

		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: 0012229 Facility Name: Bethesda Rehab Senior Care Address: 2833 N Nordica Ave Chicago 60634 Number City Zip Code County: Cook Telephone Number: 773-622-6144 Fax # 773-622-8261 HFS ID Number: Date of Initial License for Current Owners: 6/6/1959 Type of Ownership: X VOLUNTARY,NON-PROFIT X Charitable Corp. Trust IRS Exemption Code PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Deb Emerson Telephone Number: 317-569-6230 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) Bruce Harris (Title) Senior Controller Paid Preparer (Signed) (Print Name and Title) Deb Emerson Principal (Firm Name & Address) CLA - CliftonLarsonAllen 9365 Counselors Row, Suite 200, Indianapolis, IN 46240 (Telephone) 317-569-6230 Fax # 317-574-9707 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
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Facility Name & ID Number Bethesda Rehab Senior Care

0012229 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	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	<u>62</u>	Skilled (SNF)	<u>62</u>	<u>22,692</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>34</u>	Intermediate (ICF)	<u>34</u>	<u>12,444</u>	3
4		Intermediate/DD			4
5	<u>39</u>	Sheltered Care (SC)	<u>39</u>	<u>14,274</u>	5
6		ICF/DD 16 or Less			6
7	<u>135</u>	TOTALS	<u>135</u>	<u>49,410</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,086</u>	<u>5,882</u>	<u>4,599</u>	<u>28,567</u>	8
9	SNF/PED					9
10	ICF			<u>4,602</u>	<u>4,602</u>	10
11	ICF/DD					11
12	SC	<u>910</u>		<u>5,123</u>	<u>6,033</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,996</u>	<u>5,882</u>	<u>14,324</u>	<u>39,202</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.34%

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 1/1/1925

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 62 and days of care provided 4,599

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: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Bethesda Rehab Senior Care # 0012229 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	565,811	125,085	274,810	965,706		965,706		965,706			1
2	Food Purchase		388,329		388,329		388,329	(1,193)	387,136			2
3	Housekeeping	340,519	99,207	8,298	448,024		448,024		448,024			3
4	Laundry		2,153	92,206	94,359		94,359		94,359			4
5	Heat and Other Utilities			173,927	173,927		173,927	(6,114)	167,813			5
6	Maintenance	241,952		447,947	689,899		689,899		689,899			6
7	Other (specify):*											7
8	TOTAL General Services	1,148,282	614,774	997,188	2,760,244		2,760,244	(7,307)	2,752,937			8
	B. Health Care and Programs											
9	Medical Director			25,481	25,481		25,481		25,481			9
10	Nursing and Medical Records	4,035,914	134,642	514,825	4,685,381		4,685,381		4,685,381			10
10a	Therapy											10a
11	Activities	308,770	12,159	8,435	329,364		329,364		329,364			11
12	Social Services	112,983	11,218		124,201		124,201		124,201			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,457,667	158,019	548,741	5,164,427		5,164,427		5,164,427			16
	C. General Administration											
17	Administrative	180,888		512,602	693,490		693,490		693,490			17
18	Directors Fees											18
19	Professional Services			92,809	92,809		92,809	(2,051)	90,758			19
20	Dues, Fees, Subscriptions & Promotions			108,747	108,747		108,747	(14,889)	93,858			20
21	Clerical & General Office Expenses	373,181	11,992	996,395	1,381,568		1,381,568	(1,073,529)	308,039			21
22	Employee Benefits & Payroll Taxes			1,011,386	1,011,386		1,011,386	(7,702)	1,003,684			22
23	Inservice Training & Education					11,408	11,408		11,408			23
24	Travel and Seminar			13,380	13,380	(11,408)	1,972		1,972			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			186,927	186,927		186,927		186,927			26
27	Other (specify):*											27
28	TOTAL General Administration	554,069	11,992	2,922,246	3,488,307		3,488,307	(1,098,171)	2,390,136			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,160,018	784,785	4,468,175	11,412,978		11,412,978	(1,105,478)	10,307,500			29

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

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

Facility Name & ID Number Bethesda Rehab Senior Care #0012229 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			810,113	810,113		810,113	12,508	822,621			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			193,951	193,951		193,951		193,951			32
33	Real Estate Taxes			6,686	6,686		6,686	(6,686)				33
34	Rent-Facility & Grounds			2,621	2,621		2,621		2,621			34
35	Rent-Equipment & Vehicles			66,078	66,078		66,078		66,078			35
36	Other (specify):*			11,244	11,244		11,244	(11,244)				36
37	TOTAL Ownership			1,090,693	1,090,693		1,090,693	(5,422)	1,085,271			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		578,325	903,943	1,482,268		1,482,268		1,482,268			39
40	Barber and Beauty Shops			3,352	3,352		3,352		3,352			40
41	Coffee and Gift Shops			2,801	2,801		2,801		2,801			41
42	Provider Participation Fee			197,760	197,760		197,760		197,760			42
43	Other (specify):*			23,338	23,338		23,338	(23,338)				43
44	TOTAL Special Cost Centers		578,325	1,131,194	1,709,519		1,709,519	(23,338)	1,686,181			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,160,018	1,363,110	6,690,062	14,213,190		14,213,190	(1,134,238)	13,078,952			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.)

	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	(1,193)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,114)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,508	30		9
10	Interest and Other Investment Income				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	(7,702)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,044,758)	21		24
25	Fund Raising, Advertising and Promotional	(14,889)	20		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	(72,090)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,134,238)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,134,238)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (2,085)	21	1
2	Vending Income	(245)	21	2
3	Flowers Expense	(1,881)	21	3
4	Collection Fees	(112)	21	4
5	Bank Charges	(20,520)	21	5
6	Late Fees	(3,928)	21	6
7	Marketing Expense	(23,338)	43	7
8	Amortization Bond Fees	(11,244)	36	8
9	Non-Care Real Estate Taxes	(6,686)	33	9
10	Non-Allowable Legal	(2,051)	19	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	(72,090)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethesda Rehab Senior Care# 0012229

Report Period Beginning:

01/01/2020

Ending:

12/31/2020**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,193)	0	0	0	0	0	0	0	0	0	0	(1,193)	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	(6,114)	0	0	0	0	0	0	0	0	0	0	(6,114)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,307)	0	0	0	0	0	0	0	0	0	0	(7,307)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,051)	0	0	0	0	0	0	0	0	0	0	(2,051)	19
20	Fees, Subscriptions & Promotions	(14,889)	0	0	0	0	0	0	0	0	0	0	(14,889)	20
21	Clerical & General Office Expenses	(1,073,529)	0	0	0	0	0	0	0	0	0	0	(1,073,529)	21
22	Employee Benefits & Payroll Taxes	(7,702)	0	0	0	0	0	0	0	0	0	0	(7,702)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	(1,098,171)	0	0	0	0	0	0	0	0	0	0	(1,098,171)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,105,478)	0	0	0	0	0	0	0	0	0	0	(1,105,478)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethesda Rehab Senior Care # 0012229 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Capital Expense	PAGES	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	12,508	0	0	0	0	0	0	0	0	0	0	12,508	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(6,686)	0	0	0	0	0	0	0	0	0	0	(6,686)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(11,244)	0	0	0	0	0	0	0	0	0	0	(11,244)	36
37	TOTAL Ownership	(5,422)	0	0	0	0	0	0	0	0	0	0	(5,422)	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):*	(23,338)	0	0	0	0	0	0	0	0	0	0	(23,338)	43
44	TOTAL Special Cost Centers	(23,338)	0	0	0	0	0	0	0	0	0	0	(23,338)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,134,238)	0	0	0	0	0	0	0	0	0	0	(1,134,238)	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
				Norwood Management	Chicago, IL	Management Co
				Parasol Alliance	Chicago, IL	IT Support
				Anderson Rasor	Chicago, IL	Attorney
				Trinity Risk Solutions	St. Charles, IL	Insurance
				Quales Insurance	Chicago, IL	Insurance

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)	
1	V	17	Management Fees	\$ 512,602	Norwood Management Company		\$ 512,602		1
2	V	19	IT Support Services	66,845	Parasol Alliance		66,845		2
3	V	19	Legal Services	20,874	Anderson Rasor		20,874		3
4	V	26	Insurance	14,176	Trinity Risk Solutions		14,176		4
5	V	26	Insurance	122,474	Quales Insurance		122,474		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			\$ 736,971			\$ 736,971	\$ *	14

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

Facility Name & ID Number

Bethesda Rehab Senior Care

0012229

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Maria Gabriela Rodil	BOD						1
2	Michele Calbi	BOD						2
3	Robert Chiostrri	BOD						3
4	Dirk Danker	BOD						4
5	Susan Kroll	BOD						5
6	Ron Norene	BOD						6
7	Mike Schaik	BOD						7
8	Suzanne Venema	BOD						8
9	Michael Toohey	BOD						9
10	Silvia Morici	BOD						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 Bethesda Rehab Senior Care # 0012229 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 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 Bethesda Rehab Senior Care # 0012229 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	Fifth Third Bank		X	Constructino of Skilled Unit	\$35,878.45	12/15/15	\$ 7,517,000	\$ 5,939,848	9/1/23	2.4600	\$ 177,450	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	US Bank		X	Line of Credit	Int Only		410,000		None	Varies	16,501	6	
7												7	
8												8	
9	TOTAL Facility Related				\$35,878.45		\$ 7,927,000	\$ 5,939,848			\$ 193,951	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 7,927,000	\$ 5,939,848			\$ 193,951	15	

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

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

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

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.	\$	7,050	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.)			\$	6,753	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(297)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	6,983	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.			\$	6,686	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015		8	
		2016		9	
		2017		10	
		2018		11	
		2019	6,753	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.

FACILITY NAME Bethesda Rehab Senior Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012229

CONTACT PERSON REGARDING THIS REPORT Bruce Harris

TELEPHONE 773-577-5325 FAX #: 773-631-4850

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.

B. Real Estate Tax Cost Allocations

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.)

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.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,558

B. General Construction Type: Exterior BrickFrameNumber of Stories 4

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).

Apartment Buildings - 13 units

Land - Sayre Avenue (formerly rental houses)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	78,844	1919	\$ 13,589	1
2					2
3	TOTALS	78,844		\$ 13,589	3

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	135		1925	1925	\$ 182,722	\$		\$		\$ 182,722	4
5			1955	1955	657,001		65	7,574	7,574	657,001	5
6			1991	1991	2,123,475		50	42,470	42,470	1,271,734	6
7			1997	1997	263,809					263,809	7
8											8
	Improvement Type**										
9	Various			1956	4,130		20			4,130	9
10	Various			1957	4,771		20			4,771	10
11	Various			1958	14,177		20			14,177	11
12	Various			1960	27,510		20			27,510	12
13	Various			1966	15,090		20			15,090	13
14	Various			1970	434		20			434	14
15	Various			1975	5,599		20			5,599	15
16	Various			1976	10,615		20			10,615	16
17	Various			1978	12,100		20			12,100	17
18	Various			1985	8,596		20			8,596	18
19	Various			1986	1,436,330		20			1,436,330	19
20	Various			1987	6,537		20			6,537	20
21	Various			1988	50,000		20			50,000	21
22	Various			1991	1,343,365		20			1,343,365	22
23	Various			1992	52,486		20			52,486	23
24	Various			1993	59,772		20			59,772	24
25	Various			1994	4,298		20			4,298	25
26	Various			1995	80,569		20			80,569	26
27	Various			1996	136,115		20			136,115	27
28	Various			1997	123,231		20			123,231	28
29	Various			1998	122,204		20			122,204	29
30	Various			1999	178,878		20			178,878	30
31	Various			2000	1,119,263		20			1,119,263	31
32	Various			2001	140,009		20	3,882	3,882	140,009	32
33	Various			2002	432,861		20	21,748	21,748	432,861	33
34	Various			2003	614,916		20	30,746	30,746	614,916	34
35	Various			2004	33,366		20	3,527	3,527	33,366	35
36	Various			2006	255,425		20	12,771	12,771	255,425	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 Bethesda Rehab Senior Care

0012229

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2007	\$ 25,509	\$	20	\$ 1,275	\$ 1,275	\$ 17,856	37
38	Various	2008	3,775		20	189	189	2,454	38
39	Various	2009	124,806		20	6,240	6,240	74,883	39
40	Various	2011	138,555		20	6,944	6,944	69,441	40
41	Various	2012	208,170		20	10,409	10,409	93,677	41
42	Various	2013	43,628		20	2,181	2,181	17,451	42
43	Various	2014	234,807		20	11,740	11,740	82,182	43
44	Various	2015	282,143		20	14,107	14,107	84,643	44
45	Various	2016	104,683		20	4,235	4,235	25,171	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)		\$ 10,685,730	\$		\$ 180,038	\$ 180,038	\$ 9,135,671	70

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

Facility Name & ID Number Bethesda Rehab Senior Care

0012229

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,685,730	\$		\$ 180,038	\$ 180,038	\$ 9,135,671	1
2	Garbage Enclosure - Code Upgrade	2017	26,851		20	1,343	1,343	5,371	2
3	Diamond Rehab Expansion-Construction, Architech, Civil	2017	6,999,629		20	349,981	349,981	1,399,925	3
4	Engineering, Legal, Consulting & Compliance, Foreman	2017							4
5	Technology Wiring	2017	17,442		20	872	872	3,488	5
6	Elevator Upgrd, North Bldg	2017	6,910		20	346	346	1,383	6
7	Phone System Upgrade	2017	10,751		20	538	538	2,151	7
8	Security Cameras	2017	11,212		20	561	561	2,243	8
9	Nurse Call System Upgrade	2017	7,925		20	396	396	1,585	9
10	Boiler, Kitchen	2017	3,208		20	160	160	641	10
11	Roof Repairs	2017	2,895		20	145	145	579	11
12	Ms Renovation - Plumbing	2018	42,829		20	2,141	2,141	4,282	12
13	Alarm Panel Installation	2018	2,688		20	134	134	268	13
14	Gazebo Roof	2018	2,700		20	135	135	270	14
15	Led Light Fixtures - 4th Floor	2018	2,795		20	140	140	280	15
16	Fire Sprinkler System - Jockey Pump	2018	3,237		20	162	162	324	16
17	Front Walk-Way Canopy	2018	3,900		20	195	195	390	17
18	Common Area Restroom Granite & Public Bathroom Toilets	2018	4,180		20	209	209	418	18
19	AC Unit	2018	4,365		20	218	218	436	19
20	Plumbing Repair	2018	4,500		20	225	225	450	20
21	Conference Room Remodel - Granite Countertop	2018	6,024		20	301	301	602	21
22	Office Lighting Fixtures, Ceiling, Paint, Electrical work	2018	4,750		20	238	238	476	22
23	Wall Covering - 1st Floor	2018	6,986		20	349	349	698	23
24	Front Entrance Lighting	2018	7,045		20	352	352	704	24
25	West Elevator - Replace Tamper Switch	2018	7,160		20	358	358	716	25
26	Office/Shop-Lighting Fixtures, Ceiling, Painting, Electrical	2018	8,750		20	438	438	876	26
27	HVAC	2018	12,427		20	621	621	1,242	27
28	Tub - 1C	2018	12,810		20	641	641	1,282	28
29	Tub - 3rd Floor	2018	12,810		20	641	641	1,282	29
30	Flooring 3rd Floor	2018	13,204		20	660	660	1,320	30
31	Memory Support Unit - Tub	2018	13,279		20	664	664	1,328	31
32	2nd Floor Center - Tub	2018	13,279		20	664	664	1,328	32
33	Unit 206 Rms/Bathrms-ceiling, walls, tile, new lighting, elec	2018	15,165		20	758	758	1,516	33
34	TOTAL (lines 1 thru 33)		\$ 17,977,436	\$		\$ 544,624	\$ 544,624	\$ 10,573,525	34

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

Facility Name & ID Number Bethesda Rehab Senior Care

0012229

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 17,977,436	\$		\$ 544,624	\$ 544,624	\$ 10,573,525	1
2	24 Through Wall AC Units	2018	15,640		20	782	782	1,564	2
3	Flooring - Hallways and Chapel	2018	15,650		20	783	783	1,566	3
4	Unit 201 Rms/Bathrms-Ceiling, walls, tile, lighting, electric	2018	15,651		20	783	783	1,566	4
5	Flooring 1st Floor Common Areas	2018	17,263		20	863	863	1,726	5
6	Nurse Call and Wander Guard - 4th Floor	2018	35,001		20	1,750	1,750	3,500	6
7	Flooring - 4th Floor	2018	48,989		20	2,449	2,449	4,898	7
8	MS Unit Reno-Rms/Bathrm Remodel, Electric work	2018	338,156		20	16,908	16,908	33,816	8
9	Lobby - Men/Womens Bathroom Remodeling/Toilets	2018	16,990		20	850	850	1,700	9
10	3rd Flr Rms/Bathrooms-Ceiling, walls, tile, lighting, electric	2018	221,133		20	11,057	11,057	22,114	10
11	3N - Repair Failed Mortor Starter	2018	2,675		20	134	134	268	11
12	Damper Repair	2018	5,667		20	283	283	566	12
13	Repair Hot Water Boiler - Loop Leaks/Low Pressure	2018	15,498		20	775	775	1,550	13
14	Front Garden Patio Pavement Installation and Repair	2019	2,760		20	138	138	276	14
15	Cut Opening for new Window in Bathroom	2019	2,908		20	145	145	290	15
16	Sanitary Pipe Covering In Kitchen	2019	3,150		20	158	158	316	16
17	HVAC Riser - M. Toughy Office	2019	3,852		20	193	193	386	17
18	Rooftop Repair - Staircase/Elevator Tower	2019	4,260		20	213	213	426	18
19	4 Floors - building Plans & Measurements Drawing	2019	4,335		20	217	217	434	19
20	Roof Leak Repair	2019	4,490		20	225	225	450	20
21	Office Remodeling - Paint Walls, Replace Tile, Window	2019	4,750		20	238	238	476	21
22	Repair Gasket on HVAC Pipe - Center Bldg	2019	5,124		20	256	256	512	22
23	New Custom Windows - 2nd fl rm W213, W215	2019	5,270		20	264	264	528	23
24	Install Backflow Preventors for Water Supply Line	2019	5,305		20	265	265	530	24
25	Paint Lobby & West Hallway	2019	6,337		20	317	317	634	25
26	Paint Walls in Training Room	2019	6,819		20	341	341	682	26
27	New Rubber/Roof - West Building	2019	7,642		20	382	382	764	27
28	Exhaust Fan Replacement - Center Bldg	2019	8,170		20	409	409	818	28
29	Sink Installation - Food prep areas	2019	8,450		20	423	423	846	29
30	Exhaust Fan Installation - 1st, 2nd, 4th, Flr Bathrooms	2019	8,976		20	449	449	898	30
31	Admin Office Remodel - New Flooring	2019	9,683		20	484	484	968	31
32	2nd Flr Dining Rm Repair and Paint Walls, Install Lights	2019	11,486		20	574	574	1,148	32
33	Side Stream Filters for HVAC/5 Heating Loops	2019	13,385		20	669	669	1,338	33
34	TOTAL (lines 1 thru 33)		\$ 18,852,901	\$		\$ 588,401	\$ 588,401	\$ 10,661,079	34

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

Facility Name & ID Number Bethesda Rehab Senior Care

0012229

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 18,852,901	\$		\$ 588,401	\$ 588,401	\$ 10,661,079	1
2	Masonry Work-Rebuild/Repair Fire Wall in Courtyard Bldg	2019	16,218			811	811	1,622	2
3	Life Enrichment Office - Install Flooring, Paint Walls	2019	16,952			848	848	1,696	3
4	Paint Lobby	2019	18,758			938	938	1,876	4
5	Window Installation	2019	23,589			1,179	1,179	2,358	5
6	South Parking - Tore out and Replaced Entire Lot	2019	24,400			1,220	1,220	2,440	6
7	2nd Flr Common Area/Dining Rm - Door Installation	2019	29,859			1,493	1,493	2,986	7
8	3rd Fl Common Areas/Bathrooms - Door Installation	2019	30,884			1,544	1,544	3,088	8
9	Fan Coil Unit Replacements	2019	39,003			1,950	1,950	3,900	9
10	2nd Flr Tub Rm Reno - Flooring Installation,Electrical Work	2019	69,372			3,469	3,469	6,938	10
11	Boiler Plant - Replace 10 Heat Pumps	2019	94,374			4,719	4,719	9,438	11
12	West Building - Repiping	2019	95,841			4,792	4,792	9,584	12
13	Remodeling of Rms and Bathrooms on 2nd/3rd Flr Units	2019	915,598			45,780	45,780	91,560	13
14	Fron Door Entry Repair - Auto Operator	2019	2,523			126	126	252	14
15	Domestic Hot Water Boiler Repair	2019	3,433			172	172	344	15
16	4th Flr Chiller Repair - Replace Flow Switch	2019	3,309			165	165	330	16
17	Tuckpointing - 3rd Floor and Chapel	2019	3,316			166	166	332	17
18	West Building - Tuckpointing - Leak Repair	2019	12,496			625	625	1,250	18
19	New Window Installation	2019	4,396			220	220	440	19
20	Plumbing - 3rd Floor Dining Room, 4th Floor	2019	88,664			4,433	4,433	8,866	20
21	Carpet Tile - 1 Center	2020	1,237			227	227	227	21
22	Hot Water Pump Replacement-West Bldg	2020	3,950			329	329	329	22
23	Repair Boiler 1, 2 & 3	2020	1,426			95	95	95	23
24	Chiller Ground Level	2020	15,132			336	336	336	24
25	Replace Balancing Valve in Attic-Installation	2020	2,850			48	48	48	25
26									26
27									27
28									28
29									29
30									30
31									31
32	Financial Statement Depreciation			651,578			(651,578)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 20,370,481	\$ 651,578		\$ 664,086	\$ 12,508	\$ 10,811,414	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,812,107	\$153,655	\$153,655	\$	10	\$	71
72	Current Year Purchases	30,246	4,880	4,880		10	4,880	72
73	Fully Depreciated Assets	100,902					100,902	73
74								74
75	TOTALS	\$1,943,255	\$158,535	\$158,535	\$		\$105,782	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)	\$22,327,325	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$810,113	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$822,621	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$12,508	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$10,917,196	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	East Building Renovation - Prior 2017	\$1,478,812	\$	\$	86
87	Furnishings - 2017	6,074			87
88	Land - Sayre Avenue - 2017	926,411			88
89					89
90					90
91	TOTALS	\$2,411,297	\$	\$	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: 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	Off-Site Document Storage				2,621			5
6								6
7	TOTAL				\$ 2,621			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? YES NO X
16. Rental Amount for movable equipment: \$ 55,878 Description: Copiers
(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.

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

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 274,359	\$		\$ 274,359	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			127,088			127,088	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			331,953			331,953	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				300,363		300,363	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): Various Ancillary	39.2					277,962		277,962	12
13	Other (specify): X-Ray, Lab, Etc.	39-3				170,543			170,543	13
14	TOTAL			\$		\$ 903,943	\$ 578,325		\$ 1,482,268	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.

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	\$ 668,832	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,831,220)	2,124,069		3
4	Supply Inventory (priced at cost)	42,178		4
5	Short-Term Investments	164,995		5
6	Prepaid Insurance	10,711		6
7	Other Prepaid Expenses	62,252		7
8	Accounts Receivable (owners or related parties)	1,845,842		8
9	Other(specify): <u>Misc. Receivables</u>	18,649		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,937,528	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	940,000		13
14	Buildings, at Historical Cost	9,962,825		14
15	Leasehold Improvements, at Historical Cost	10,416,946		15
16	Equipment, at Historical Cost	2,076,757		16
17	Accumulated Depreciation (book methods)	(10,505,026)		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): <u>Bond Issuance Fees</u>	30,929		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,922,431	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,859,959	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 771,703	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	254,865		29
30	Accrued Salaries Payable	369,554		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,091		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,983		32
33	Accrued Interest Payable	12,986		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,567,916		36
37	<u>COVID-19 Advance</u>	542,045		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,555,143	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,684,983		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	2,512,635		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 8,197,618	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,752,761	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 6,107,198	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,859,959	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,151,861	1
2	Restatements (describe):		2
3	PY Audit Adjustments	(217,758)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,934,103	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	173,092	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) Rounding	3	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 173,095	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)	\$ 6,107,198	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bethesda Rehab Senior Care

0012229

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,438,400	1
2	Discounts and Allowances for all Levels	(4,736,931)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,701,469	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,494,475	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,494,475	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,983	12
13	Barber and Beauty Care	3,824	13
14	Non-Patient Meals	1,193	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	314,414	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	64,070	19
20	Radiology and X-Ray	15,501	20
21	Other Medical Services	352,505	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 754,490	23
	D. Non-Operating Revenue		
24	Contributions	1,108,850	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,108,850	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	70,105	28
28a	COVID-19 PHE Funding	2,256,893	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,326,998	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,386,282	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,760,244	31
32	Health Care	5,164,427	32
33	General Administration	3,488,307	33
	B. Capital Expense		
34	Ownership	1,090,693	34
	C. Ancillary Expense		
35	Special Cost Centers	1,511,759	35
36	Provider Participation Fee	197,760	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,213,190	40
41	Income before Income Taxes (line 30 minus line 40)**	173,092	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 173,092	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,111,604	44
45	Private Pay - Net Inpatient Revenue	2,689,673	45
46	Medicare - Net Inpatient Revenue	2,012,281	46
47	Other-(specify) <u>Respite, Memory Support</u>	1,266,616	47
48	Other-(specify) <u>Insurance, ManagedCare (BC), Other</u>	1,621,295	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,701,469	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,767	1,767	\$ 102,827	\$ 58.19	1
2	Assistant Director of Nursing	2,434	2,434	111,272	45.72	2
3	Registered Nurses	38,756	38,756	1,392,932	35.94	3
4	Licensed Practical Nurses	15,822	15,822	482,768	30.51	4
5	CNAs & Orderlies	105,308	105,308	1,841,874	17.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,950	1,950	53,860	27.62	9
10	Activity Assistants	14,565	14,565	254,910	17.50	10
11	Social Service Workers	4,079	4,079	112,983	27.70	11
12	Dietician					12
13	Food Service Supervisor	2,081	2,081	45,807	22.01	13
14	Head Cook	6,447	6,447	124,730	19.35	14
15	Cook Helpers/Assistants	27,661	27,661	395,274	14.29	15
16	Dishwashers					16
17	Maintenance Workers	10,962	10,962	241,952	22.07	17
18	Housekeepers	19,908	19,908	340,519	17.10	18
19	Laundry					19
20	Administrator	3,740	3,740	180,888	48.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,077	15,077	373,181	24.75	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	2,041	2,041	45,403	22.25	31
32	Other Health C: <u>Director of MS</u>	1,950	1,950	58,838	30.17	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	274,548	274,548	\$ 6,160,018 *	\$ 22.44	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 230,705	1-3	35
36	Medical Director		25,481	9-3	36
37	Medical Records Consultant		455	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,690	39-3	39
40	Physical Therapy Consultant		484	39-3	40
41	Occupational Therapy Consultant		250	39-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		537	11-3	44
45	Social Service Consultant				45
46	Other(specify) <u>Chaplain</u>	Stipend	11,000	12-3	46
47	<u>MDS</u>		74,370	10-3	47
48	_____				48
49	TOTAL (lines 35 - 48)		\$ 352,972		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	579	\$ 40,656	10-3	50
51	Licensed Practical Nurses	799	43,098	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,378	\$ 83,754		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberBethesda Rehab Senior Care# 0012229Report Period Beginning:01/01/2020Ending:12/31/2020Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Erin Conley	Administrator	0	\$ 94,105
Paul Lloyd	Administrator	0	86,783
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 180,888

B. Administrative - Other

Description	Amount
Norwood Management Company - Management Fees	\$ 512,602
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kronos	Payroll Processing	\$ 21,190
Marcum LLP	Accounting	24,811
CLA	Accounting	3,862
Anderson Rasor	Legal	23,953
Klein, Paull, Holleb & Jacobs Ltd.	Legal	3,600
Berens-Tate Consulting Group	Legal	700
Legal Fees Revenue Bond	Legal	12,642
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 90,758

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 86,218
Unemployment Compensation Insurance	24,273
FICA Taxes	453,121
Employee Health Insurance	366,715
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Incentive & Recognition	11,475
401K Plan	61,882
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	31,754
Health Care Worker Background Check (Indicate # of checks performed 52)	1,436
Patient Background Checks	1463,531
Dues & Subscriptions	19,972
Employee Medical Testing	35,175
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	1,972
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,972

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>No</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>Leading Age - \$8,081</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>Yes</u> <u>Yes</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>10 years</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>77,570</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	YES <u>NO</u> <u>X</u> <u>N/A</u>
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.	\$ <u>197,760</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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?	<u>Yes</u>
(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? 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.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?	\$ <u>No</u> <u>Yes</u> Indicate the amount. \$ <u>1,193</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?	<u>No</u> <u>No</u> \$ <u>N/A</u> <u>N/A</u> <u>No</u> <u>N/A</u> <u>N/A</u>
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>N/A</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>Yes</u> <u>CLA</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?	<u>Yes</u>
(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. Attach invoices and a summary of services for all architect and appraisal fees.	<u>Yes</u>