAL FEES	719,535	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		4,760	(714,775)
20	V	20 DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		127	127
21	V	21 CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		11,237	11,237
22	V	21 CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		189,405	189,405
23	V	24 SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		901	901
24	V	26 INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,949	1,949
25	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		47,023	47,023
26	V	32 INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		7	7
27	V	34 RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		34,495	34,495
28	V	17 CONSULTING FEES	359,765	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.			(359,765)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,079,300			\$ 390,354	\$ * (688,946)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$		15
16	V	19 PROFESSIONAL FEES		PREMIER HEALTHCARE REALTY, LLC		1,838	1,838	16
17	V	20 LICENSES & PERMITS		PREMIER HEALTHCARE REALTY, LLC				17
18	V	30 DEPRECIATION		PREMIER HEALTHCARE REALTY, LLC				18
19	V	32 INTEREST EXPENSE		PREMIER HEALTHCARE REALTY, LLC		2,622	2,622	19
20	V	33 REAL ESTATE TAXES		PREMIER HEALTHCARE REALTY, LLC		3,018	3,018	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	14,942	PREMIER HEALTHCARE REALTY, LLC			(14,942)	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		\$ 14,942			\$ 7,478	\$ * (7,464)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINTENANCE	\$ 34,800	ICARE CONSULTING SERVICES LLC		\$ 29,433	\$ (5,367)
16	V	7 R&M EMPLOYEE BENEFITS		ICARE CONSULTING SERVICES LLC		3,484	3,484
17	V	10 NURSING SALARIES	244,500	ICARE CONSULTING SERVICES LLC		68,135	(176,365)
18	V	15 EMPLOYEE BEN. HC PROGRAMS		ICARE CONSULTING SERVICES LLC		8,664	8,664
19	V	17 ADMINISTRATIVE WAGES		ICARE CONSULTING SERVICES LLC		47,072	47,072
20	V	19 PROFESSIONAL FEES		ICARE CONSULTING SERVICES LLC		3,497	3,497
21	V	20 DUES FEES SUBSCRIPTIONS		ICARE CONSULTING SERVICES LLC		109	109
22	V	21 CLERICAL AND GENERAL	47,600	ICARE CONSULTING SERVICES LLC		4,252	(43,348)
23	V	21 CLERICAL & GENERAL WAGES		ICARE CONSULTING SERVICES LLC		126,660	126,660
24	V	24 SEMINARS & EDUCATION		ICARE CONSULTING SERVICES LLC		222	222
25	V	25 AUTO EXPENSE		ICARE CONSULTING SERVICES LLC		7,260	7,260
26	V	26 INSURANCE		ICARE CONSULTING SERVICES LLC		4,036	4,036
27	V	27 EMPLOYEE BEN. GEN ADMIN.		ICARE CONSULTING SERVICES LLC		20,592	20,592
28	V						
29	V	43 MARKETING CONSULTANT	22,800	ICARE CONSULTING SERVICES LLC			(22,800)
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 349,700			\$ 323,416	\$ * (26,284)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V	19 PROFESSIONAL FEES		8131 MONTICELLO REALTY, LLC				16
17	V	20 LICENSES & PERMITS		8131 MONTICELLO REALTY, LLC				17
18	V	30 DEPRECIATION		8131 MONTICELLO REALTY, LLC				18
19	V	32 INTEREST EXPENSE		8131 MONTICELLO REALTY, LLC		6,476	6,476	19
20	V	33 REAL ESTATE TAXES		8131 MONTICELLO REALTY, LLC		8,839	8,839	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	19,553	8131 MONTICELLO REALTY, LLC			(19,553)	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		\$ 19,553			\$ 15,315	\$ * (4,238)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 INSURANCE	\$ 432,004	ICARE HEALTH SERVICES INCORPORATED CELL		\$ 432,004	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 432,004			\$ 432,004	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name &amp; ID Number

The Austin Oasis

# 0055087

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	Shimon Webster	Member	Administrative	29.63%	See Attached	6.87	17.17%	Alloc Salary	\$ 23,915	17-7	1	
2	Yeruchom Levovitz	Member	Administrative	27.78%	See Attached	6.87	17.17%	Alloc Salary	22,343	17-7	2	
3	Kevin Chankin	Member	Administrative	4.63%	See Attached	6.87	17.17%	Alloc Salary	42,935	17-7	3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 89,193		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 The Austin Oasis

# 0055087

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number The Austin Oasis

# 0055087

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 PREMIER HEALTHCARE & FIN. SVCS, INC.  
 Street Address 8131 MONTICELLO  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (773) 945-1000  
 Fax Number (773) 751-2027

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	358,626	8	\$ 27,572	\$ 61,591	\$ 4,735	1
2	5	UTILITIES	PATIENT DAYS	358,626	8	17,798	61,591	3,057	2
3	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	358,626	8	20,184	61,591	3,466	3
4	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	358,626	8	519,346	519,346	89,193	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	27,719	61,591	4,760	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	358,626	8	738	61,591	127	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	358,626	8	65,429	1,102,850	11,237	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	358,626	8	1,102,850	61,591	189,405	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	358,626	8	5,249	61,591	901	9
10	26	INSURANCE	PATIENT DAYS	358,626	8	11,347	61,591	1,949	10
11	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	358,626	8	273,803	61,591	47,023	11
12	32	INTEREST	PATIENT DAYS	358,626	8	39	61,591	7	12
13	34	RENT	PATIENT DAYS	358,626	8	200,851	61,591	34,495	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					\$ 2,272,926	\$ 1,622,196	\$ 390,354	25

Facility Name & ID Number The Austin Oasis

# 0055087

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization PREMIER HEALTHCARE REALTY, LLC  
 Street Address 8153 LAWNSDALE  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (773) 945-1000  
 Fax Number (773) 945-6107

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	10,700	61,591	1,838	2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8		61,591		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8		61,591		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	15,267	61,591	2,622	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	17,574	61,591	3,018	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				\$ 43,541	\$		\$ 7,478	25

Facility Name & ID Number The Austin Oasis

# 0055087

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 ICARE CONSULTING SERVICES LLC  
 Street Address 8131 MONTICELLO  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 773) 945-1000  
 Fax Number ( 773) 945-6107

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	REPAIRS AND MAINTENANCE	CONSULTING FEES	1,730,000	8	\$ 145,610	\$ 145,409	349,700	\$ 29,433	1
2	7	R&M EMPLOYEE BENEFITS	CONSULTING FEES	1,730,000	8	17,235		349,700	3,484	2
3	10	NURSING SALARIES	CONSULTING FEES	1,730,000	8	337,071	337,071	349,700	68,135	3
4	15	EMPLOYEE BEN. HC PROGRA	CONSULTING FEES	1,730,000	8	42,861		349,700	8,664	4
5	17	ADMINISTRATIVE WAGES	CONSULTING FEES	1,730,000	8	232,870	232,870	349,700	47,072	5
6	19	PROFESSIONAL FEES	CONSULTING FEES	1,730,000	8	17,301		349,700	3,497	6
7	20	DUES FEES SUBSCRIPTIONS	CONSULTING FEES	1,730,000	8	538		349,700	109	7
8	21	CLERICAL AND GENERAL	CONSULTING FEES	1,730,000	8	21,035		349,700	4,252	8
9	21	CLERICAL & GENERAL WAGI	CONSULTING FEES	1,730,000	8	626,600	626,600	349,700	126,660	9
10	24	SEMINARS & EDUCATION	CONSULTING FEES	1,730,000	8	1,099		349,700	222	10
11	25	AUTO EXPENSE	CONSULTING FEES	1,730,000	8	35,917		349,700	7,260	11
12	26	INSURANCE	CONSULTING FEES	1,730,000	8	19,965		349,700	4,036	12
13	27	EMPLOYEE BEN. GEN ADMIN.	CONSULTING FEES	1,730,000	8	101,871		349,700	20,592	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					\$ 1,599,973	\$ 1,341,950		\$ 323,416	25

Facility Name & ID Number The Austin Oasis

# 0055087

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization 8131 MONTICELLO REALTY, LLC  
 Street Address 8131 MONTICELLO  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (773) 945-1000  
 Fax Number (773) 945-6107

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8		61,591		1
2	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8		61,591		2
3	30	DEPRECIATION	PATIENT DAYS	358,626	8		61,591		3
4	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	37,708	61,591	6,476	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	51,468	61,591	8,839	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					\$ 89,176	\$	\$ 15,315	25

Facility Name & ID Number The Austin Oasis

# 0055087

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

Name of Related Organization

ICARE HEALTH SERVICES INCORP. CELL

Street Address

30 MAIN STREET, SUITE 330

City / State / Zip Code

BURLINGTON, VERMONT 05401

Phone Number

( )

Fax Number

( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	26	INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 432,004	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				\$	\$		\$ 432,004	25

Facility Name & ID Number The Austin Oasis

# 0055087

Report Period Beginning:

01/01/20

Ending: 12/31/20

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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

Facility Name & ID Number The Austin Oasis

# 0055087 Report Period Beginning: 01/01/20 Ending: 12/31/20

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

Facility Name & ID Number The Austin Oasis

# 0055087 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Austin Oasis

# 0055087

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number

The Austin Oasis

# 0055087

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	First Midwest Bank		X	Line of Credit						17,439										
7	Other Interest Expense		X							9,000										
8	See Supplemental Schedule									9,105										
9	<b>TOTAL Facility Related</b>									<b>35,544</b>										
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(2,536)										
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>									<b>(2,536)</b>										
15	<b>TOTALS (line 9+line14)</b>									<b>33,008</b>										

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

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

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

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

**B. Real Estate Taxes**

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

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.)		\$	<b>365,430</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>365,430</b>	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>1,791</b>	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>367,221</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	<b>285,075</b>	8
	2016	<b>311,588</b>	9
	2017	<b>334,895</b>	10
	2018	<b>347,627</b>	11
	2019	<b>353,573</b>	12

**FOR BHF USE ONLY**

<b>Facility Does Not Accrue RE Taxes</b>				
<b>Allocated From Premier RE = \$3,018</b>				
<b>Allocated From 8131 Monticello = \$8,839</b>				
	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 The Austin Oasis COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055087

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

**A. Summary of Real Estate Tax Cost**

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-17-401-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>116,171.74</u>	\$ <u>116,171.74</u>
2. <u>16-17-401-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>50,248.98</u>	\$ <u>50,248.98</u>
3. <u>16-17-401-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>187,152.31</u>	\$ <u>187,152.31</u>
4. <u>10-23-324-047-0000</u>	<u>Allocated From Premier RE</u>	\$ <u>34,381.62</u>	\$ <u>5,904.75</u>
5. <u>10-23-325-045-0000</u>	<u>Allocated From 8131 Monticello</u>	\$ <u>51,467.63</u>	\$ <u>8,839.13</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>439,422.28</u></u>	\$ <u><u>368,316.91</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

**IMPORTANT NOTICE**

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

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

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

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

**2019 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME The Austin Oasis COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055087

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number The Austin Oasis

# 0055087 Report Period Beginning:

01/01/20 Ending:

12/31/20

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 29,685 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 6

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated Premiere Healthcare Realty, LLC</u>		<u>2011</u>	<u>\$ 3,263</u>	<u>1</u>
2	<u>Allocated from 8131 N. Monticello</u>		<u>2019</u>	<u>8,287</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 11,550</b>	<b>3</b>

Facility Name & ID Number The Austin Oasis

# 0055087

Report Period Beginning:

01/01/20

Ending:

12/31/20

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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			334,874		12,180	12,180	75,711	68
69				9,402		(9,402)		69
70		\$	334,874	\$	12,180	\$	75,711	70

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

Facility Name & ID Number The Austin Oasis

# 0055087

Report Period Beginning:

01/01/20

Ending:

12/31/20

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 334,874	\$ 9,402		\$ 12,180	\$ 2,778	\$ 75,711	1
2	Fire Alarm Panel And Repiping	2019	3,881		20	194	194	388	2
3	Boiler Repairs	2019	6,301		20	315	315	630	3
4	Cast Iron Replacement In Lunch Room Ceiling	2019	3,100		20	155	155	310	4
5	New Valves Replacement & Insulation	2019	5,255		20	263	263	526	5
6	Boiler Room Gate Valve Replacement	2019	5,453		20	273	273	546	6
7	Elevator-Door Track Brackets, Gibb Plates, Emergency Light	2019	3,446		20	172	172	344	7
8	Boiler Repairs-New Boiler Tubes & Gaskets	2019	12,600		20	630	630	1,260	8
9	Ejector Pit Clog Repair	2019	2,625		20	131	131	262	9
10	Elevator Repair - New Valve And Oil Cooler	2020	10,650		20	533	533	533	10
11	Boiler Leak Repairs - Replace Water Lines, Valves	2020	21,370		20	1,069	1,069	1,069	11
12	Installed Signs	2020	8,935		20	447	447	447	12
13	2Nd-5Th Floor Bathrooms - Piping/Drain Repairs	2020	3,437		20	172	172	172	13
14	Repair 2" Leaking Copper Pipe Above Storage Tanks	2020	4,680		20	234	234	234	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 426,608	\$ 9,402		\$ 16,767	\$ 7,365	\$ 82,430	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 426,608	\$ 9,402		\$ 16,767	\$ 7,365	\$ 82,430	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 426,608	\$ 9,402		\$ 16,767	\$ 7,365	\$ 82,430	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 426,608	\$ 9,402		\$ 16,767	\$ 7,365	\$ 82,430	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 426,608	\$ 9,402		\$ 16,767	\$ 7,365	\$ 82,430	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 426,608	\$ 9,402		\$ 16,767	\$ 7,365	\$ 82,430	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 426,608	\$ 9,402		\$ 16,767	\$ 7,365	\$ 82,430	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 <b>Building Company</b>		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8 <b>Leasehold Improvements:</b>								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 <b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated Premiere Healthcare Realty, LLC	2011	63,958		20	1,827	1,827	16,597	3
4	Allocated Premiere Healthcare Realty, LLC	2012	8,143		20	233	233	2,094	4
5	Allocated from 8131 N. Monticello	2019	140,871		20	4,025	4,025	8,050	5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Premier HC & Financial Services	2012	1,451		20	73	73	654	10
11	Allocated from Premier HC & Financial Services	2016	3,400		20	170	170	850	11
12									12
13	Allocated Premiere Healthcare Realty, LLC	2011	113,753		20	5,688	5,688	45,982	13
14	Allocated Premiere Healthcare Realty, LLC	2012	3,297		20	165	165	1,484	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 334,874	\$		\$ 12,180	\$ 12,180	\$ 75,711	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 334,874	\$		\$ 12,180	\$ 12,180	\$ 75,711	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 334,874	\$		\$ 12,180	\$ 12,180	\$ 75,711	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 82,507	\$	\$ 8,250	\$ 8,250	10	\$ 47,944	71
72	Current Year Purchases	3,374		338	338	10	338	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 85,881	\$	\$ 8,588	\$ 8,588		\$ 48,282	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)	\$ 524,038	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,402	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,355	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,953	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 130,712	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Columbus Park 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.  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:	<u>1976</u>	<u>216</u>		\$ <u>1,352,400</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>216</u>		\$ <u>1,352,400</u>			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2021</u>	\$ _____
13.	<u>/2022</u>	\$ _____
14.	<u>/2023</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 845 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

\* 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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 166,362	\$		\$ 166,362	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			132,617			132,617	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			129,534			129,534	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				54,802		54,802	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Attached</u>			77,063		2,990	29,405		109,458	13
14	TOTAL			\$ 77,063		\$ 431,503	\$ 84,207		\$ 592,773	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      The Austin Oasis

#      0055087

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	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,302,862	\$	1
2	Cash-Patient Deposits	12,391		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	986,403		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	604,669		6
7	Other Prepaid Expenses	1,250		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	561		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,908,136	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	69,831		15
16	Equipment, at Historical Cost	31,676		16
17	Accumulated Depreciation (book methods)	(15,334)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 86,173	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,994,309	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 915,503	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	184,700		30
31	Accrued Taxes Payable (excluding real estate taxes)	252,939		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached</u>	1,391,038		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,744,185	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached</u>	457,945		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 457,945	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,202,130	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 792,179	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,994,309	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>98,029</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Sequestration</u>	(3,277)	<b>3</b>
<b>4</b>	<u>Bad Debt Expense</u>	(20,349)	<b>4</b>
<b>5</b>	<u>Rounding</u>	(1)	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>74,402</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	717,777	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>717,777</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>792,179</b>	<b>24</b> *

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

Facility Name &amp; ID Number The Austin Oasis

# 0055087

Report Period Beginning: 01/01/20

Ending: 12/31/20

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,502,188	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,502,188	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	300,179	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 300,179	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,536	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,536	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Attached	1,437,004	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,437,004	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,241,907	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,153,918	31
32	Health Care	4,180,306	32
33	General Administration	3,317,510	33
<b>B. Capital Expense</b>			
34	Ownership	1,764,086	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	616,623	35
36	Provider Participation Fee	491,687	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,524,130	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	717,777	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 717,777	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 9,630,555	44
45	Private Pay - Net Inpatient Revenue	35,901	45
46	Medicare - Net Inpatient Revenue	1,655,157	46
47	Other-(specify) Hospice	180,575	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 11,502,188	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number The Austin Oasis

# 0055087

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	1,881	2,018	\$ 109,400	\$ 54.21	1
2	Assistant Director of Nursing	1,374	1,474	64,094	43.48	2
3	Registered Nurses	19,830	22,225	656,113	29.52	3
4	Licensed Practical Nurses	44,446	47,685	1,249,024	26.19	4
5	CNAs & Orderlies	76,818	82,416	1,107,171	13.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,879	3,089	59,629	19.30	8
9	Activity Director	558	599	11,099	18.53	9
10	Activity Assistants	8,631	9,260	118,988	12.85	10
11	Social Service Workers	11,955	12,827	248,345	19.36	11
12	Dietician					12
13	Food Service Supervisor	2,237	2,400	48,272	20.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,697	27,569	364,338	13.22	15
16	Dishwashers					16
17	Maintenance Workers	6,943	7,448	156,263	20.98	17
18	Housekeepers	37,300	40,017	513,796	12.84	18
19	Laundry	11,683	12,534	161,640	12.90	19
20	Administrator	3,518	3,775	155,112	41.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,831	13,765	211,981	15.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,333	1,431	22,771	15.91	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	6,793	7,288	77,063	10.57	33
34	TOTAL (lines 1 - 33)	276,707	297,820	\$ 5,335,099 *	\$ 17.91	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	\$ 17,866	01-03	35
36	Medical Director	Monthly	22,950	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	247,700	10-03	38
39	Pharmacist Consultant	Monthly	18,038	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,988	11-03	44
45	Social Service Consultant	Monthly	4,602	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 317,944		49

C. CONTRACT NURSES

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Angela Cash	Administrator	0	\$ 57,503	Workers' Compensation Insurance	\$ 100,315	IDPH License Fee	\$ 3,683		
Darnell Fortney	Administrator	0	49,767	Unemployment Compensation Insurance	39,199	Advertising: Employee Recruitment	16,375		
Ladon Harris	Administrator	0	47,841	FICA Taxes	408,135	Health Care Worker Background Check (Indicate # of checks performed <u>64</u> )	636		
				Employee Health Insurance	160,244	Patient Background Checks			
				Employee Meals	16,196	Dues IL Council	17,520		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	3,205		
				Employee Expense	39,915				
				Xmas Expense	3,261				
				Pension Expense	44,179				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 155,112	TOTAL (agree to Schedule V, line 22, col.8)		\$ 811,444	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 41,655
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Consulting Fees - Premier HC & Financial Services			\$ 359,765				Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 359,765				In-State Travel		
C. Professional Services				TOTAL			Seminar Expense		
Vendor/Payee	Type		Amount						
Marcum LLP	Accounting		\$ 36,429				See Supplemental Schedule		
Premier HC & Financial Services	Bookkeeping Fees		719,535				1,123		
Point Click Care	Data Processing		41,179				Entertainment Expense		
Reliable Health Care	Data Processing		14,800				( )		
Creative Technologies	IT Support		14,179				(agree to Sch. V, line 24, col. 8)		
EON Applications	Computer Services		978				\$ 1,123		
Ability Network	Medicare Billing		1,917						
OnShift	HR Consulting		14,586						
Zirmed	Data Processing		640						
Kipp Computer Solutions	Computer Services		1,000						
See Attached	Legal		32,733						
See Supplemental Schedule			9,365						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 887,341						

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number The Austin Oasis# 0055087Report Period Beginning: 01/01/20Ending: 12/31/20**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. HCCI - \$35,039
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,909 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 491,687  
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. \$ 16,196 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. **Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.