

Facility Name & ID Number HIGHLAND HEALTH CARE CENTER

0055897 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	128	Skilled (SNF)	128	46,848	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,848	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	15,717	3,827	7,879	27,423	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,717	3,827	7,879	27,423	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.54%

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 9/1/2019

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/1/2019 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 128 and days of care provided 2,472

Medicare Intermediary National Government Services

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: 12/31/201

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

Facility Name & ID Number **HIGHLAND HEALTH CARE CENTER** # **0055897** Report Period Beginning: **01/01/20** Ending: **12/31/20**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	196,468	16,765	3,894	217,127		217,127	14,838	231,965		1
2	Food Purchase		160,095		160,095		160,095		160,095		2
3	Housekeeping	118,093	12,661	61,181	191,935		191,935		191,935		3
4	Laundry		8,066	26,220	34,286		34,286		34,286		4
5	Heat and Other Utilities			138,166	138,166		138,166		138,166		5
6	Maintenance	89,672	49,755	36,012	175,439		175,439	5,381	180,820		6
7	Other (specify):*										7
8	TOTAL General Services	404,233	247,342	265,473	917,048		917,048	20,219	937,267		8
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	1,787,401	220,345	342,919	2,350,665		2,350,665	37,671	2,388,336		10
10a	Therapy			344,513	344,513		344,513		344,513		10a
11	Activities	93,557	13,889		107,446		107,446		107,446		11
12	Social Services	42,201		6,316	48,517		48,517		48,517		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,923,159	234,234	729,748	2,887,141		2,887,141	37,671	2,924,812		16
	C. General Administration										
17	Administrative	123,378			123,378		123,378	99,783	223,161		17
18	Directors Fees										18
19	Professional Services			382,086	382,086		382,086	(162,451)	219,635		19
20	Dues, Fees, Subscriptions & Promotions			23,426	23,426		23,426		23,426		20
21	Clerical & General Office Expenses	103,654	20,134	528,959	652,747		652,747	(327,717)	325,030		21
22	Employee Benefits & Payroll Taxes			577,967	577,967		577,967	24,166	602,133		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,309	4,309		4,309	13	4,322		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			139,701	139,701		139,701		139,701		26
27	Other (specify):*										27
28	TOTAL General Administration	227,032	20,134	1,656,448	1,903,614		1,903,614	(366,206)	1,537,408		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,554,424	501,710	2,651,669	5,707,803		5,707,803	(308,316)	5,399,487		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			8,506	8,506		8,506	79,043	87,549		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			25,675	25,675		25,675	215,589	241,264		32
33	Real Estate Taxes			79,918	79,918		79,918	938	80,856		33
34	Rent-Facility & Grounds			600,000	600,000		600,000	(600,000)			34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*							15,522	15,522		36
37	TOTAL Ownership			714,099	714,099		714,099	(288,908)	425,191		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			7,520	7,520		7,520		7,520		38
39	Ancillary Service Centers		239,567		239,567		239,567		239,567		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			168,762	168,762		168,762		168,762		42
43	Other (specify):* Bad Debt			63,172	63,172		63,172	(63,172)			43
44	TOTAL Special Cost Centers		239,567	239,454	479,021		479,021	(63,172)	415,849		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,554,424	741,277	3,605,222	6,900,923		6,900,923	(660,395)	6,240,528		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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	39,086	30		9
10	Interest and Other Investment Income	(161)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,172)	43		24
25	Fund Raising, Advertising and Promotional	(75,208)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (99,455)		\$	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)			34
35	Other- Attach Schedule	(560,941)	Various	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (560,941)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (660,396)		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

ID# 0055897

Report Period Beginning: 01/01/20

Ending: 12/31/20

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 HIGHLAND HEALTH CARE CENTER# 0055897

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	0	14,838	0	0	0	0	0	0	0	0	0	14,838	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	5,294	87	0	0	0	0	0	0	0	0	5,381	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	20,131	87	0	0	0	0	0	0	0	0	20,219	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	37,671	0	0	0	0	0	0	0	0	0	37,671	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	37,671	0	0	0	0	0	0	0	0	0	37,671	16
	C. General Administration													
17	Administrative	0	99,783	0	0	0	0	0	0	0	0	0	99,783	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,856	(165,306)	0	0	0	0	0	0	0	0	(162,451)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(75,208)	(252,596)	87	0	0	0	0	0	0	0	0	(327,717)	21
22	Employee Benefits & Payroll Taxes	0	24,153	13	0	0	0	0	0	0	0	0	24,166	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	13	0	0	0	0	0	0	0	0	13	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(75,208)	(125,804)	(165,194)	0	0	0	0	0	0	0	0	(366,206)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(75,208)	(68,001)	(165,106)	0	0	0	0	0	0	0	0	(308,316)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HIGHLAND HEALTH CARE CENTER

0055897

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	39,086	39,957	0	0	0	0	0	0	0	0	0	79,043	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(161)	215,750	0	0	0	0	0	0	0	0	0	215,589	32
33	Real Estate Taxes	0	938	0	0	0	0	0	0	0	0	0	938	33
34	Rent-Facility & Grounds	0	(600,000)	0	0	0	0	0	0	0	0	0	(600,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	15,522	0	0	0	0	0	0	0	0	15,522	36
37	TOTAL Ownership	38,925	(343,354)	15,522	0	0	0	0	0	0	0	0	(288,908)	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):*	(63,172)	0	0	0	0	0	0	0	0	0	0	(63,172)	43
44	TOTAL Special Cost Centers	(63,172)	0	0	0	0	0	0	0	0	0	0	(63,172)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(99,455)	(411,356)	(149,585)	0	0	0	0	0	0	0	0	(660,395)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
CREST ILLINOIS HOLDCO LLC	100	Cedar Ridge	Lebanon	Crest Consulting	Chicago	Consulting Co
		Hallmark of Perkin	Perkin	Crest Realty LLC	Chicago	Real Estate
		Hallmark of Carnville	Carnville	Crest Management	Chicago	Management Co
		Hilltop Care	Chareston			
		Jacksonville Care	Jacksonville			
		Paris Health	Paris			
		Sunrise Care	Virден			

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	21 Management Fees	\$ 267,109	Crest Consulting		\$	(267,109)	1
2	V	1 Dietary		Crest Consulting		14,838	14,838	2
3	V	6 Maintenance		Crest Consulting		5,294	5,294	3
4	V	10 Nursing and Medical Records		Crest Consulting		37,671	37,671	4
5	V	17 Administrative		Crest Consulting		99,783	99,783	5
6	V	21 Clerical & General Office Expenses		Crest Consulting		14,513	14,513	6
7	V	22 Employee Benefits & Payroll Taxes		Crest Consulting		24,153	24,153	7
8	V	19 Professional Services		Crest Realty LLC		2,856	2,856	8
9	V	30 Depreciation		Crest Realty LLC		39,957	39,957	9
10	V	32 Interest		Crest Realty LLC		215,750	215,750	10
11	V	33 Real Estate Taxes		Crest Realty LLC		938	938	11
12	V	34 Rent	600,000	Crest Realty LLC			(600,000)	12
13	V							13
14	Total		\$ 867,109			\$ 455,753	\$ * (411,356)	14

* 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 Maintenance	\$	Crest Management		\$ 87	\$	87	15
16	V	19 Professional Services	333,545	Crest Management		168,239		(165,306)	16
17	V	21 Clerical & General Office Expenses		Crest Management		87		87	17
18	V	22 Employee Benefits & Payroll Taxes		Crest Management		13		13	18
19	V	24 Travel and Seminar		Crest Management		13		13	19
20	V	36 Other (specify):*		Crest Management		15,522		15,522	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		\$ 333,545			\$ 183,960	\$ *	(149,585)	39

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

Facility Name & ID Number

HIGHLAND HEALTH CARE CENTER

0055897

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

Facility Name & ID Number HIGHLAND HEALTH CARE CENTER # 0055897 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number HIGHLAND HEALTH CARE CENTER

0055897

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number **HIGHLAND HEALTH CARE CENTER**

0055897

Report Period Beginning:

01/01/20

Ending:

12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Mortgage	No	Mortgage	Various		\$ 4,966,446			\$ 114,113	1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$ 4,966,446			\$ 114,113	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related									14										
15	TOTALS (line 9+line14)					\$ 4,966,446			\$ 114,113	15										

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

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

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

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.)		\$	80,292	2
3. Under or (over) accrual (line 2 minus line 1).		\$	80,292	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(374)	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.		\$	79,918	7

Real Estate Tax History:

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

FOR BHF USE ONLY

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HIGHLAND HEALTH CARE CENTER COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0055897

CONTACT PERSON REGARDING THIS REPORT AARON MAUER

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <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>01-2-24-08-08-201-004</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>80,292.08</u>	\$ <u>80,292.08</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>80,292.08</u></u>	\$ <u><u>80,292.08</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? YES X 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 **HIGHLAND HEALTH CARE CENTER**

0055897 Report Period Beginning:

01/01/20 Ending:

12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,432 B. General Construction Type: Exterior Frame Number of Stories 1

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **HIGHLAND HEALTH CARE CENTER**

0055897

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	128	2019		\$ 1,277,003	\$ 32,744	39	\$ 32,744	\$ (0)	\$ 64,110	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	plumbing work underneath kitchen	2019		2,600	173	39	67	(107)	217	9
10	Litteken Plumbing - Kitchen	2019		5,250	350	39	135	(215)	408	10
11	flooring fron entrance	2019		2,255	150	39	58	(93)	175	11
12	roof repair throughout building	2020		15,010	667	39	192	(475)	667	12
13	flooring resident rooms and bathrooms Hall G	2020		1,137	38	39	15	(23)	38	13
14	HVAC in the Kitchen	2020		3,217	89	39	41	(48)	89	14
15	facility signage thoughout the building	2020		7,830	131	39	100	(30)	131	15
16	New door for dementia unit	2020		1,413	24	39	18	(5)	24	16
17	door lock system for the dementia unit	2020		6,839	76	39	88	12	76	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **HIGHLAND HEALTH CARE CENTER**

0055897

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	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								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,322,556	\$ 34,442		\$ 33,457	\$ (985)	\$ 65,935	70

**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	\$ 239,438	\$ 7,213	\$ 47,888	\$ 40,675	5	\$ 52,033	71
72	Current Year Purchases	62,040	6,808	6,204	(604)	5	8,013	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 301,478	\$ 14,021	\$ 54,092	\$ 40,071		\$ 60,046	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,624,034	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,463	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 87,549	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 39,086	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 125,981	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: NA

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

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	\$ _____

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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	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.)

	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	10a-3	hrs	\$	1,718	\$ 121,232	\$	1,718	\$ 121,232	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,326	99,901		1,326	99,901	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,814	123,380		1,814	123,380	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 prescripts				226,680		226,680	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-Ray</u>	39-2					4,050		4,050	12
13	Other (specify): <u>Lab</u>	39-2					8,837		8,837	13
14	TOTAL			\$	4,857	\$ 344,513	\$ 239,567	4,857	\$ 584,080	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.

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 382,021	\$ 716,838	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	607,506	3,493,464	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	166,250	166,250	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	126,483	126,483	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,282,260	\$ 4,503,035	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		79,813	13
14	Buildings, at Historical Cost		1,277,003	14
15	Leasehold Improvements, at Historical Cost	45,553	45,553	15
16	Equipment, at Historical Cost	62,040	301,478	16
17	Accumulated Depreciation (book methods)	(9,841)	(125,984)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		113,128	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Goodwill		603,746	22
23	Other(specify): Replacement Reserve		14,725	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 97,752	\$ 2,309,462	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,380,012	\$ 6,812,497	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 470,002	\$ 470,780	26
27	Officer's Accounts Payable	89,645	89,645	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,546	140,546	30
31	Accrued Taxes Payable (excluding real estate taxes)	57,043	57,043	31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,918	79,918	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 837,154	\$ 837,932	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	542,325	542,325	39
40	Mortgage Payable		4,966,446	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)	\$ 542,325	\$ 5,508,771	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,379,479	\$ 6,346,703	46
47	TOTAL EQUITY(page 18, line 24)	\$ 533	\$ 465,794	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,380,012	\$ 6,812,497	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (306,605)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (306,605)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	321,420	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	(14,285)	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)	\$ 307,135	17
	B. Transfers (Itemize):		
18	Rounding	3	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 3	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 533	24 *

* This must agree with page 17, line 47.

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

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,154,786	1
2	Discounts and Allowances for all Levels	992	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,155,778	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	155,557	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 155,557	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	871,901	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	30,649	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,745	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 910,295	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	161	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 161	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		552	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 552	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,222,343	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	917,048	31
32	Health Care	2,887,141	32
33	General Administration	1,903,614	33
B. Capital Expense			
34	Ownership	714,099	34
C. Ancillary Expense			
35	Special Cost Centers	479,021	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,900,923	40
41	Income before Income Taxes (line 30 minus line 40)**	321,420	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 321,420	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,519,025	44
45	Private Pay - Net Inpatient Revenue	716,373	45
46	Medicare - Net Inpatient Revenue	1,526,087	46
47	Other-(specify) <u>Insurance</u>	1,215,700	47
48	Other-(specify) <u>Hospice</u>	178,593	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,155,778	49

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

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

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

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

Facility Name & ID Number HIGHLAND HEALTH CARE CENTER

0055897

Report Period Beginning: 01/01/20

Ending: 12/31/20

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	2,008	\$ 94,684	\$ 45.35	1
2	Assistant Director of Nursing	16	559	34.94	2
3	Registered Nurses	10,728	403,670	34.32	3
4	Licensed Practical Nurses	15,822	500,529	28.19	4
5	CNAs & Orderlies	48,797	792,119	14.69	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	2,286	35,588	14.60	9
10	Activity Assistants	3,671	51,752	13.28	10
11	Social Service Workers	1,963	33,691	16.43	11
12	Dietician				12
13	Food Service Supervisor	2,032	42,790	20.53	13
14	Head Cook				14
15	Cook Helpers/Assistants	13,379	136,545	10.01	15
16	Dishwashers				16
17	Maintenance Workers	5,335	106,959	19.17	17
18	Housekeepers	9,181	90,416	9.36	18
19	Laundry				19
20	Administrator	1,968	113,398	54.31	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	5,846	95,836	15.56	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) <u>MDS</u>	1,984	55,888	26.78	33
34	TOTAL (lines 1 - 33)	125,000	\$ 2,554,424 *	\$ 18.89	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	\$		35
36	Medical Director	Monthly 30,000	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	Monthly 2,954	10-3	38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 32,954		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	455 \$ 43,524	10-3	50
51	Licensed Practical Nurses	651 27,934	10-3	51
52	Certified Nurse Assistants/Aides	359 9,864	10-3	52
53	TOTAL (lines 50 - 52)	1,464 \$ 81,321		53

C. Professional Services

Vendor/Payee	Type	Amount
<u>Compliance Consulting Group</u>	<u>Professional Fees</u>	<u>\$ 7,200</u>
<u>Meyer Magaence</u>	<u>Professional Fees</u>	<u>3,169</u>
<u>CFG</u>	<u>Professional Fees</u>	<u>3,837</u>
<u>Vcorp</u>	<u>Professional Fees</u>	<u>575</u>
<u>LTC Consulting</u>	<u>Professional Fees</u>	<u>2,121</u>
<u>Stone Pogrund and Korey</u>	<u>Professional Fees</u>	<u>75</u>
<u>Mts consulting</u>	<u>Professional Fees</u>	<u>360</u>
<u>Dovid Stern</u>	<u>Professional Fees</u>	<u>19</u>
<u>Pease</u>	<u>Professional Fees</u>	<u>389</u>
<u>Activated Insights</u>	<u>Professional Fees</u>	<u>722</u>
<u>Pathway Health Services</u>	<u>Professional Fees</u>	<u>200</u>
<u>Apex Global Solutions</u>	<u>Professional Fees</u>	<u>2,750</u>
<u>EMR Compliance</u>	<u>Professional Fees</u>	<u>5,550</u>
	<u>Professional Fees</u>	
	<u>Professional Fees</u>	

26,967.08

Facility Name & ID Number **HIGHLAND HEALTH CARE CENTER**# **0055897**Report Period Beginning: **01/01/20**Ending: **12/31/20****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. HCCI \$19,584
- (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. \$ 18,945 Line 10-02
- (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. \$ 168,762
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NO Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% LN
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
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.