

		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>0052837</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>The Estates of Hyde Park</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</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>4505 S Drexel Blvd</u> <u>Chicago</u> <u>60653</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 285-0550</u> Fax # <u>(773) 285-5618</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) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>* Subject to the attached Accountants' Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	* Subject to the attached Accountants' Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>												
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	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																								
Date of Initial License for Current Owners: <u>6/30/2014</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>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																									
Email Address: _____																									

Facility Name & ID Number

The Estates of Hyde Park

#

0052837

Report Period Beginning:

01/01/20

Ending:

12/31/20

III. STATISTICAL DATA

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

N/A

1	2	3	4		
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period		
1	155	Skilled (SNF)	155	56,730	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	155	TOTALS	155	56,730	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	33,769	527	5,096	39,392	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,769	527	5,096	39,392	14

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

69.44%

D. How many bed reserve days during this year were paid by the Department?

None

(Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

06/30/2014

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

06/30/2014

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

155

and days of care provided

3,951

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/20

Fiscal Year:

12/31/20

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

Facility Name & ID Number The Estates of Hyde Park # 0052837 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	361,018	47,125	14,340	422,483		422,483	282	422,765			1
2	Food Purchase		236,698		236,698		236,698	(572)	236,126			2
3	Housekeeping	255,343	31,439		286,782		286,782	1,165	287,947			3
4	Laundry	51,572	13,923		65,495		65,495		65,495			4
5	Heat and Other Utilities			172,643	172,643		172,643	(11,267)	161,376			5
6	Maintenance	175,434	35	120,744	296,213		296,213	17,785	313,998			6
7	Other (specify):*							3,413	3,413			7
8	TOTAL General Services	843,367	329,220	307,727	1,480,314		1,480,314	10,806	1,491,120			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,959,965	206,459	31,257	3,197,681		3,197,681	5,847	3,203,528			10
10a	Therapy	151,828		210	152,038		152,038		152,038			10a
11	Activities	142,632	15,352		157,984		157,984		157,984			11
12	Social Services	261,103	285	16,890	278,278		278,278	4,005	282,283			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							1,859	1,859			15
16	TOTAL Health Care and Programs	3,515,528	222,096	66,357	3,803,981		3,803,981	11,711	3,815,692			16
	C. General Administration											
17	Administrative	106,681		5,000	111,681		111,681	41,625	153,306			17
18	Directors Fees											18
19	Professional Services			739,828	739,828	(413)	739,415	(374,775)	364,640			19
20	Dues, Fees, Subscriptions & Promotions			91,431	91,431		91,431	(13,492)	77,939			20
21	Clerical & General Office Expenses	135,060	11,640	277,374	424,074		424,074	(118,461)	305,613			21
22	Employee Benefits & Payroll Taxes			727,921	727,921		727,921	(2,861)	725,060			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,194	1,194		1,194	442	1,636			24
25	Other Admin. Staff Transportation			7,233	7,233		7,233	645	7,878			25
26	Insurance-Prop.Liab.Malpractice			372,375	372,375		372,375	1,486	373,861			26
27	Other (specify):*							29,340	29,340			27
28	TOTAL General Administration	241,741	11,640	2,222,356	2,475,737	(413)	2,475,324	(436,051)	2,039,273			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,600,636	562,956	2,596,440	7,760,032	(413)	7,759,619	(413,534)	7,346,085			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			56,785	56,785		56,785	99,920	156,705			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,228	68,228		68,228	(593)	67,635			32
33	Real Estate Taxes			246,944	246,944	413	247,357	4,472	251,829			33
34	Rent-Facility & Grounds			749,689	749,689		749,689	(749,580)	109			34
35	Rent-Equipment & Vehicles			63,651	63,651		63,651	236	63,887			35
36	Other (specify):*			1,459	1,459		1,459	(1,459)				36
37	TOTAL Ownership			1,186,756	1,186,756	413	1,187,169	(647,004)	540,165			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,123	622,312	734,435		734,435	(7,890)	726,545			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			311,489	311,489		311,489		311,489			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		112,123	933,801	1,045,924		1,045,924	(7,890)	1,038,034			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,600,636	675,079	4,716,997	9,992,712		9,992,712	(1,068,428)	8,924,284			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	(12,540)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	24,509	30		9
10	Interest and Other Investment Income	(8,383)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,780)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	02		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	(1,625)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(232,679)	21		24
25	Fund Raising, Advertising and Promotional	(3,642)	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	(56,551)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (294,222)		\$	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)	(774,206)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (774,206)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,068,428)		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	Vending Income	\$ (635)	02	1
2	Patient Clothing	(40)	10	2
3	Collection Expense	(7,039)	21	3
4	Amortization	(1,459)	36	4
5	Building Co. - Bank Charges	(358)	21	5
6	Building Co. - Filing Fee	(75)	20	6
7	Capitalized R&M	(3,164)	06	7
8	Non-Allowable Legal	(12,010)	19	8
9	PAC Dues	(11,742)	20	9
10	Prior Period Legal Fees	(16,909)	19	10
11	Duplicate Expense	(3,120)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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32				32
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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	(56,551)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Estates of Hyde Park # 0052837 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			129	153								282	1
2	Food Purchase	(666)		94									(572)	2
3	Housekeeping			1,125	40								1,165	3
4	Laundry													4
5	Heat and Other Utilities	(12,540)		1,233	40								(11,267)	5
6	Maintenance	(3,164)		20,909	40								17,785	6
7	Other (specify):*			3,391	22								3,413	7
8	TOTAL General Services	(16,370)		26,881	295								10,806	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(40)			8,868	(2,981)							5,847	10
10a	Therapy													10a
11	Activities													11
12	Social Services				4,005								4,005	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				1,859								1,859	15
16	TOTAL Health Care and Programs	(40)			14,732	(2,981)							11,711	16
	C. General Administration													
17	Administrative			16,119	25,506								41,625	17
18	Directors Fees													18
19	Professional Services	(28,919)		(263,191)	(82,665)								(374,775)	19
20	Fees, Subscriptions & Promotions	(15,959)	75	2,099	293								(13,492)	20
21	Clerical & General Office Expenses	(247,601)	358	115,462	13,320								(118,461)	21
22	Employee Benefits & Payroll Taxes			(2,861)			(0)						(2,861)	22
23	Inservice Training & Education													23
24	Travel and Seminar			342	100								442	24
25	Other Admin. Staff Transportation			645									645	25
26	Insurance-Prop.Liab.Malpractice			1,383	103								1,486	26
27	Other (specify):*			23,723	5,617								29,340	27
28	TOTAL General Administration	(292,479)	433	(106,279)	(37,726)		(0)						(436,051)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(308,889)	433	(79,398)	(22,699)	(2,981)	(0)						(413,534)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Estates of Hyde Park # 0052837 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	24,509	73,204	2,170	37								99,920	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,383)		7,756	34								(593)	32
33	Real Estate Taxes			4,317	155								4,472	33
34	Rent-Facility & Grounds		(749,580)										(749,580)	34
35	Rent-Equipment & Vehicles			236									236	35
36	Other (specify):*	(1,459)											(1,459)	36
37	TOTAL Ownership	14,667	(676,376)	14,479	226								(647,004)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(7,890)							(7,890)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers					(7,890)							(7,890)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(294,222)	(675,943)	(64,919)	(22,473)	(10,872)	(0)						(1,068,428)	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
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		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	34	Rent	\$ 749,580	Avenue Associates, LLC		\$	(749,580)	1
2	V	33	Real Estate Taxes	246,944	Avenue Associates, LLC		246,944		2
3	V	21	Bank Charges		Avenue Associates, LLC		358	358	3
4	V	20	Filing Fee		Avenue Associates, LLC		75	75	4
5	V	30	Depreciation		Avenue Associates, LLC		73,204	73,204	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			\$ 996,524			\$ 320,581	\$ * (675,943)	14

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

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	Atied Associates LLC	100.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	AVENUE ASSOCIATES, LLC	CHICAGO	BUILDING COMPANY	1
2			BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL DYER	DYER, IN				8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRVILLE, IN				13
14			MCKINLEY HEALTH CARE CENTER	CANTON, OH				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMewood				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC		\$ 129	\$ 129	15
16	V	02	Food		Extended Care Consulting, LLC		94	94	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,125	1,125	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,233	1,233	18
19	V	06	Maintenance		Extended Care Consulting, LLC		2,455	2,455	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	268,209	Extended Care Consulting, LLC		5,018	(263,191)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		2,099	2,099	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		11,051	11,051	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		342	342	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		645	645	25
26	V	26	Insurance		Extended Care Consulting, LLC		1,383	1,383	26
27	V	30	Depreciation		Extended Care Consulting, LLC		2,170	2,170	27
28	V	32	Interest		Extended Care Consulting, LLC		7,756	7,756	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		4,317	4,317	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		236	236	30
31	V	06	Maintenance Salaries	140	Extended Care Consulting, LLC		18,594	18,454	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		3,391	3,391	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		16,119	16,119	33
34	V	21	Office and Clerical Salaries	9,549	Extended Care Consulting, LLC		113,960	104,411	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		23,723	23,723	35
36	V	22	Employee Benefits	2,861	Extended Care Consulting, LLC			(2,861)	36
37	V								37
38	V								38
39	Total			\$ 280,759			\$ 215,840	\$ * (64,919)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Salary	\$	Extended Care Clinical, LLC		\$ 153	\$ 153	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		40	40	16
17	V	5	Utilities		Extended Care Clinical, LLC		40	40	17
18	V	6	Maintenance		Extended Care Clinical, LLC		40	40	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		22	22	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		8,644	8,644	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		224	224	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		4,005	4,005	22
23	V	15	Emp. Ben. - Direct Alloc.		Extended Care Clinical, LLC				23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		1,859	1,859	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		25,506	25,506	25
26	V	19	Professional Fees	83,019	Extended Care Clinical, LLC		354	(82,665)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC				27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		293	293	28
29	V	21	Office Salary		Extended Care Clinical, LLC		12,711	12,711	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		609	609	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		100	100	31
32	V	26	Insurance		Extended Care Clinical, LLC		103	103	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		5,617	5,617	33
34	V	30	Depreciation		Extended Care Clinical, LLC		37	37	34
35	V	32	Interest		Extended Care Clinical, LLC		34	34	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		155	155	36
37	V								37
38	V								38
39	Total			\$ 83,019			\$ 60,546	\$ * (22,473)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 31,901	MAC Rx, LLC		\$ 28,919	\$ (2,981)	15
16	V	39	Ancillary	84,425	MAC Rx, LLC		76,535	(7,890)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 116,326			\$ 105,454	\$ * (10,872)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group		\$ 64,504	\$ 64,504	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	64,504	CCS Employee Benefits Group			(64,504)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 64,504			\$ 64,504	\$ * (0)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number The Estates of Hyde Park # 0052837 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	0	See Attached	0.32	0.80	Alloc Salary	\$ 573	22-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 573		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.

Ending: 12/31/20

Facility Name & ID Number The Estates of Hyde Park# 0052837

Report Period Beginning:

01/01/20Ending: 12/31/20

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

Extended Care Consulting, LLC

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

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, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	01	Dietary	Patient Days	38	\$ 3,992	\$	39,392	\$ 129	1
2	02	Food	Patient Days	38	2,910		39,392	94	2
3	03	Housekeeping	Patient Days	38	34,856		39,392	1,125	3
4	05	Utilities	Patient Days	38	38,173		39,392	1,233	4
5	06	Maintenance	Patient Days	38	76,040		39,392	2,455	5
6	17	Administrative	Patient Days	38			39,392		6
7	19	Professional Fees	Patient Days	38	155,408		39,392	5,018	7
8	20	Dues and Subscriptions	Patient Days	38	64,998		39,392	2,099	8
9	21	Office and Clerical	Patient Days	38	342,251		39,392	11,051	9
10	24	Seminar and Travel	Patient Days	38	10,602		39,392	342	10
11	25	Other Staff Admin. Trans.	Patient Days	38	19,988		39,392	645	11
12	26	Insurance	Patient Days	38	42,836		39,392	1,383	12
13	30	Depreciation	Patient Days	38	67,209		39,392	2,170	13
14	32	Interest	Patient Days	38	240,208		39,392	7,756	14
15	33	Real Estate Taxes	Patient Days	38	133,701		39,392	4,317	15
16	35	Rent - Equipment	Patient Days	38	7,304		39,392	236	16
17	06	Maintenance Salaries	Patient Days	38	575,856	575,856	39,392	18,594	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	38	105,021		39,392	3,391	18
19	17	Administrative Salaries	Patient Days	38	499,202	499,202	39,392	16,119	19
20	21	Office and Clerical Salaries	Patient Days	38	3,529,267	3,529,267	39,392	113,960	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	38	734,685		39,392	23,723	21
22									22
23									23
24									24
25	TOTALS				\$ 6,684,506	\$ 4,604,325		\$ 215,840	25

Facility Name & ID Number The Estates of Hyde Park# 0052837

Report Period Beginning:

01/01/20Ending: 12/31/20

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

Extended Care Clinical, LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

	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	1	Dietary Salary	Patient Days	603,308	20	\$ 8,692	\$ 8,692	10,595	\$ 153	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		10,595	40	2
3	5	Utilities	Patient Days	603,308	20	2,264		10,595	40	3
4	6	Maintenance	Patient Days	603,308	20	2,283		10,595	40	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		10,595	22	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	10,595	8,644	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		10,595	224	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	10,595	4,005	8
9	15	Emp. Ben. - Direct Alloc.	Direct Allocation		4	44,957				9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		10,595	1,859	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	10,595	25,506	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		10,595	354	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220				13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		10,595	293	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	10,595	12,711	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		10,595	609	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		10,595	100	17
18	26	Insurance	Patient Days	603,308	20	5,874		10,595	103	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		10,595	5,617	19
20	30	Depreciation	Patient Days	603,308	20	2,099		10,595	37	20
21	32	Interest	Patient Days	603,308	20	1,914		10,595	34	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		10,595	155	22
23										23
24										24
25	TOTALS					\$ 3,507,824	\$ 2,905,144		\$ 60,546	25

Ending: 12/31/20

(224)220-2730

Ending: 12/31/20

(847)905-4040

IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20**Fax Number**

()

IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

IL478-2471

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							\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X					2,851,415			66,754	6
7	Other Misc. Interest		X								1,474	7
8												8
9	TOTAL Facility Related						\$	2,851,415				\$ 68,228 9
	B. Non-Facility Related*											
10	Interest Income		X								(8,383)	10
11	Alloc from Extended Care Consulting										7,756	11
12	Alloc from Extended Care Clinical										34	12
13												13
14	TOTAL Non-Facility Related						\$					\$ (593) 14
15	TOTALS (line 9+line14)						\$	2,851,415				\$ 67,635 15

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

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

** 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.		\$	250,507	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.)				\$	247,131	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	(3,376)	3																				
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	254,792	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.)				\$	413	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.				\$	251,829	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:		2015	210,194	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2019</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td colspan="2">AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr></table>			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
	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																							
	2016	229,743	9																							
	2017	246,927	10																							
	2018	238,578	11																							
	2019	242,659	12																							
2020 Accrual = \$242,659 x 1.05 = \$254,792 (rounded)																										
Allocated from Extended Care Consulting - \$4,317																										
Allocated from Extended Care Clinical - \$155																										

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 The Estates of Hyde Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052837

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

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.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Estates of Hyde Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052837

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

A. Square Feet: 43,293

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	51,415	2014	\$ 100,000	1
2	Allocated from Care Center Building			18,600	2
3	TOTALS	51,415		\$ 118,600	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	155		2014	1970	\$ 3,490,000	\$ 73,204	35	\$ 99,714	\$ 26,510	\$ 709,515	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2014		84,685		20	4,235	4,235	33,988	9
10	Various		2015		245,461		20	12,217	12,217	85,650	10
11	Various		2016		66,853		20	3,344	3,344	16,314	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Estates of Hyde Park

0052837

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		93,592	1,471		1,471		65,636	68
69	Financial Statement Depreciation			56,785			(56,785)		69
70	TOTAL (lines 4 thru 69)		\$ 3,980,591	\$ 131,460		\$ 120,981	\$ (10,479)	\$ 911,103	70

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

Facility Name & ID Number The Estates of Hyde Park

0052837

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,980,591	\$ 131,460		\$ 120,981	\$ (10,479)	\$ 911,103	1
2	Electrical Services	2017	6,500		20	325	325	1,273	2
3	New Tub Faucet	2017	3,762		20	188	188	752	3
4	Telephone Systems	2017	13,281		20	664	664	2,601	4
5	New Switch Gear	2017	6,294		20	315	315	1,180	5
6	Hydraulic Cylinder - Elevator	2017	33,000		20	1,650	1,650	5,500	6
7	4 Doors	2017	5,048		20	252	252	820	7
8	Installation Of New Switch Gear	2017	5,700		20	285	285	1,069	8
9	Shunt Trip For Elevators	2017	7,490		20	375	375	1,436	9
10	Circuits & Outlets In Dining Rm, Therapy Rm, Rooms #215 & #3	2018	11,000		20	550	550	1,604	10
11	2 Kitchen Faucets, Replace Drain	2018	3,500		20	175	175	394	11
12	Generator Battery, Radiator, Coolant & Thermostat	2018	6,850		20	343	343	828	12
13	Elevator Guide Rollers	2018	2,792		20	140	140	419	13
14	Elevator Repair - Gaskets & Hydraulic Oil	2018	4,921		20	246	246	738	14
15	Elevator Pump Motor, Oil, Gaskets	2018	4,751		20	238	238	575	15
16	Elevator Valve, Gasket, Oil, Valve Couplings	2018	5,258		20	263	263	635	16
17	Installed New Motors For Exhaust Fans	2018	2,556		20	128	128	352	17
18	Repaired Pipes And Valves On Hot Water Heater	2018	7,994		20	400	400	1,199	18
19	Fixed Valves On Hot Water Boiler	2019	3,787		20	189	189	378	19
20	Installed Ac Units	2019	2,555		20	128	128	383	20
21	Fixed Broken Parts On Olr Relay	2019	2,797		20	140	140	280	21
22	Remove And Rebuild Deck	2020	83,250		20	4,163	4,163	4,163	22
23	Cubicle Curtains	2020	3,164		20	158	158	158	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,206,841	\$ 131,460		\$ 132,296	\$ 836	\$ 937,840	34

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

Facility Name & ID Number The Estates of Hyde Park

0052837

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,206,841	\$ 131,460		\$ 132,296	\$ 836	\$ 937,840	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,206,841	\$ 131,460		\$ 132,296	\$ 836	\$ 937,840	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,206,841	\$ 131,460		\$ 132,296	\$ 836	\$ 937,840	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,206,841	\$ 131,460		\$ 132,296	\$ 836	\$ 937,840	34

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

Facility Name & ID Number The Estates of Hyde Park

0052837

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,206,841	\$ 131,460		\$ 132,296	\$ 836	\$ 937,840	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,206,841	\$ 131,460		\$ 132,296	\$ 836	\$ 937,840	34

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

Facility Name & ID Number The Estates of Hyde Park

0052837

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number The Estates of Hyde Park

0052837

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number The Estates of Hyde Park

0052837

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	24,743	634	35	634		11,605	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	7,750	172	35	172		2,317	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	889	23	35	23		417	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	20,440		20			20,440	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	24,088		20			24,088	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,197		20			1,197	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	216	11	20	11		130	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,073	104	20	104		725	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	340	17	20	17		220	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,345	67	20	67		336	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,333	117	20	117		467	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,069	53	20	53		160	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	403	20	20	20		40	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	108	5	20	5		5	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2002	735		20			735	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2003	866		20			866	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2005	43		20			43	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2009	8		20			5	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2014	72	4	20	4		25	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2015	12	1	20	1		8	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2016	48	2	20	2		12	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2017	84	4	20	4		17	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2018	38	2	20	2		6	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2019	14	1	20	1		1	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2020	4		20				29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 88,917	\$ 1,237		\$ 1,237	\$	\$ 63,865	34

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

Facility Name & ID Number The Estates of Hyde Park

0052837

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 88,917	\$ 1,237		\$ 1,237		\$ 63,865	1
2									2
3									3
4									4
5									5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting	2007	149	7	20	7		104	8
9	Allocated from Extended Care Consulting	2009	89	4	20	4		53	9
10	Allocated from Extended Care Consulting	2010	871	44	20	44		479	10
11	Allocated from Extended Care Consulting	2011	314	16	20	16		157	11
12	Allocated from Extended Care Consulting	2012	103	5	20	5		46	12
13	Allocated from Extended Care Consulting	2014	1,432	72	20	72		501	13
14	Allocated from Extended Care Consulting	2016	1,717	86	20	86		429	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	TOTAL (lines 1 thru 33)		\$ 93,592	\$ 1,471		\$ 1,471		\$ 65,636	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	\$ 245,443	\$ 736	\$ 23,592	\$ 22,856	10	\$ 167,211	71
72	Current Year Purchases	8,171		817	817	10	817	72
73	Fully Depreciated Assets	109,536				10	109,536	73
74								74
75	TOTALS	\$ 363,150	\$ 736	\$ 24,409	\$ 23,673		\$ 277,564	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		Alloc. Extended Care Clinical	2012	\$ 902	\$	\$	\$	5	\$ 902	76
77		Alloc. Extended Care Consulting	2014	822				5	822	77
78										78
79										79
80	TOTALS			\$ 1,724	\$	\$	\$		\$ 1,724	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)	\$ 4,690,314	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 132,196	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 156,705	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24,509	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,217,128	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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	Offsite Storage				109			5
6								6
7	TOTAL				\$ 109			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: \$ 63,887
- Description:
- See Attached

(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.)

12345678												
	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 - 03	hrs	\$		\$	252,967	\$		\$	252,967	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				91,805				91,805	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				274,956				274,956	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					94,695			94,695	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): See Attached						2,584	17,428			20,012	13
14	TOTAL			\$		\$	622,312	\$	112,123	\$	734,435	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	\$ 137,741	\$ 141,869	1
2	Cash-Patient Deposits	79,964	79,964	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,728,480	3,728,480	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	104,318	104,318	6
7	Other Prepaid Expenses	2,321	2,321	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,052,824	\$ 4,056,952	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		3,624,349	14
15	Leasehold Improvements, at Historical Cost	535,340	535,340	15
16	Equipment, at Historical Cost	65,976	220,976	16
17	Accumulated Depreciation (book methods)	(330,071)	(4,027,297)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	389,080	389,080	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 660,325	\$ 842,448	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,713,149	\$ 4,899,400	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 273,345	\$ 273,344	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	76,985	76,985	28
29	Short-Term Notes Payable	2,851,415	2,851,415	29
30	Accrued Salaries Payable	264,928	264,928	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,218	16,218	31
32	Accrued Real Estate Taxes(Sch.IX-B)	254,792	254,792	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,190,741	1,190,741	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,928,424	\$ 4,928,423	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	727,935	1,812,125	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 727,935	\$ 1,812,125	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,656,359	\$ 6,740,548	46
47	TOTAL EQUITY(page 18, line 24)	\$ (943,210)	\$ (1,841,148)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,713,149	\$ 4,899,400	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,105,714)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,105,714)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,162,504	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,162,504	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)	\$ (943,210)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Estates of Hyde Park

0052837

Report Period Beginning: 01/01/20

Ending:

12/31/20

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	\$ 9,436,121	1
2	Discounts and Allowances for all Levels	(1,888,532)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,547,589	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,088,969	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,088,969	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	81,741	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,362	19
20	Radiology and X-Ray	9,675	20
21	Other Medical Services	10,897	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 129,675	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,383	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,383	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,380,600	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,380,600	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,155,216	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,480,314	31
32	Health Care	3,803,981	32
33	General Administration	2,475,737	33
	B. Capital Expense		
34	Ownership	1,186,756	34
	C. Ancillary Expense		
35	Special Cost Centers	734,435	35
36	Provider Participation Fee	311,489	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,992,712	40
41	Income before Income Taxes (line 30 minus line 40)**	1,162,504	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,162,504	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,322,378	44
45	Private Pay - Net Inpatient Revenue	144,384	45
46	Medicare - Net Inpatient Revenue	844,535	46
47	Other-(specify) Hospice	148,365	47
48	Other-(specify) Insurance	87,927	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,547,589	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	1,251	1,372	\$ 77,304	\$ 56.36	1
2	Assistant Director of Nursing	529	537	25,999	48.42	2
3	Registered Nurses	4,647	5,082	174,217	34.28	3
4	Licensed Practical Nurses	38,458	42,530	1,406,603	33.07	4
5	CNAs & Orderlies	60,658	69,502	1,181,504	17.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,632	6,246	151,828	24.31	8
9	Activity Director	1,669	1,792	40,854	22.80	9
10	Activity Assistants	5,933	6,430	101,778	15.83	10
11	Social Service Workers	10,673	11,380	261,103	22.94	11
12	Dietician					12
13	Food Service Supervisor	1,935	2,103	46,498	22.11	13
14	Head Cook	5,341	6,097	101,914	16.71	14
15	Cook Helpers/Assistants	11,795	13,136	212,606	16.18	15
16	Dishwashers					16
17	Maintenance Workers	8,903	9,583	175,434	18.31	17
18	Housekeepers	14,397	16,025	255,343	15.93	18
19	Laundry	3,170	3,318	51,572	15.54	19
20	Administrator	1,774	1,883	106,681	56.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,867	2,050	52,138	25.43	23
24	Clerical	3,482	3,769	82,922	22.00	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	1,971	2,163	47,215	21.83	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,056	2,383	47,123	19.78	33
34	TOTAL (lines 1 - 33)	186,139	207,382	\$ 4,600,636 *	\$ 22.18	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	301	\$ 14,340	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	22,323	10-03	38
39	Pharmacist Consultant	Monthly	8,934	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Per Visit	210	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Per Visit	390	12-03	45
46	Other(specify)				46
47	Psychiatrist Consultant	Monthly	16,500	12-03	47
48					48
49	TOTAL (lines 35 - 48)	301	\$ 80,697		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Latanya Owens	Administrator	0	\$ 75,055	Workers' Compensation Insurance		\$ 119,579	IDPH License Fee	\$ 1,990	
Mercedes Vaughn	Administrator	0	31,626	Unemployment Compensation Insurance		61,118	Advertising: Employee Recruitment	53,806	
				FICA Taxes		351,949	Health Care Worker Background Check		
				Employee Health Insurance		138,337	(Indicate # of checks performed 92)	1,034	
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	16,438	
				Pension Expense		37,481	Licenses & Fees	2,279	
				Other Employee Welfare		12,010			
				Holiday Expense		4,586			
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)									

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$23,484

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,827 Line 10

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 311,489
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? N/A

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? No
Firm Name: N/A

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

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