FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0032029

Facility Name: Hickory Nursing Pavilion

Address: 9246 S Roberts Road (Number) Hickory Hills (City) 60457 (Zip Code)

County: Cook

Telephone Number: 708-598-4040 **Fax #** 708-598-3796

HFS ID Number:

Date of Initial License for Current Owners: 03/01/1987

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mendel Schneider **Telephone Number:** (847)933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) See Accountant's Report Attached
(Firm Name & Address) Mendel S. Schneider CPA & Associates, 4051 Old Orchard rd, Skokie, Il 60076
(Telephone) (847)933-1274 Fax # (847)933-1283

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,444	1
2		Skilled Pediatric (SNF/PED)			2
3	40	Intermediate (ICF)	40	14,640	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,466		378	8,844	8
9	SNF/PED					9
10	ICF	14,600			14,600	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,066		378	23,444	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.56%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 03/01/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 03/01/1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 28 and days of care provided 378

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	225,048	17,364	6,419	248,831		248,831	5,309	254,140			1
2	Food Purchase		145,488		145,488		145,488	(128)	145,360			2
3	Housekeeping	212,869	38,079	7,044	257,992		257,992		257,992			3
4	Laundry	30,393	3,823	3,181	37,397		37,397		37,397			4
5	Heat and Other Utilities			47,927	47,927		47,927	1,094	49,021			5
6	Maintenance	34,079	81,697		115,776		115,776	1,297	117,073			6
7	Other (specify):*											7
8	**TOTAL General Services**	502,389	286,451	64,571	853,411		853,411	7,572	860,983			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,319,902	109,016	9,831	1,438,749		1,438,749		1,438,749			10
10a	Therapy											10a
11	Activities	89,442	1,218	496	91,156		91,156		91,156			11
12	Social Services	78,982		816	79,798		79,798		79,798			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,488,326	110,234	23,143	1,621,703		1,621,703		1,621,703			16
	C. General Administration											
17	Administrative	85,815		237,000	322,815		322,815	(188,244)	134,571			17
18	Directors Fees											18
19	Professional Services			81,029	81,029		81,029	(47,019)	34,010			19
20	Dues, Fees, Subscriptions & Promotions			62,599	62,599		62,599	(1,412)	61,187			20
21	Clerical & General Office Expenses	33,598	39,927	100,795	174,320		174,320	97,281	271,601			21
22	Employee Benefits & Payroll Taxes			301,438	301,438		301,438		301,438			22
23	Inservice Training & Education											23
24	Travel and Seminar			850	850		850	87	937			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			127,757	127,757		127,757	2,459	130,216			26
27	Other (specify):* **Allocated Benifets**							47,970	47,970			27
28	**TOTAL General Administration**	119,413	39,927	911,468	1,070,808		1,070,808	(88,878)	981,930			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,110,128	436,612	999,182	3,545,922		3,545,922	(81,306)	3,464,616			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Hickory Nursing Pavilion #0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			46,935	46,935		46,935	10,427	57,362			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(5,754)	(5,754)			32
33	Real Estate Taxes			179,991	179,991		179,991	3,382	183,373			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles							6,283	6,283			35
36	Other (specify):*											36
37	**TOTAL Ownership**			406,926	406,926		406,926	(165,662)	241,264			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,198	90,268	96,466		96,466		96,466			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,637	180,637		180,637		180,637			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		6,198	270,905	277,103		277,103		277,103			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,110,128	442,810	1,677,013	4,229,951		4,229,951	(246,968)	3,982,983			45

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(24,966)	30		9
10	Interest and Other Investment Income	(5,760)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(128)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,065)	21		24
25	Fund Raising, Advertising and Promotional	(1,487)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,041)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (48,447)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(198,521)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (198,521)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (246,968)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Hickory Nursing Pavilion

ID# 0032029

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	5,309	0	0	0	0	0	0	0	0	5,309	1
2	Food Purchase	(128)	0	0	0	0	0	0	0	0	0	0	(128)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,094	0	0	0	0	0	0	0	0	1,094	5
6	Maintenance	0	0	1,297	0	0	0	0	0	0	0	0	1,297	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(128)	0	7,700	0	0	0	0	0	0	0	0	7,572	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(188,244)	0	0	0	0	0	0	0	0	(188,244)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	250	(47,948)	679	0	0	0	0	0	0	0	(47,019)	19
20	Fees, Subscriptions & Promotions	(1,487)	75	0	0	0	0	0	0	0	0	0	(1,412)	20
21	Clerical & General Office Expenses	(16,106)	2,093	111,177	117	0	0	0	0	0	0	0	97,281	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	87	0	0	0	0	0	0	0	0	87	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,780	679	0	0	0	0	0	0	0	2,459	26
27	Other (specify):*	0	0	47,970	0	0	0	0	0	0	0	0	47,970	27
28	**TOTAL General Administration**	(17,593)	2,418	(75,178)	1,475	0	0	0	0	0	0	0	(88,878)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(17,721)	2,418	(67,478)	1,475	0	0	0	0	0	0	0	(81,306)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(24,966)	35,393	0	0	0	0	0	0	0	0	0	10,427	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,760)	(56)	0	62	0	0	0	0	0	0	0	(5,754)	32
33	Real Estate Taxes	0	0	0	3,382	0	0	0	0	0	0	0	3,382	33
34	Rent-Facility & Grounds	0	(180,000)	13,503	(13,503)	0	0	0	0	0	0	0	(180,000)	34
35	Rent-Equipment & Vehicles	0	0	6,283	0	0	0	0	0	0	0	0	6,283	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(30,726)	(144,663)	19,786	(10,059)	0	0	0	0	0	0	0	(165,662)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(48,447)	(142,245)	(47,692)	(8,584)	0	0	0	0	0	0	0	(246,968)	45

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 180,000			$	$ (180,000)	1
2	V	32	Interest	56				(56)	2
3	V	19	accounting				250	250	3
4	V	20	License				75	75	4
5	V	30	Depreciation				35,393	35,393	5
6	V	21	Replacement tax				2,093	2,093	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 180,056			$ 37,811	$ * (142,245)	14

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	STAYCARE MANAGEMENT	100.00%	$ 1,094	$ 1,094	15
16	V	6	Repairs & Maintenance		STAYCARE MANAGEMENT		1,297	1,297	16
17	V	17	Admin Salary-H Wengrow		STAYCARE MANAGEMENT		23,371	23,371	17
18	V	17	Admin Salary-J Webster		STAYCARE MANAGEMENT		25,385	25,385	18
19	V	19	Professional Fees		STAYCARE MANAGEMENT		332	332	19
20	V	21	Clerical Salaries		STAYCARE MANAGEMENT		135,123	135,123	20
21	V	21	Office Supplies		STAYCARE MANAGEMENT		8,518	8,518	21
22	V	26	Insurance		STAYCARE MANAGEMENT		1,780	1,780	22
23	V	27	Health Insurance		STAYCARE MANAGEMENT		29,136	29,136	23
24	V	1	Dietary Salary-S Webster		STAYCARE MANAGEMENT		1,338	1,338	24
25	V	1	Dietary Salary-D Wengrow		STAYCARE MANAGEMENT		3,971	3,971	25
26	V	24	Seminars		STAYCARE MANAGEMENT		87	87	26
27	V	34	Rent		STAYCARE MANAGEMENT		13,503	13,503	27
28	V	27	Payroll taxes		STAYCARE MANAGEMENT		12,008	12,008	28
29	V	27	Employee Benifets		STAYCARE MANAGEMENT		6,826	6,826	29
30	V	35	Equipment Rental -Auto		STAYCARE MANAGEMENT		6,283	6,283	30
31	V								31
32	V	17	Management Fees	237,000	STAYCARE MANAGEMENT			(237,000)	32
33	V	19	Administrative Consultant	48,280	STAYCARE MANAGEMENT			(48,280)	33
34	V	21	Admissions Director	12,750	STAYCARE MANAGEMENT			(12,750)	34
35	V	21	Reimbursement Consultant	19,714	STAYCARE MANAGEMENT			(19,714)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 317,744			$ 270,052	$ * (47,692)	39

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	DOUBLE YOU REALTY	100.00%	$ 679	$ 679	15
16	V	26	Insurance		DOUBLE YOU REALTY	100.00%	679	679	16
17	V	30	Depreciation		DOUBLE YOU REALTY	100.00%			17
18	V	32	Interest Expense		DOUBLE YOU REALTY	100.00%	62	62	18
19	V	33	Real Estate Taxes		DOUBLE YOU REALTY	100.00%	3,382	3,382	19
20	V	21	Office Supplies		DOUBLE YOU REALTY	100.00%	117	117	20
21	V								21
22	V	34	Rent	13,503	DOUBLE YOU REALTY	100.00%		(13,503)	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			$ 13,503			$ 4,919	$ * (8,584)	39

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Abraham J. Stern	1.351	Arbour Health Care Center, LTD	Chicago	Hickory Health Care A	Lincolnwood	Bldg rental	1
2	Deborah Wengrow	12.838	Atrium Health Care Center, LTD	Chicago	Staycare Management	Lincolnwood	Management	2
3	Frances Mauer	2.027	Abbington Rehan & Nursing, LTD	Roselle	Double You realty	Lincolnwood	Bldg Rental	3
4	Howard L. Wengrow	14.189	Zikanim, INC D/B/A All American Nursing Hom	Chicago				4
5	Jeffrey J. Webster	14.189						5
6	Marshall A. Mauer	2.027						6
7	Maurice Aaron	5.406						7
8	Miriam Latinik	5.406						8
9	Ralph Brooks	1.351						9
10	Bashir Kagda	1.351						10
11	Sandy Bokor	1.351						11
12	Sara Webster	12.838						12
13	Susan l. Stern	25.676						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 Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeffrey Webster	Owner	Administartive	50.00	166,376	8	20.00	Alloc Salary	$ 25,385	17-07	1
2	Howard Wengrow	Owner	Administartive	50.00	153,174	8	20.00	Alloc Salary	23,371	17-07	2
3	Sara Webster	Relative	Dietary		8,766	8	20.00	Alloc Salary	1,338	01-07	3
4	Deborah Wengrow	Relative	Dietary		26,029	8	20.00	Alloc Salary	3,971	01-07	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 54,065		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 Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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 [X] NO [ ]

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

Name of Related Organization: STAYCARE MANAGEMENT
Street Address: 3737 W ARTHUR AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847)679-2121
Fax Number: ((847)679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Number of Beds	559	5	$ 8,261	$	74	$ 1,094	1
2	6	Repairs & Maintenance	Number of Beds	559	5	9,800		74	1,297	2
3	17	Admin Salary-H Wengrow	Number of Beds	559	5	176,545	176,545	74	23,371	3
4	17	Admin Salary-J Webster	Number of Beds	559	5	191,761	191,761	74	25,385	4
5	19	Professional Fees	Number of Beds	559	5	2,509		74	332	5
6	21	Clerical Salaries	Number of Beds	559	5	1,020,725	1,020,725	74	135,123	6
7	21	Office Supplies	Number of Beds	559	5	64,344		74	8,518	7
8	26	Insurance	Number of Beds	559	5	13,444		74	1,780	8
9	27	Health Insurance	Number of Beds	559	5	220,093		74	29,136	9
10	1	Dietary Salary-S Webster	Number of Beds	559	5	10,104	10,104	74	1,338	10
11	1	Dietary Salary-D Wengrow	Number of Beds	559	5	30,000	30,000	74	3,971	11
12	24	Seminars	Number of Beds	559	5	660		74	87	12
13	34	Rent	Number of Beds	559	5	102,000		74	13,503	13
14	27	Payroll taxes	Number of Beds	559	5	90,708		74	12,008	14
15	27	Employee Benifets	Number of Beds	559	5	51,563		74	6,826	15
16	35	Equipment Rental -Auto	Number of Beds	559	5	47,460		74	6,283	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,039,977	$ 1,429,135		$ 270,052	25

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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 [X] NO [ ]

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

Name of Related Organization: Double You Realty
Street Address: 3737 W Arthur
City / State / Zip Code: Lincolnwood, Il 60712
Phone Number: ((847)679-2121
Fax Number: ((847)679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Number of Beds	559	5	$ 5,127	$	74	$ 679	1
2	26	Insurance	Number of Beds	559	5	5,130		74	679	2
3	30	Depreciation	Number of Beds	559	5			74		3
4	32	Interest Expense	Number of Beds	559	5	465		74	62	4
5	33	Real Estate Taxes	Number of Beds	559	5	25,547		74	3,382	5
6	21	Office Supplies	Number of Beds	559	5	881		74	117	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					$ 37,150	$		$ 4,919	25

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Allocated from Double you realty										62	10
11	Interest Income Realty										(56)	11
12	Interest Income										(5,760)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,754)	14
15	TOTALS (line 9+line14)						$	$			$ (5,754)	15

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 173,830	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.)		$ 174,296	2
3. Under or (over) accrual (line 2 minus line 1).		$ 466	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 179,525	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 183,373	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	157,201	8
	2016	160,302	9
	2017	164,043	10
	2018	170,422	11
	2019	174,296	12

Accrual:174296 x 1.03=179525

Allocated from Double You Realty 3382

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hickory Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Mendel Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-01-302-021-0000	Long Term Care Property	$ 12,050.10	$ 12,050.10
2.	23-02-420-007-0000	Long Term Care Property	$ 3,410.38	$ 3,410.38
3.	23-02-420-008-0000	Long Term Care Property	$ 74,975.83	$ 74,975.83
4.	23-02-420-015-0000	Long Term Care Property	$ 8,919.36	$ 8,919.36
5.	23-02-420-016-0000	Long Term Care Property	$ 74,940.39	$ 74,940.39
6.	10-35-329-014-0000	Alloc from Double You Realty	$ 25,547.00	$ 3,382.00
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 199,843.06	$ 177,678.06

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,200 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1990	$ 74,000	1
2	Allocated from Double You realty			4,867	2
3	TOTALS			$ 78,867	3

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1990	1961	$ 1,115,000	$ 35,393	35	$	$ (35,393)	$ 1,115,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	22,801		20			19,708	9
10	Various			1988	50,319		20			44,178	10
11	Various			1989	7,409		20			6,346	11
12	Various			1990	38,661		20			35,350	12
13	Various			1991	6,422		20			5,916	13
14	Various			1993	30,582		20			29,642	14
15	Various			1994	13,592		20			13,542	15
16	Various			1995	102,781		20			102,757	16
17	Various			1996	142,210		20			141,955	17
18	Various			1997	52,149		20			51,876	18
19	Various			1998	53,522		20			53,522	19
20	Various			1999	18,879		20			18,879	20
21	Various			2000	2,520		20	126	126	2,520	21
22	Various			2001	7,081		20	354	354	6,762	22
23	Various			2002	23,923		20			23,923	23
24	Various			2003	67,353		20	3,178	3,178	58,661	24
25	Various			2004	2,732		20	137	137	2,246	25
26	Various			2005	5,239		20			5,239	26
27	Various			2006	9,298		20	290	290	7,800	27
28	Various			2007	12,000		20			12,000	28
29	Various			2008	24,350		20			24,350	29
30	Various			2009	33,827		20			33,827	30
31	Various			2010	62,992		20	3,440	3,440	62,992	31
32	Various			2011	76,314		20	7,307	7,307	67,915	32
33	Various			2012	3,080		20	154	154	1,245	33
34	Various			2013	72,730		20	3,531	3,531	28,182	34
35	Various			2014	76,200		20	4,116	4,116	26,594	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Related Party Allocation		$	$		$	$	$	37
38	Buildings:								38
39	Allocated from Double You Realty LLC	2003	46,523		35	1,193	1,193	21,424	39
40									40
41									41
42									42
43									43
44									44
45									45
46	Leasehold Improvements:								46
47	Allocated from Staycare Management	2016	2,531		20	127	127	591	47
48	Allocated from Staycare Management	2003	2,155		20	108	108	1,892	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	Financial Statement Depreciation			46,935			(46,935)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,185,175	$ 82,328		$ 24,061	$ (58,267)	$ 2,026,834	70

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,185,175	$ 82,328		$ 24,061	$ (58,267)	$ 2,026,834	1
2	Security Cameras	2015	5,055		20	253	253	1,412	2
3	Boiler	2015	10,450		20	523	523	2,918	3
4	Remove Rear Entry Cove Base/Carpet, Install New Carpet	2015	2,961		20	148	148	864	4
5	Replace Leaky pipes/Concrete & Rodding Shower Room Drain	2016	3,900		20	390	390	1,918	5
6	Parapet wall repair	2016	16,500		20	1,650	1,650	7,700	6
7	Water Heater	2016	12,310		20	1,231	1,231	5,642	7
8	rodded Out Main Sewer from North/South End of Building	2016	6,325		20	633	633	2,795	8
9	Removal/Replacement of Facility Exterior Subsoil/Concrete	2016	4,783		20	478	478	2,072	9
10	Plumbing Improvements-Catch Basin	2016	13,500		20	386	386	1,704	10
11	Electrical improvements to Emergency Systems-Main Power Box	2017	9,500		20	475	475	1,860	11
12	Handrails and Bumper Guards-North Wing	2017	3,350		20	168	168	559	12
13	Remove Flooring,Replace Pipe, reinstall Ice Machine-Kitchen	2017	7,128		20	356	356	1,217	13
14	Install New Control Board& delay Card-Transformer	2017	3,906		20	195	195	781	14
15	Remove/Install New Cove Base, Prep Flooring-Nurses Station	2017	3,059		20	153	153	497	15
16	Install New Circuit Breaker & Baseboard Heater-Room 124	2017	3,050		20	153	153	560	16
17	AC units for Activity Room & Lobby	2018	14,000		20	700	700	1,808	17
18	20 New Windows-Various patient Rms, Small Dining room,DON O	2018	14,200		20	710	710	1,834	18
19	Repaired Broken pipe In Hallway	2018	4,900		20	245	245	735	19
20	Replaced 7 pieces of zpipe & Fittings in basement	2018	2,650		20	132	132	397	20
21	Installed a new 4.00 mm Torch modified bitumen roof	2019	78,090		20	3,904	3,904	5,856	21
22	Installed 5 Fire rated doors	2019	6,620		20	330	330	495	22
23	Rodded Out all drain lines and drain branches and powerjet	2019	5,900		20	296	296	444	23
24	pump for right Heating boiler	2019	3,188		20	160	160	240	24
25	Install 2 sets of vinyl windows in room 103 and 106	2020	3,040		20	152	152	152	25
26	Purchase and installation of new condenser, evaporator	2020	8,298		20	415	415	415	26
27	expansion valve, line set, and solenoid valve for a/c unit								27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,431,838	$ 82,328		$ 38,297	$ (44,031)	$ 2,071,709	34

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 172,348	$	$ 17,235	$ 17,235	10	$ 141,963	71
72	Current Year Purchases	18,295		1,830	1,830	10	1,830	72
73	Fully Depreciated Assets	315,295					315,295	73
74								74
75	TOTALS	$ 505,938	$	$ 19,065	$ 19,065		$ 459,088	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		Allocated from Staycare Management		$ 3,294	$	$	$		$ 3,294	76
77										77
78										78
79										79
80	TOTALS			$ 3,294	$	$	$		$ 3,294	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)	$ 3,019,937	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 82,328	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,362	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,966)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,534,091	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Staycare Mgmt		$	$ 6,283	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,283	21

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	39-3	hrs	$		$ 44,176	$		$ 44,176	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			46,092			46,092	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				6,198		6,198	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 90,268	$ 6,198		$ 96,466	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 Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,395,156	$ 1,522,717	1
2	Cash-Patient Deposits	113,401	113,401	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	429,231	429,231	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,917	29,917	6
7	Other Prepaid Expenses	72,887	72,887	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Partner		14,039	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,040,592	$ 2,182,192	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,000	13
14	Buildings, at Historical Cost		1,115,000	14
15	Leasehold Improvements, at Historical Cost	979,987	979,987	15
16	Equipment, at Historical Cost	392,998	503,998	16
17	Accumulated Depreciation (book methods)	(1,055,589)	(2,232,928)	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	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 317,396	$ 440,057	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,357,988	$ 2,622,249	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 243,031	$ 243,031	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	113,411	113,411	28
29	Short-Term Notes Payable	338,360	338,360	29
30	Accrued Salaries Payable	164,445	164,445	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,063	1,063	31
32	Accrued Real Estate Taxes(Sch.IX-B)	179,525	179,525	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Partnership	211,678		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,251,513	$ 1,039,835	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,251,513	$ 1,039,835	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,106,475	$ 1,582,414	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,357,988	$ 2,622,249	48

***(See instructions.)**

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,084,699	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,084,699	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	317,776	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(296,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 21,776	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,106,475	24 *

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,932,619	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,932,619	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,760	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,760	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Stimulus Income	609,348	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 609,348	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,547,727	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	853,411	31
32	Health Care	1,621,703	32
33	General Administration	1,070,808	33
	B. Capital Expense		
34	Ownership	406,926	34
	C. Ancillary Expense		
35	Special Cost Centers	96,466	35
36	Provider Participation Fee	180,637	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,229,951	40
41	**Income before Income Taxes (line 30 minus line 40)****	317,776	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 317,776	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,606,081	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	250,797	46
47	Other-(specify) Med b	75,741	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,932,619	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No,cash basis If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,192	$ 88,848	$ 40.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,885	13,658	459,078	33.61	3
4	Licensed Practical Nurses	8,079	8,359	285,614	34.17	4
5	CNAs & Orderlies	24,404	26,787	441,882	16.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,475	2,611	44,480	17.04	8
9	Activity Director	1,993	2,273	38,246	16.83	9
10	Activity Assistants	2,952	3,297	51,196	15.53	10
11	Social Service Workers	3,984	4,172	78,982	18.93	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,096	45,400	21.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,857	11,165	179,648	16.09	15
16	Dishwashers					16
17	Maintenance Workers	1,189	1,277	34,079	26.69	17
18	Housekeepers	13,077	14,066	212,869	15.13	18
19	Laundry	1,652	1,880	30,393	16.17	19
20	Administrator	2,040	2,160	85,815	39.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,050	2,194	33,598	15.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,597	98,187	$ 2,110,128 *	$ 21.49	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,419	1-3	35
36	Medical Director	Monthly	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,176	10-3	39
40	Physical Therapy Consultant	43	2,163	10-3	40
41	Occupational Therapy Consultant	30	1,491	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	496	11-3	44
45	Social Service Consultant	16	816	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	99	$ 29,561		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Latonia Smith	Administrative	0	$ 85,815
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,815

B. Administrative - Other

Description	Amount
Staycare Management	$ 237,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 237,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider CPA	Accounting	$ 12,000
Staycare Management	Other Prof Fees	48,280
Personnel Planners	UI Consultant	1,709
Cukierski & Cochrane	accounting	1,036
Ohagon Meyer	Legal	5,812
Much Shelist	Legal	6,021
Stout Risius	Financial consultant	6,171
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 81,029

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,987
Unemployment Compensation Insurance	9,995
FICA Taxes	154,493
Employee Health Insurance	77,357
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union pension	16,606
TOTAL (agree to Schedule V, line 22, col.8)	$ 301,438

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,581
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	3,284
Advertising	1,487
Dues and Subs	13,172
Misc License	41,160
Less: Public Relations Expense	( )
Non-allowable advertising	(1,487)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 61,187

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Illinois Council on LTC	850
Allocated from Staycare Mgmt	87
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 937

**See instructions.

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 13172**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,581** 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.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **180,637**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
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:

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.