

		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: <u>0056275</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Dunham Rehab Healthcare</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>2/1/2020</u> to <u>12/31/2020</u> 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.																							
Address: <u>850 Dunham Road</u> <u>St Charles</u> <u>60174</u>																									
Number City Zip Code																									
County: <u>Kane</u>																									
Telephone Number: <u>(630) 443-6146</u> Fax # <u>(630) 443-4461</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>David Trimble</u></td></tr><tr><td>(Title) <u>Vice President, Reimbursement</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>David Trimble</u>	(Title) <u>Vice President, Reimbursement</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
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	(Type or Print Name) <u>David Trimble</u>																								
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	(Date) _____																								
Paid Preparer	(Signed) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>2/1/2020</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>David Trimble</u> Telephone Number: <u>(813)675-2318</u>																									
Email Address: _____																									

Facility Name & ID Number Dunham Rehab Healthcare

0056275 Report Period Beginning: 2/1/2020 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 _____

	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	109	Skilled (SNF)	109	36,515	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	36,515	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	18,556	4,420	5,608	28,584	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,556	4,420	5,608	28,584	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.28%

D. How many bed reserve days during this year were paid by the Department? N/A (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) N/A

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 2/1/2020

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 2/1/2020 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 109 and days of care provided 2,829

Medicare Intermediary Novitas Solutions, Inc.

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 Dunham Rehab Healthcare # 0056275 Report Period Beginning: 2/1/2020 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 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	90,570	9,008	204,230	303,808		303,808	4,323	308,131			1
2	Food Purchase		185,847		185,847		185,847		185,847			2
3	Housekeeping			190,930	190,930		190,930		190,930			3
4	Laundry		5,625	84,962	90,587		90,587		90,587			4
5	Heat and Other Utilities			216,218	216,218		216,218	(12,884)	203,334			5
6	Maintenance	42,304	11,278	86,108	139,690		139,690	1,540	141,230			6
7	Other (specify):*											7
8	TOTAL General Services	132,874	211,758	782,448	1,127,080		1,127,080	(7,021)	1,120,059			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	2,493,436	629,656	250,575	3,373,667		3,373,667	102,092	3,475,759			10
10a	Therapy		992	498,573	499,565		499,565	(365,501)	134,064			10a
11	Activities	85,139	1,283	2,501	88,923		88,923		88,923			11
12	Social Services	52,206		2,104	54,310		54,310		54,310			12
13	CNA Training											13
14	Program Transportation			3,230	3,230		3,230		3,230			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,630,781	631,931	767,983	4,030,695		4,030,695	(263,409)	3,767,286			16
	C. General Administration											
17	Administrative	124,599		367,479	492,078		492,078	29,347	521,425			17
18	Directors Fees											18
19	Professional Services			14,092	14,092		14,092		14,092			19
20	Dues, Fees, Subscriptions & Promotions			9,984	9,984		9,984	(953)	9,031			20
21	Clerical & General Office Expenses	242,582	20,206	282,610	545,398		545,398	(138,659)	406,739			21
22	Employee Benefits & Payroll Taxes			423,244	423,244		423,244		423,244			22
23	Inservice Training & Education			1,067	1,067		1,067		1,067			23
24	Travel and Seminar			4,807	4,807		4,807		4,807			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			122,714	122,714		122,714		122,714			26
27	Other (specify):*											27
28	TOTAL General Administration	367,181	20,206	1,225,997	1,613,384		1,613,384	(110,265)	1,503,119			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,130,836	863,895	2,776,428	6,771,159		6,771,159	(380,695)	6,390,464			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							101,847	101,847			30
31	Amortization of Pre-Op. & Org.			226	226		226	(226)				31
32	Interest			107,872	107,872		107,872	186,080	293,952			32
33	Real Estate Taxes			164,374	164,374		164,374	(2,758)	161,616			33
34	Rent-Facility & Grounds			203,110	203,110		203,110	(188,578)	14,532			34
35	Rent-Equipment & Vehicles			6,883	6,883		6,883		6,883			35
36	Other (specify):*											36
37	TOTAL Ownership			482,465	482,465		482,465	96,365	578,830			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		160,984	18,305	179,289		179,289	368,110	547,399			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			203,214	203,214		203,214		203,214			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		160,984	221,519	382,503		382,503	368,110	750,613			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,130,836	1,024,879	3,480,412	7,636,127		7,636,127	83,780	7,719,907			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				4
5	Telephone, TV & Radio in Resident Rooms	(12,884)	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				9
10	Interest and Other Investment Income	(1,397)	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	(37)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(151,284)	21		24
25	Fund Raising, Advertising and Promotional	(953)	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	(5,846)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (172,401)		\$	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)	256,181		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 256,181		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 83,780		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	Misc Rev Other	\$ (2,862)	21	1
2	Amortization of Operating Rights	(226)	31	2
3	Real Estate Tax to Actual	(2,758)	33	3
4	Medicare Therapy Costs	368,110	39	4
5	Medicare Therapy Costs	(368,110)	10a	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
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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	(5,846)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Dunham Rehab Healthcare# 0056275

Report Period Beginning:

2/1/2020

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	4,323	0	0	0	0	0	0	0	0	0	4,323	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(12,884)	0	0	0	0	0	0	0	0	0	0	(12,884)	5
6	Maintenance	0	1,540	0	0	0	0	0	0	0	0	0	1,540	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,884)	5,863	0	0	0	0	0	0	0	0	0	(7,021)	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	102,092	0	0	0	0	0	0	0	0	0	102,092	10
10a	Therapy	(368,110)	2,609	0	0	0	0	0	0	0	0	0	(365,501)	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	(368,110)	104,701	0	0	0	0	0	0	0	0	0	(263,409)	16
	C. General Administration													
17	Administrative	0	29,347	0	0	0	0	0	0	0	0	0	29,347	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(953)	0	0	0	0	0	0	0	0	0	0	(953)	20
21	Clerical & General Office Expenses	(154,183)	15,524	0	0	0	0	0	0	0	0	0	(138,659)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	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	(155,136)	44,871	0	0	0	0	0	0	0	0	0	(110,265)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(536,130)	155,435	0	0	0	0	0	0	0	0	0	(380,695)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Dunham Rehab Healthcare # 0056275 Report Period Beginning: 2/1/2020 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	0	101,847	0	0	0	0	0	0	0	0	0	101,847	30
31	Amortization of Pre-Op. & Org.	(226)	0	0	0	0	0	0	0	0	0	0	(226)	31
32	Interest	(1,397)	187,477	0	0	0	0	0	0	0	0	0	186,080	32
33	Real Estate Taxes	(2,758)	0	0	0	0	0	0	0	0	0	0	(2,758)	33
34	Rent-Facility & Grounds	0	(188,578)	0	0	0	0	0	0	0	0	0	(188,578)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,381)	100,746	0	0	0	0	0	0	0	0	0	96,365	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	368,110	0	0	0	0	0	0	0	0	0	0	368,110	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	368,110	0	0	0	0	0	0	0	0	0	0	368,110	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(172,401)	256,181	0	0	0	0	0	0	0	0	0	83,780	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
NH Operator Holdings VII LLC	100	Edwardsville NH LLC	Edwardsville,IL	Wood River NH LLC	Wood River, IL	Supportive Living Facility
850 Dunham Road LLC	0	Rockford NH LLC	Rockford,IL	Springs of Lady Lake	Lady Lake,FL	Assisted Living Facility
Greystone Healthcare Management Corp	0	Moline NH LLC	Moline,IL	Greystone Home Health	Orlando, FL	Home Health
		Elgin NH LLC	Elgin,IL	Greystone Home Health	Sun City Center, FL	Home Health
		Inverness NH LLC	Inverness,IL	Greystone Home Health	Clearwater, FL	Home Health
		Northbrook NH LLC	Northbrook,IL	Greystone Home Health	The Villages, FL	Home Health
		See Page 6 - Supplemental	See Page 6 - Supplemental	See Page 6 - Supplemental	See Page 6 - Supplemental	See Page 6 - Supplemental

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

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

1 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	17	Home Office Cost - Admin	\$ 367,479	Greystone Healthcare Management Corp.	0.00%	\$ 359,264	\$ (8,215)	1
2	V	10	Home Office Cost - Nursing		Greystone Healthcare Management Corp.	0.00%	98,188	98,188	2
3	V	1	Home Office Cost - Dietary		Greystone Healthcare Management Corp.	0.00%	4,323	4,323	3
4	V	10a	Home Office Cost - Ancillary		Greystone Healthcare Management Corp.	0.00%	2,609	2,609	4
5	V	34	Home Office Cost - Property		Greystone Healthcare Management Corp.	0.00%	14,532	14,532	5
6	V	34	Rent	203,110	850 Dunham Road LLC	0.00%		(203,110)	6
7	V	32	Interest		850 Dunham Road LLC	0.00%	187,477	187,477	7
8	V	30	Depreciation/Amortization		850 Dunham Road LLC	0.00%	101,847	101,847	8
9	V	17	Other Administrative		850 Dunham Road LLC	0.00%	37,562	37,562	9
10	V	6	Expense Equip - Maintenance		850 Dunham Road LLC	0.00%	1,540	1,540	10
11	V	10	Expense Equip - Nursing		850 Dunham Road LLC	0.00%	3,904	3,904	11
12	V	21	Expense Equip - Admin		850 Dunham Road LLC	0.00%	15,524	15,524	12
13	V								13
14	Total			\$ 570,589			\$ 826,770	\$ * 256,181	14

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

Facility Name & ID Number

Dunham Rehab Healthcare

0056275

Report Period Beginning:

2/1/2020

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			Joliet NH LLC	Joliet,IL	Greystone Home Health	Daytona Beach, FL	Home Health	1
2			East Peoria NH LLC	East Peoria,IL	Solana Home Health A	Sarasota, FL	Home Health	2
3			Alton NH LLC	Alton,IL				3
4			Peoria NH LLC	Peoria,IL				4
5			St. Louis NH LLC	St. Louis,MO				5
6			Alhambra NH, L.L.C.	Saint Petersburg,FL				6
7			Greenbrook NH, L.L.C.	Saint Petersburg,FL				7
8			LP Orlando LLC	Apopka,FL				8
9			Carlton Shores NH LLC	Daytona Beach,FL				9
10			Greenbriar NH, L.L.C.	Bradeenton,FL				10
11			Isle Health NH LLC	Orange Park,FL				11
12			La Mer LLC	Miami,FL				12
13			Lady Lake NH, L.L.C.	Lady Lake,FL				13
14			Lehigh Acres NH LLC	Lehigh Acres,FL				14
15			Colonial Care NH, L.L.C.	Saint Petersburg,FL				15
16			Heritage NH, L.L.C.	North Miami Beach,FL				16
17			North Rehab NH, L.L.C.	Saint Petersburg,FL				17
18			The Oaks NH, L.L.C.	Gainesville,FL				18
19			Ridgecrest NH, L.L.C.	Deland,FL				19
20			Riverwood Health NH LLC	Starke,FL				20
21			Rockledge NH, L.L.C.	Rockledge,FL				21
22			Venice NH, L.L.C.	Venice,FL				22
23			Terrace Health NH LLC	Gainesville,FL				23
24			Mulberry Grove NH LLC	The Villages,FL				24
25			Gardens Health NH LLC	Daytona Beach,FL				25
26			Citrus Hills NH LLC	Hernando,FL				26
27			Innovative Medical Management Solutions LLC	Clermont,FL				27
28			New Horizon NH, L.L.C.	Ocala,FL				28
29			Ponce NH LLC	St. Augustine,FL				29
30			See PG6-Supp (2)	See PG6-Supp (2)				30

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			Jackson Heights NH, L.L.C.	Miami,FL				1
2			Viera NH LLC	Viera,FL				2
3			Villa Health NH LLC	Deland,FL				3
4			Village Place NH LLC	Port Charlotte,FL				4
5			Palm Court NH, L.L.C.	Wilton Manors,FL				5
6			Woodland Grove NH LLC	Jacksonville,FL				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Dunham Rehab Healthcare # 0056275 Report Period Beginning: 2/1/2020 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 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 Dunham Rehab Healthcare # 0056275 Report Period Beginning: 2/1/2020 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 ☒ NO ☐

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

Name of Related Organization Greystone Healthcare Management Corp
Street Address 4042 Park Oaks Blvd., Suite 300
City / State / Zip Code Tampa, FL 33610
Phone Number (813)675-2318
Fax Number (813) 635-0008

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	10	Clinical Nursing	Accumulated Costs	462,711,567	43	\$ 6,254,384	\$	7,264,125	\$ 98,188	1
2	1	Dietary	Accumulated Costs	465,656,695	44	277,112		7,264,125	4,323	2
3	10a	Ancillary	Accumulated Costs	460,282,346	42	165,316		7,264,125	2,609	3
4	34	Property	Accumulated Costs	481,058,730	50	962,398		7,264,125	14,532	4
5	17	Admin	Accumulated Costs	481,058,730	50	23,791,846		7,264,125	359,264	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					\$ 31,451,056	\$		\$ 478,916	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	Mizuho Capital Markets LLC		X	Mortgage		2/1/20	\$ 2,902,165	\$ 2,902,165	2/1/2045	0.0700	\$ 187,477	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Mizuho Capital Markets LLC		X	Line of Credit		2/1/20	1,676,041	1,676,041	2/1/2025	0.0700	107,872	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,578,206	\$ 4,578,206			\$ 295,349	9	
	B. Non-Facility Related*												
10	Interest Income/Misc Rev Int		X								(1,397)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,397)	14	
15	TOTALS (line 9+line14)						\$ 4,578,206	\$ 4,578,206			\$ 293,952	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

[illegible]

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dunham Rehab Healthcare COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0056275

CONTACT PERSON REGARDING THIS REPORT David Trimble

TELEPHONE (813) 675 - 2318 FAX #: (813) 635 - 0008

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 09-26-226-008	Long Term Care Property	\$ 176,307.88	\$ 176,307.88
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 176,307.88	\$ 176,307.88

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

40,012

B. General Construction Type:

Exterior

Brick Veneer

Frame

Steel

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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:

N/A

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

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Facility Land	380,845	2020	\$ 402,419	1
2	Nursing Facility	40,012	2020		2
3	TOTALS	420,857		\$ 402,419	3

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	109	2020	1999	\$ 2,554,697	\$ 78,057	39	\$ 78,057		\$ 78,057	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1 A/C Compressor		2020	6,448	461	7	461		461	9
10	Meter Cap for Water Softner, Orins		2020	5,176	308	7	308		308	10
11	2 Water Pumps		2020	7,099	423	7	423		423	11
12	2 Boilers		2020	11,724	391	15	391		391	12
13	Water Valves for Water Softener		2020	2,529	84	15	84		84	13
14	Roof Replacement		2020	188,470	5,235	15	5,235		5,235	14
15	Parking Lot Resurface		2020	30,961	1,548	15	1,548		1,548	15
16	Iron Fence		2020	4,800	160	15	160		160	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

****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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	110,572	15,180	15,180		5-7	15,180	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 110,572	\$ 15,180	\$ 15,180	\$		\$ 15,180	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	3,324,895
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	101,847
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	101,847
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	101,847

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$ 624,241
93		
94		
95		\$ 624,241

* 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: _____
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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 | \$ |

* 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	\$		\$ 137,502	\$		\$ 137,502	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			50,359			50,359	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			180,249			180,249	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			1,650			1,650	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				160,984		160,984	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):	39-3				790			790	12
13	Other (specify): Lab/X-Ray	39-3				15,866			15,866	13
14	TOTAL			\$		\$ 386,416	\$ 160,984		\$ 547,399	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 19,302	\$ 27,038	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 146,991)	1,145,106	1,145,106	3
4	Supply Inventory (priced at cost)	13,683	13,683	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,071	15,071	6
7	Other Prepaid Expenses	7,453	7,453	7
8	Accounts Receivable (owners or related parties)	50,330	80,802	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,250,945	\$ 1,289,153	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,419	13
14	Buildings, at Historical Cost		2,554,697	14
15	Leasehold Improvements, at Historical Cost		238,484	15
16	Equipment, at Historical Cost		150,261	16
17	Accumulated Depreciation (book methods)		(103,922)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	15,680	35,913	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(226)	(3,931)	20
21	Restricted Funds		483,639	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP		624,241	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,454	\$ 4,381,801	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,266,399	\$ 5,670,954	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 786,967	\$ 1,054,318	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,239	146,239	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,684	5,999	31
32	Accrued Real Estate Taxes(Sch.IX-B)	164,374	164,374	32
33	Accrued Interest Payable		17,050	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	50,169	61,719	36
37	Accounts Payable - Related Parties	453,142	574,351	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,606,575	\$ 2,024,050	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		2,902,165	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)	\$	\$ 2,902,165	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,606,575	\$ 4,926,215	46
47	TOTAL EQUITY(page 18, line 24)	\$ (340,176)	\$ 744,739	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,266,399	\$ 5,670,954	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	288,029	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,914,150	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(4,542,355)	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)	\$ (340,176)	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)	\$ (340,176)	24

* This must agree with page 17, line 47.

Facility Name & ID Number Dunham Rehab Healthcare

0056275

Report Period Beginning: 2/1/2020

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.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,552,611	1
2	Discounts and Allowances for all Levels	(3,001,440)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,551,171	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,516,635	6
7	Oxygen	9,368	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,526,003	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	574,579	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	225,679	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,042	19
20	Radiology and X-Ray	9,423	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 842,723	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,397	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,397	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Rev Other</u>	2,862	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,862	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,924,156	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,127,080	31
32	Health Care	4,030,695	32
33	General Administration	1,613,384	33
	B. Capital Expense		
34	Ownership	482,465	34
	C. Ancillary Expense		
35	Special Cost Centers	179,289	35
36	Provider Participation Fee	203,214	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,636,127	40
41	Income before Income Taxes (line 30 minus line 40)**	288,029	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 288,029	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,335,876	44
45	Private Pay - Net Inpatient Revenue	1,011,503	45
46	Medicare - Net Inpatient Revenue	563,607	46
47	Other-(specify) <u>HMO/Ins</u>	395,949	47
48	Other-(specify) <u>Hospice</u>	244,236	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,551,171	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.

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	1,773	1,853	\$ 100,924	\$ 54.47	1
2	Assistant Director of Nursing	632	656	28,438	43.35	2
3	Registered Nurses	22,008	23,511	809,473	34.43	3
4	Licensed Practical Nurses	16,677	17,697	558,040	31.53	4
5	CNAs & Orderlies	51,159	53,244	894,986	16.81	5
6	CNA Trainees	8	8	116	14.50	6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,276	1,323	25,769	19.48	9
10	Activity Assistants	4,459	4,739	59,370	12.53	10
11	Social Service Workers	2,304	2,385	52,206	21.89	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	733	760	20,123	26.48	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	4,676	4,831	70,447	14.58	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,975	2,159	42,304	19.59	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	1,866	1,989	124,599	62.64	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	5,994	6,362	171,956	27.03	22
23	Office Manager	1,950	2,080	63,202	30.39	23
24	Clerical	4,099	4,409	50,324	11.41	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,554	1,757	31,772	18.08	31
32	Other Health Care(specify)	1,202	1,292	26,786	20.73	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	124,345	131,055	\$ 3,130,835 *	\$ 23.89	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	88	11,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	115	9,933	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,677	11-3	44
45	Social Service Consultant	38	2,104	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	271	\$ 24,714		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	103	\$ 6,229	10-3	50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	6,965	204,881	10-3	52
53	TOTAL (lines 50 - 52)	7,068	\$ 211,109		53

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

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? 5.29
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,065 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? N/A 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. \$ 203,214
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (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
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? In Process
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.