FOR BHF USE

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

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

I. IDPH License ID Number: 0051854

Facility Name: Pershing Gardens HC Center

Address: 3900 S Oak Park Ave (Number) Stickney (City) 60402 (Zip Code)

County: Cook

Telephone Number: (708)484-7543 **Fax #** (708)484-1412

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2012

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/2020 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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 N/A

	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	31	Skilled (SNF)	31	11,346	1
2		Skilled Pediatric (SNF/PED)			2
3	20	Intermediate (ICF)	20	7,320	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	51	TOTALS	51	18,666	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	330	6	3,830	4,166	8
9	SNF/PED					9
10	ICF	8,805	904		9,709	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,135	910	3,830	13,875	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.33%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 3,167

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	98,976	8,455	5,664	113,095		113,095		113,095			1
2	Food Purchase		99,139		99,139		99,139		99,139			2
3	Housekeeping	57,486	26,676	45,350	129,512		129,512		129,512			3
4	Laundry	23,394	5,509		28,903		28,903		28,903			4
5	Heat and Other Utilities			53,887	53,887		53,887	494	54,381			5
6	Maintenance	59,977		40,023	100,000		100,000	2,810	102,810			6
7	Other (specify):* Waste Removal			30,851	30,851		30,851		30,851			7
8	TOTAL General Services	239,833	139,779	175,775	555,387		555,387	3,304	558,691			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,408,828	127,588	3,375	1,539,791		1,539,791	30,923	1,570,714			10
10a	Therapy			13,629	13,629		13,629	(13,629)				10a
11	Activities	13,352		251	13,603		13,603		13,603			11
12	Social Services	304		1,410	1,714		1,714		1,714			12
13	CNA Training											13
14	Program Transportation			3,418	3,418		3,418		3,418			14
15	Other (specify):* Mgmt Co Benefits Alloc							6,442	6,442			15
16	TOTAL Health Care and Programs	1,422,484	127,588	34,083	1,584,155		1,584,155	23,736	1,607,891			16
	C. General Administration											
17	Administrative	148,763		234,456	383,219		383,219	(200,887)	182,332			17
18	Directors Fees											18
19	Professional Services			257,515	257,515		257,515	7,598	265,113			19
20	Dues, Fees, Subscriptions & Promotions			30,512	30,512		30,512	7,236	37,748			20
21	Clerical & General Office Expenses	126,830	7,099	22,117	156,046		156,046	71,513	227,559			21
22	Employee Benefits & Payroll Taxes			231,235	231,235		231,235		231,235			22
23	Inservice Training & Education											23
24	Travel and Seminar			540	540		540	106	646			24
25	Other Admin. Staff Transportation			3,444	3,444		3,444	1,141	4,585			25
26	Insurance-Prop.Liab.Malpractice			34,935	34,935		34,935	1,909	36,844			26
27	Other (specify):* Mgmt Co Benefits Alloc							20,256	20,256			27
28	TOTAL General Administration	275,593	7,099	814,754	1,097,446		1,097,446	(91,128)	1,006,318			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,937,910	274,466	1,024,612	3,236,988		3,236,988	(64,088)	3,172,900			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Pershing Gardens HC Center #0051854 Report Period Beginning: 1/1/2020 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			124,140	124,140		124,140	(3,855)	120,285			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,723	51,723		51,723	439,588	491,311			32
33	Real Estate Taxes			256,530	256,530		256,530		256,530			33
34	Rent-Facility & Grounds			504,000	504,000		504,000	(494,823)	9,177			34
35	Rent-Equipment & Vehicles			45,237	45,237		45,237	943	46,180			35
36	Other (specify):* Amortization			58,333	58,333		58,333		58,333			36
37	TOTAL Ownership			1,039,963	1,039,963		1,039,963	(58,147)	981,816			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,452	398,148	428,600		428,600	(31,469)	397,131			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			94,560	94,560		94,560		94,560			42
43	Other (specify):* Disallowed Costs		5,543	443,297	448,840		448,840	(448,840)				43
44	TOTAL Special Cost Centers		35,995	936,005	972,000		972,000	(480,309)	491,691			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,937,910	310,461	3,000,580	5,248,951		5,248,951	(602,544)	4,646,407			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	(3,132)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,889)	30		9
10	Interest and Other Investment Income	(7,563)	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	(353,131)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,581)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(70,337)	43		24
25	Fund Raising, Advertising and Promotional	(22,240)	43		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 See Page 5A	(55,195)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (533,068)		$	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)	(69,476)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (69,476)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (602,544)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Pershing Gardens HC Center

ID# 0051854

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Amortization Expense	$ (61,322)	36	1
2	Expense Repairs under $2,500	2,809	6	2
3	Expense Repairs under $2,500	3,319	21	3
4	Offset Miscellaneous Income Against Expense	(1)	21	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**	(55,195)		49

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	30	Depreciation		Pershing Gardens Realty, LLC	100.00%	$ 14,893	$ 14,893	1
2	V	32	Interest		Pershing Gardens Realty, LLC	100.00%	439,869	439,869	2
3	V	34	Rent-Facility & Grounds	504,000	Pershing Gardens Realty, LLC	100.00%		(504,000)	3
4	V	36	Amortization		Pershing Gardens Realty, LLC	100.00%	61,322	61,322	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 504,000			$ 516,084	$ * 12,084	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 494	$ 494	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	1	1	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	30,923	30,923	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	6,442	6,442	18
19	V	17	Administrative	234,456	Premier Healthcare Management, LLC	100.00%	33,569	(200,887)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	4,757	4,757	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	129	129	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	67,514	67,514	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	106	106	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	778	778	24
25	V	26	Insurance-Prop.Liab.Malpractice		Premier Healthcare Management, LLC	100.00%	49	49	25
26	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	20,256	20,256	26
27	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	9,177	9,177	27
28	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	943	943	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			$ 234,456			$ 175,138	$ * (59,318)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	10A	Therapy	$ 13,629	REX Therapeutics	100.00%	$	$ (13,629)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	5,422	5,422	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	7,107	7,107	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	681	681	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	363	363	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	1,860	1,860	20
21	V	30	Depreciation		REX Therapeutics	100.00%	141	141	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	7,282	7,282	22
23	V	39	Therapy Management Wages		REX Therapeutics	100.00%	14,161	14,161	23
24	V								24
25	V								25
26	V								26
27	V	39	Therapy Wages	386,180	REX Therapeutics	100.00%	226,181	(159,999)	27
28	V	39	Contract Therapy		REX Therapeutics	100.00%	90,464	90,464	28
29	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	23,905	23,905	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			$ 399,809			$ 377,567	$ * (22,242)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	Barak Baver	100	Gilman Healthcare Center	Gilman	Premier Healthcare	Skokie	Management Co.	1
2			Winfield Woods Healthcare Center	Winfield	Management, LLC			2
3			Norridge Gardens	Norridge	Premier Healthcare	Skokie	Medical Supply	3
4			Gardenview Manor	Danville	Supplies, LLC			4
5			Champaign Urbana Nursing and Rehab	Savoy	Pershing Gardens	Stickney	Lessor	5
6			Premier Healthcare of New Harmony, LLC	New Harmony, IN	Realty, LLC			6
7					REX Therapeutics	Skokie	Therapy	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	Sara Baver	Relative	Clerical	0.00	See Att Sch 7A	2.90	7.25	Alloc Salary	$ 3,207	21-7	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	$ 3,207		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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: Premier Healthcare Management, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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	Heat and Other Utilities	Operating Revenues	64,636,666	8	$ 6,803	$	4,689,119	$ 494	1
2	6	Maintenance	Operating Revenues	64,636,666	8	20		4,689,119	1	2
3	10	Nursing and Medical Records	Operating Revenues	64,636,666	8	426,253	426,253	4,689,119	30,923	3
4	15	Emp Benefit Alloc-Healthcare	Operating Revenues	64,636,666	8	88,802		4,689,119	6,442	4
5	17	Administrative	Operating Revenues	64,636,666	8	462,726	462,726	4,689,119	33,569	5
6	19	Professional Services	Operating Revenues	64,636,666	8	65,562		4,689,119	4,757	6
7	20	Dues, Fees, Subs & Promo	Operating Revenues	64,636,666	8	1,782		4,689,119	129	7
8	21	Clerical & Gen Office Expenses	Operating Revenues	64,636,666	8	930,635	877,535	4,689,119	67,514	8
9	24	Travel and Seminar	Operating Revenues	64,636,666	8	1,464		4,689,119	106	9
10	25	Other Admin. Staff Trans	Operating Revenues	64,636,666	8	10,729		4,689,119	778	10
11	26	Insurance-Prop.Liab.Malpractice	Operating Revenues	64,636,666	8	675		4,689,119	49	11
12	27	Emp Benefit Alloc-Gen Admin	Operating Revenues	64,636,666	8	279,218		4,689,119	20,256	12
13	34	Rent-Facility & Grounds	Operating Revenues	64,636,666	8	126,494		4,689,119	9,177	13
14	35	Equipment Rental	Operating Revenues	64,636,666	8	12,997		4,689,119	943	14
15										15
16	17	Professional Services	Direct Allocation	60,000	1	60,000			0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,474,160	$ 1,766,514		$ 175,138	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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: REX Therapeutics
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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 Services	Therapy Revenue	8,309,425	12	$ 112,512	$	400,514	$ 5,422	1
2	20	Fees and Subscriptions	Therapy Revenue	8,309,425	12	147,440		400,514	7,107	2
3	21	Clerical & General Office Exp	Therapy Revenue	8,309,425	12	14,128		400,514	681	3
4	25	Other Admin Staff Transp	Therapy Revenue	8,309,425	12	7,522		400,514	363	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	8,309,425	12	38,581		400,514	1,860	5
6	30	Depreciation	Therapy Revenue	8,309,425	12	2,921		400,514	141	6
7	32	Interest Expense	Therapy Revenue	8,309,425	12	151,084		400,514	7,282	7
8	39	Therapy Management Wages	Therapy Revenue	8,309,425	12	293,802	293,802	400,514	14,161	8
9										9
10										10
11										11
12	39	Therapy Wages	Direct Allocation	5,717,814	12	5,424,012	5,424,012	226,181	226,181	12
13	39	Contract Therapy	Direct Allocation	206,555	3	206,555		90,464	90,464	13
14	39	Allocated Employee Benefits	Total Wages	5,717,814	12	569,187		240,342	23,905	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,967,744	$ 5,717,814		$ 377,567	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	Bank Leumi		X	Mortgage		7/12/2016	5,000,000	4,799,033	7/12/2021	variable	$ 439,869	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit		8/1/2016		716,940	8/1/2017	variable	51,723	6
7												7
8												8
9	TOTAL Facility Related						$ 5,000,000	$ 5,515,973			$ 491,592	9
	B. Non-Facility Related*											
10												10
11								Allocated from REX Therapeutics			7,282	11
12								Offset Interest Income			(7,563)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (281)	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 5,515,973			$ 491,311	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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.**		$ 485,408	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.)	2019	$ 141,157	2
3. Under or (over) accrual (line 2 minus line 1).		$ (344,251)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 600,781	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.		$ 256,530	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	107,279	8
	2016	110,790	9
	2017	133,925	10
	2018	137,801	11
	2019	141,157	12

Accrual based on prior year tax bill.

Adjusted beginning accrual to actual-prior year post closing adjustment

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.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pershing Gardens HC Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051854

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ( )

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-06-103-035-0000	Long Term Care Property	$ 102,201.58	$ 102,201.58
2.	19-06-103-034-0000	Long Term Care Property	$ 38,955.49	$ 38,955.49
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 141,157.07	$ 141,157.07

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 Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,845 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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. [X] (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		2012	$ 14,786	1
2					2
3	TOTALS			$ 14,786	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	51		2012	1964	$ 1,220,815	$	35	$ 34,880	$ 34,880	$ 267,079	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Automatic Wet Pipe Fire Sprinkler System			2012	67,793		20	3,390	3,390	30,509	9
10	Fire Protection Coverage-ISt & 2Nd Floor Dining Rooms			2012	4,560		20	228	228	2,052	10
11	Removal Of Underground Storage Tank			2012	4,036		20	202	202	1,817	11
12	Installation Of Wander System And Cables			2012	5,721		20	286	286	2,573	12
13	New Signage			2012	9,858		20	493	493	4,437	13
14	Replace A/C System On Second Floor			2012	3,000		20	150	150	1,350	14
15	Fire Alarm Installation			2012	3,200		20	160	160	1,440	15
16	A: 1St Floor Day Room- New Blinds And Custom Fireplace			2012	3,857		20	193	193	1,736	16
17	B: Porch- Demolish Existing Porches And Build New Stairs Railings And I			2012	9,904		20	495	495	4,456	17
18	C: Lobby- New Custom Baseboard Heaters			2012	3,792		20	190	190	1,708	18
19	D: 1St Floor Day Room-Structural Wood Repair; Replace Ceiling; New D			2012	28,689		20	1,434	1,434	12,908	19
20	E: Lobby-New Flooring;Ceiling; Lighting;Wallcoverings;Window Treatm			2012	19,878		20	994	994	8,946	20
21	F: Basement Corridor-New Flooring; Signage; Lighting			2012	6,453		20	323	323	2,906	21
22	G: Therapy Room-New Flooring;Wall Partitions; Lighting; Electrical; Do			2012	54,039		20	2,702	2,702	24,318	22
23	H: 1St Floor Corridor-Removal Of Old Cove Base; New Flooring;Wall Ba			2012	30,741		20	1,537	1,537	13,833	23
24	I: 2Nd Floor Corridor- New Flooring; Removal Of Old Cove Base; New W			2012	35,164		20	1,758	1,758	15,823	24
25	J: New Elevator			2012	8,123		20	406	406	3,655	25
26	K: 2Nd Floor Day Room- Replace Ceiling; Millwork Base; Window Treat			2012	18,891		20	945	945	8,503	26
27	L: Resident Rooms- New Flooring; Paint Walls; Lighting; Cubicle Curtair			2012	82,484		20	4,124	4,124	37,968	27
28	M: Various Areas-New Wooden Handrails And Bumper Gaurds; Painting			2012	65,457		20	3,273	3,273	29,456	28
29	New Fire Alarm Panel Analog Notifier			2012	4,950		20	248	248	2,230	29
30	Various Bathroom Remodels: Remove & Replace Tub,Toilet,Sink, New Fl			2012	48,310		20	2,416	2,416	16,911	30
31	New Wiring And Motor For Kitchen Exhaust Fan			2013	2,837		20	142	142	1,136	31
32	New Outlets For Window A/C Units			2013	2,900		20	145	145	1,100	32
33	New Generator, New 400 Amp Main Service			2013	141,085		20	7,054	7,054	52,318	33
34	Additional Work On Exterior Remodel: Demo Existing, New Concrete, Dc			2013	16,903		20	845	845	6,197	34
35	Fire Alarm Installation Charge			2013	9,423		20	471	471	3,297	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	Install Door Automator To Front Entry	2013	5,575		20	279	$ 279	$ 1,952	37
38	Various Areas: Light Fixtures;Floor & Wall Tile;	2013	$ 24,566	$	20	$ 1,228	1,228	8,597	38
39	Main Entrance Exterior Remodel: Demolish Entire Old Exterior-	2013	59,204		20	2,960	2,960	20,720	39
40	Fire System	2014	3,103		20	155	155	1,085	40
41	Tuckpoint Wall Where Overhang From Roof Was Removed	2014	5,800		20	290	290	2,030	41
42	Hot Water Tank Wiring	2014	3,125		20	156	156	1,093	42
43	Champion Roofing	2014	2,850		20	143	143	1,000	43
44	Install Wire Panelboard In Boiler Room	2014	7,000		20	350	350	2,450	44
45	Elevator Wiring & Shunt Trip Breaker	2014	19,000		20	950	950	6,650	45
46	Champion Roofing	2014	3,248		20	162	162	1,135	46
47	New Elevator	2014	2,500		20	125	125	875	47
48	Elevator Modernization	2014	125,000		20	6,250	6,250	43,750	48
49	Install Fire Alarm System In Basement Elevator Room	2014	10,548		20	527	527	2,635	49
50	Repaired 2 Lower Level Circuits, 1 Battery Pack, And 2 Fluoresce	2015	7,675		20	384	384	2,304	50
51	Rewired Kitchen With Two 20 Amp 120 Volt Circuits	2015	4,750		20	238	238	1,428	51
52	Replace Kitchen Door and Drywall in Dining Rm Ceiling	2017	4,125		20	206	206	721	52
53	Install New Circuit and Feeder in Laundry Room	2017	4,215		20	211	211	738	53
54	Replace Condenser Unit on Walk-In-Freezer	2018	4,739		20	237	237	592	54
55	Remove and Replace Door	2019	2,637		20	132	132	198	55
56	Repair Elevator Circuit Breaker	2019	3,265		20	163	163	245	56
57	New Roof	2020	74,624		20	1,866	1,866	1,866	57
58									58
59									59
60									60
61									61
62									62
63									63
64	Allocated from Premier Healthcare Management LLC.	2013	1,805		20	90	90	558	64
65									65
66	Allocated from REX Therapeutics					141	141		66
67									67
68	Financial Statement Depreciation			111,614			(111,614)		68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,292,217	$ 111,614		$ 86,727	$ (24,887)	$ 663,284	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	$ 332,708	$ 12,526	$ 33,271	$ 20,745	10 yrs	$ 260,002	71
72	Current Year Purchases	2,866	287	287			287	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 335,574	$ 12,813	$ 33,558	$ 20,745		$ 260,289	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	N/A									77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,642,577	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 124,427	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 120,285	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,142)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 923,573	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	Allocated from Management Co.				9,177			5
6								6
7	TOTAL				$ 9,177 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: $ 45,237 Description: See Attached Schedule 14A
(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	Allocated from Management Co			943	19
20					20
21	TOTAL		$	$ 943	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/2020**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	40,957
Office Equipment	4,280
Total - Line 16	**45,237**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)(7)	3229	hrs	$ 75,046		$ 30,016	$	3,229	$ 105,062	1
2	Licensed Speech and Language Development Therapist	39(3)(7)	1019	hrs	23,680		9,471		1,019	33,151	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(3)(7)	5483	hrs	127,455		50,977		5,483	178,432	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				30,201		30,201	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Therapy Management	39(7)	101		14,161				101	14,161	12
13	Other (specify): See Attached Sch 16A	39(2)(3)					11,968	251		12,219	13
14	TOTAL				$ 240,342		$ 102,432	$ 30,452	9,832	$ 373,226	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/2020**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	11,968
Medical Supplies - MCA	39(2)	251
Total - Line 13		**12,219**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	$ 276,999	$ 276,999	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 488,789)	1,763,633	1,763,633	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,044	1,044	6
7	Other Prepaid Expenses	182,649	182,649	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	75,000	75,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,299,325	$ 2,299,325	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		14,786	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,186,967	2,292,217	15
16	Equipment, at Historical Cost	296,554	335,574	16
17	Accumulated Depreciation (book methods)	(1,128,873)	(923,573)	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): See Attached Schedule 17A		213,977	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 354,648	$ 1,932,981	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,653,973	$ 4,232,306	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 710,353	$ 678,121	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	716,940	716,940	29
30	Accrued Salaries Payable	249,422	249,422	30
31	Accrued Taxes Payable (excluding real estate taxes)	419,302	419,302	31
32	Accrued Real Estate Taxes(Sch.IX-B)	(16,800)	600,781	32
33	Accrued Interest Payable	(94)	(94)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	401,622	401,622	36
37	Due to Related Parties	3,135,889	2,510,690	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,616,634	$ 5,576,784	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,799,033	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)**	$	$ 4,799,033	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,616,634	$ 10,375,817	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,962,661)	$ (6,143,511)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,653,973	$ 4,232,306	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/2020**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Loan Costs		30,014
Intangibles		183,963
Total - Line 23	**-**	**213,977**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued Expenses	121,244	121,244
Accrued Bed Tax	5,894	5,894
Due to Medicare	251,735	251,735
Security Deposits	22,749	22,749
Total - Line 36	**401,622**	**401,622**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,240,326)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,240,326)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	277,665	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	( )	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)**	$ 277,665	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)**	$ (2,962,661)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	$ 3,701,855	1
2	Discounts and Allowances for all Levels	856,731	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,558,586	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,330	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 130,330	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	829,933	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	1	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	202	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 830,136	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,563	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,563	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	1	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,526,616	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	555,387	31
32	Health Care	1,584,155	32
33	General Administration	1,097,446	33
	B. Capital Expense		
34	Ownership	1,039,963	34
	C. Ancillary Expense		
35	Special Cost Centers	877,440	35
36	Provider Participation Fee	94,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,248,951	40
41	**Income before Income Taxes (line 30 minus line 40)****	277,665	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 277,665	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,887,628	44
45	Private Pay - Net Inpatient Revenue	238,000	45
46	Medicare - Net Inpatient Revenue	2,006,754	46
47	Other-(specify) Insurance	391,177	47
48	Other-(specify) Hospice	35,027	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,558,586	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 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	2,180	2,388	$ 114,865	$ 48.10	1
2	Assistant Director of Nursing	2,033	2,217	92,914	41.91	2
3	Registered Nurses	9,668	10,016	362,995	36.24	3
4	Licensed Practical Nurses	11,241	11,756	334,048	28.42	4
5	CNAs & Orderlies	26,610	27,595	504,006	18.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	843	955	13,352	13.98	10
11	Social Service Workers	16	16	304	19.00	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	39,464	18.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,522	3,877	59,512	15.35	15
16	Dishwashers					16
17	Maintenance Workers	5,252	5,316	59,977	11.28	17
18	Housekeepers	4,908	4,955	57,486	11.60	18
19	Laundry	1,731	1,933	23,394	12.10	19
20	Administrator	2,032	2,240	148,763	66.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,960	7,079	126,830	17.92	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)	78,988	82,423	$ 1,937,910 *	$ 23.51	34

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	$ 5,664	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,375	L10, C3	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	21	1,410	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	21	$ 22,449		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Taylor	Administrator	0	$ 148,763
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 148,763

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 234,456
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 234,456

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 139,918
CohnReznick LLP	Accounting	15,300
Plante & Moran	Accounting	112
Richard Peelo & Associates, Inc	Accounting	2,800
Wipfli LLP	Accounting	4,275
GCHMO	Managed Care Contracting Serv	15,900
Personnel Planners	Unemployment Consultant	1,000
M&M Financial	Financial Consultant	750
Resolute Healthcare Solutions	Healthcare Billing	14,442
Ability Network	Computer Services	2,379
Bill.Com	Bill Payment Processing	2,660
See Attached Schedule 21A		57,979
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 257,515

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,019
Unemployment Compensation Insurance	13,917
FICA Taxes	144,637
Employee Health Insurance	26,771
Employee Meals	2,718
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	7,173
TOTAL (agree to Schedule V, line 22, col.8)	$ 231,235

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,493
Advertising: Employee Recruitment	14,080
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 3	31
Dues & Subscriptions	14,658
Licenses & Permits	250
Allocated from REX Therapeutics	7,107
Allocated from Management Co.	129
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,748

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	540
Allocated from Management Co.	106
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 646

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/2020**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Sharon Lofgren	Medicare Billing	3,600
Terrill Consulting Services, Inc.	Billing Consultant	16,460
Dyatech LLC	Benefits Consultant	188
InPath Security	Data Processing	8,098
eSolutions Inc	Data Processing	2,767
Experian Health, Inc.	Revenue Cycle Management	432
HDSI	Data Processing	1,750
Matrixcare	Data Processing	12,748
Paycor	Payroll Processing	10,019
Change Healthcare	Data Processing	1,048
Sedgwick CMS	Claims Management	700
TaxSaver Plan	Benefits Administration	52
Blymas, Inc.	Tax Credit Consultant	117
Total		**57,979**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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? **No**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,790** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **94,560**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **2,718** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Line 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.