

		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>0051599</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Franklin Grove Living Rehab</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>502 North State St</u> <u>Franklin Grove</u> <u>61031</u>																									
Number City Zip Code																									
County: <u>Lee</u>																									
Telephone Number: <u>(815) 456-2374</u> Fax # <u>(815) 456-2250</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>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # (847)<u>517-7067</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # (847) <u>517-7067</u>												
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	(Telephone) <u>(847) 517-7070</u> Fax # (847) <u>517-7067</u>																								
Date of Initial License for Current Owners: <u>9/1/11</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>Amanda Springborn</u>																									
Telephone Number: <u>(314) 925-3838</u> Email Address: _____																									

Facility Name & ID Number Franklin Grove Living Rehab# 0051599 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 bedsN/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	<u>132</u>	Skilled (SNF)	<u>132</u>	<u>48,312</u>	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	<u>132</u>	TOTALS	<u>132</u>	<u>48,312</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>338</u>	<u>6,359</u>	<u>6,697</u>	8
9	SNF/PED					9
10	ICF	<u>14,621</u>	<u>7,735</u>	<u>683</u>	<u>23,039</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,621</u>	<u>8,073</u>	<u>7,042</u>	<u>29,736</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.55%

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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Note : Non-allowable costs have been
eliminated in Schedule V, Column 7.

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

YES ☐NO ☒

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

Date started 9/1/11

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

YES ☒Date 9/1/11NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 132 and days of care provided 6,359

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2020Fiscal Year: 12/31/2020

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

Facility Name & ID Number Franklin Grove Living Rehab # 0051599 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	346,066	31,143	9,213	386,422		386,422		386,422			1
2	Food Purchase		246,815		246,815		246,815	(6,220)	240,595			2
3	Housekeeping	165,465	83,230	-	248,695		248,695	13	248,708			3
4	Laundry	67,112	15,383	-	82,495		82,495		82,495			4
5	Heat and Other Utilities			128,108	128,108		128,108	1,012	129,120			5
6	Maintenance	100,906	47,964	24,100	172,970		172,970	1,819	174,789			6
7	Other (specify):*	-	-	-								7
8	TOTAL General Services	679,549	424,535	161,421	1,265,505		1,265,505	(3,376)	1,262,129			8
	B. Health Care and Programs											
9	Medical Director	-	-	-								9
10	Nursing and Medical Records	2,307,488	144,273	5,831	2,457,592		2,457,592	20,945	2,478,537			10
10a	Therapy	-	-	-								10a
11	Activities	131,250	4,481	-	135,731		135,731		135,731			11
12	Social Services	89,234	-	-	89,234		89,234		89,234			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	TOTAL Health Care and Programs	2,527,972	148,754	5,831	2,682,557		2,682,557	20,945	2,703,502			16
	C. General Administration											
17	Administrative	95,274	-	233,328	328,602		328,602	(148,816)	179,786			17
18	Directors Fees			-								18
19	Professional Services			27,118	27,118		27,118	14,081	41,199			19
20	Dues, Fees, Subscriptions & Promotions			40,172	40,172		40,172	(7,088)	33,084			20
21	Clerical & General Office Expenses	230,852	-	68,010	298,862		298,862	61,195	360,057			21
22	Employee Benefits & Payroll Taxes			445,880	445,880		445,880	6,375	452,255			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			879	879		879	352	1,231			24
25	Other Admin. Staff Transportation		-	21,011	21,011		21,011	374	21,385			25
26	Insurance-Prop.Liab.Malpractice			11,374	11,374		11,374	268,518	279,892			26
27	Other (specify):* Mgmt Alloc of Benefits			-				17,489	17,489			27
28	TOTAL General Administration	326,126		847,772	1,173,898		1,173,898	212,480	1,386,378			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,533,647	573,289	1,015,024	5,121,960		5,121,960	230,049	5,352,009			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			9,991	9,991		9,991	323,504	333,495			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			139,505	139,505		139,505	187,674	327,179			32
33	Real Estate Taxes			-				60,736	60,736			33
34	Rent-Facility & Grounds			824,917	824,917		824,917	(824,917)				34
35	Rent-Equipment & Vehicles			16,083	16,083		16,083	912	16,995			35
36	Other (specify):* Insurance - MIP			-				27,967	27,967			36
37	TOTAL Ownership			990,496	990,496		990,496	(224,124)	766,372			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	199,138	692,899	892,037		892,037		892,037			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			222,427	222,427		222,427		222,427			42
43	Other (specify):* Non-Allowable Cos	-	-	65,320	65,320		65,320	(65,320)				43
44	TOTAL Special Cost Centers		199,138	980,646	1,179,784		1,179,784	(65,320)	1,114,464			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,533,647	772,427	2,986,166	7,292,240		7,292,240	(59,395)	7,232,845			45

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

	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	80,317	30		9
10	Interest and Other Investment Income	(1,434)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(299)	43		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	(220)	43		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	(507)	43		24
25	Fund Raising, Advertising and Promotional	(10,911)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,195)	43		28
29	Other-Attach Schedule See PG5A	(144,235)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (83,484)		\$	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)	24,089		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 24,089		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (59,395)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lab Expense Med A	\$ (3,533)	43	1
2	X Ray Expense Med A	(8,593)	43	2
3	Miscellaneous Income Offset	(142)	21	3
4	Managed Care Costs	(35,062)	43	4
5	Non-Allowable Management Fees	(51,321)	17	5
6	Lobbying Expense	(9,178)	20	6
7	Adjust Real Estate Taxes	(1,075)	33	7
8	Chamber of Commerce	(414)	20	8
9	Non-Allowable State Replacement Tax	(2,000)	43	9
10	Non-Allowable Rent Expense	(32,917)	34	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(144,235)		49

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 PG6-Supp		See PG6-Supp		See PG6-Supp		

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	19	Professional Services	\$	FOM Property LLC	100%	\$ 10,215	\$ 10,215	1
2	V	26	Insurance		FOM Property LLC	100%	267,030	267,030	2
3	V	30	Depreciation		FOM Property LLC	100%	239,403	239,403	3
4	V	32	Interest	237	FOM Property LLC	100%	189,346	189,109	4
5	V	33	Real Estate Taxes		FOM Property LLC	100%	58,648	58,648	5
6	V	34	Rent Facility and Ground	792,000	FOM Property LLC	100%		(792,000)	6
7	V	36	Insurance - MIP		FOM Property LLC	100%	27,967	27,967	7
8	V	20	License		FOM Property LLC	100%	75	75	8
9	V	43	State Replacement Tax		FOM Property LLC	100%	2,000	2,000	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 792,237			\$ 794,683	\$ * 2,446	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	\$	SW Financial Services Company	100%	\$ 155	\$ 155	15
16	V	3	Housekeeping		SW Financial Services Company	100%	13	13	16
17	V	5	Utilities		SW Financial Services Company	100%	1,012	1,012	17
18	V	6	Maintenance		SW Financial Services Company	100%	1,819	1,819	18
19	V	17	Administrative	107,328	SW Financial Services Company	100%	9,833	(97,495)	19
20	V	19	Professional Services		SW Financial Services Company	100%	3,866	3,866	20
21	V	20	Dues, Fees, Subscriptions & Promotions		SW Financial Services Company	100%	2,429	2,429	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100%	82,282	82,282	22
23	V	24	Travel & Seminar		SW Financial Services Company	100%	352	352	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100%	374	374	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100%	1,488	1,488	25
26	V	27	Other		SW Financial Services Company	100%	17,489	17,489	26
27	V	30	Depreciation		SW Financial Services Company	100%	3,784	3,784	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100%	3,163	3,163	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100%	912	912	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			\$ 107,328			\$ 128,971	\$ * 21,643	39

* 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	Moshe Herman	50%	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing	Shabbona	Supportive Living	1
2	Stuart Milstein	7.33%	Caseyville Nursing and Rehab	Caseyville	Assisted Living		Facility	2
3	Ari Milstein	7.33%			SW Financial	Skokie	Bookkeeping/	3
4	Elana Minkove	7.34%			Services Co.		Management Compa	4
5	Amanda Bachrach	4.40%	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6	Yedida Wolfe	4.40%	Oregon Living & Rehabilitation, LLC	Oregon				6
7	James Wolfe	4.40%	Prairie Crossing Living & Rehab Center, LLC	Shabbona	Groves Community	Independence, MO	Hospice	7
8	Neil Wolfe	4.40%			Hospice			8
9	Richard Wolfe	4.40%	Tower Hill Rehabilitation, LLC	Soth Elgin, IL	Forest View Senior	Independence, MO	Independent	9
10	Robin Krystal	4.00%			Residences		Living	10
11	David Zuckerman	2.00%	Beauvais Manor Healthcare and Rehab	St. Louis, MO	White Oak Living	Independence, MO	Residential	11
12			Hillside Manor Healthcare and Rehab	St. Louis, MO	Center		Care	12
13			Rancho Manor Healthcare and Rehab	Florissant, MO				13
14			Rosewood Health & Rehab	Independence, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	14
15			Seasons Care Center	Kansas City, MO	Program LLC			15
16			Carriage Square	St. Joseph, MO				16
17					Cahokia Building LLC	Cahokia	Real Estae	17
18					Caseyville Property LI	Caseyville	Real Estate	18
19					Green Acres	Amboy	Real Estate	19
20					Property LLC			20
21								21
22					FOM Property LLC	Franklin Grove	Real Estate	22
23								23
24					Oregon Property LLC	Oregon	Real Estate	24
25					Shabbona Building	Shabbona	Real Estate	25
26					Associates LLC			26
27								27
28					Tower Hill Property LI	South Elgin	Real Estate	28
29								29
30								30

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	Moshe Herman	Owner	Administrative	50	See Sch 7C	15	33.33	Salary & Fees	\$ 79,012	17,3 & 17,7	1
2	David Zuckerman	Owner	Administrative	2	See Sch 7B	1.25	3.00	Salary	5,139	17(7)	2
3	Sheldon Wolfe	Administrative	Administrative	22	See Sch 7A	1.25	3.00	Salary	361	17(7)	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 84,512		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 Franklin Grove Living Rehab# 0051599 Report Period Beginning: 01/01/20 Ending: 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 SW Financial Services Company
 Street Address 7434 North Skokie Blvd
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 982-2300
 Fax Number (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	678,198	12	\$ 2,175	\$	48,312	\$ 155	1
2	3	Housekeeping	Bed Days Available	678,198	12	179		48,312	13	2
3	5	Utilities	Bed Days Available	678,198	12	14,206		48,312	1,012	3
4	6	Maintenance	Bed Days Available	678,198	12	25,536		48,312	1,819	4
5	19	Professional Services-Legal	Bed Days Available	678,198	12	29,559		48,312	2,106	5
6	19	Professional Services-Other	Bed Days Available	678,198	12	24,713		48,312	1,760	6
7	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	678,198	12	34,103		48,312	2,429	7
8	21	Clerical & General Office Expense	Bed Days Available	678,198	12	962,284	962,284	48,312	68,549	8
9	21	Clerical & General Office Expense	Bed Days Available	678,198	12	192,782		48,312	13,733	9
10	24	Travel & Seminar	Bed Days Available	678,198	12	4,935		48,312	352	10
11	25	Other Admin. Staff Transportion	Bed Days Available	678,198	12	5,250		48,312	374	11
12	26	Insurance-Prop, Liab & Malpracti	Bed Days Available	678,198	12	20,882		48,312	1,488	12
13	27	Other - Mgmt Allocation of Benefi	Bed Days Available	678,198	12	245,503		48,312	17,489	13
14	33	Real Estate Taxes	Bed Days Available	678,198	12	44,398		48,312	3,163	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	678,198	12	12,804		48,312	912	15
16										16
17	17	Administrative - Salary	Average Hours Worked	45	12	13,000	13,000	1	361	17
18	17	Administrative - Salary	Average Hours Worked	45	12	185,000	185,000	1	5,139	18
19	17	Administrative - Salary	Average Hours Worked	45	3	13,000	13,000	15	4,333	19
20										20
21	30	Depreciation	Direct Cost	53,119					3,784	21
22										22
23										23
24										24
25	TOTALS					\$ 1,830,309	\$ 1,173,284		\$ 128,971	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	Lancaster Pollard Mortgage Company, LLC		X	Mortgage	37,669	12/1/13	\$ 4,971,254	\$ 4,314,980	12/1/43	0.0438	\$ 188,462	1
2												2
3												3
4	Amortization of Loan Costs										97,240	4
5												5
	Working Capital											
6	Sheldon Wolfe	X		Working Capital	Varies	9/1/11	250,000	100,000	08/31/19	0.0128	415	6
7	Albert Milstein	X		Working Capital	Varies	9/1/11	250,000	100,000	08/31/19	0.0128	415	7
8	See Schedule 9A			Working Capital			3,433,870	1,765,651			41,435	8
9	TOTAL Facility Related				\$37,669.35		\$ 8,905,124	\$ 6,280,631			\$ 327,967	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(1,672)	12
13								Allocated from FOM Property			884	13
14	TOTAL Non-Facility Related						\$	\$			\$ (788)	14
15	TOTALS (line 9+line14)						\$ 8,905,124	\$ 6,280,631			\$ 327,179	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 27,967 Line # 36

* 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.)

Facility Name: Franklin Grove Living Rehab
IDPH License ID Number: 0051599
Fiscal Year End: 12/31/20

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

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	Franklin Grove Associates	X		Working Capital	Varies	12/1/13	1,458,598	540,379	12/1/43	0.0650	40,895		6
7	MB Financial Bank		X	Working Capital	Interest Only	2/10/16	750,000	-	2/10/19	0.0425	540		7
8	SBA-PPP Loan		X	Payroll & Oper Exp	None	4/28/20	711,630	711,630	4/28/2022	0.0100	-		8
9	Wisconsin Physician Services		X	MCR Advance Payments	\$23,769.79	4/30/20	513,642	513,642	4/30/2022	0.0000	-		8
10	TOTAL Facility Related				\$23,769.79		\$ 3,433,870	\$ 1,765,651			\$ 41,435		9
	B. Non-Facility Related*												
11													10
12													11
12													12
13													13
13													
14	TOTAL Non-Facility Related				\$0.00		\$ -	\$ -			\$ -		14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	56,275	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2019	\$	57,023	2
3. Under or (over) accrual (line 2 minus line 1).			\$	748	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	56,825	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
		Alloc. Fr. Mgmt. Co.		3,163	
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.			\$	60,736	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	42,909	8	
		2016	41,046	9	
		2017	53,129	10	
		2018	54,636	11	
		2019	57,023	12	
2020 Tax accrual = 54,636 * 1.04 = 56,821. Use 56,825					

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

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Franklin Grove Living & Rehabilitation Center, LLC COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0051599

CONTACT PERSON REGARDING THIS REPORT Moshe Herman

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 06-03-36-351-007	Long Term Care Property	\$ 57,022.68	\$ 57,022.68
2. 10-28-412-049-0000	SW Financial Services Co. Allocation	\$ 44,398.00	\$ 3,163.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 101,420.68	\$ 60,185.68

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? X 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 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: 48,667

B. General Construction Type: Exterior BrickFrame Concrete & SteelNumber of Stories One

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: 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	Resident Care		1991	\$ 36,205	1
2					2
3	TOTALS			\$ 36,205	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	121		1991		\$ 1,334,101	\$	31.5	\$ 42,352	\$ 42,352	\$ 1,249,391	4
5	11			2016	Detail of costs provided on Page 12D, Lines 3-25						5
6	Mgmt. Alloc		1995		30,833		39	881	881	22,597	6
7											7
8											8
	Improvement Type**										
9	Various		1991		6,392		20			6,392	9
10	Various		1992		29,415		20			29,415	10
11	Various		1993		47,511		20			47,511	11
12	Various		1994		17,652		20			17,652	12
13	Various		1995		10,809		20			10,809	13
14	Various		1997		55,791		20			55,791	14
15	Various		1998		87,964		20			87,964	15
16	Various		1999		24,113		20			24,113	16
17	Retroaire Chassis		2000		2,321		20	117	117	2,321	17
18	Water Main Line		2001		3,294		20	165	165	3,256	18
19	Walk In Freezer		2001		8,947		20	447	447	8,682	19
20	Wiring To Kitchen		2001		12,250		20	613	613	12,103	20
21	Kitchen Labor		2001		3,163		20	158	158	3,029	21
22	Kitchen Labor		2001		1,532		20	77	77	1,472	22
23	Carpeting		2002		16,211		5			16,211	23
24	Bathroom and Tub		2002		3,700		10			3,700	24
25	Bath		2002		7,972		10			7,972	25
26	Glass Blocks		2002		1,649		10			1,649	26
27	Voice Alarm		2003		948		20	47	47	897	27
28	Code Alert		2003		3,887		20	194	194	3,559	28
29	Magnetic Door Holders		2003		1,652		20	83	83	1,573	29
30	Air Conditioners		2003		4,244		20	212	212	4,029	30
31	Tub & Lift		2003		8,738		20	437	437	8,447	31
32	3 Air Conditioners		2003		478		20	24	24	455	32
33	Boiler Repair		2003		1,683		20	84	84	1,506	33
34	Shower - Glass, Bars		2003		550		20	28	28	498	34
35	Carpet		2003		599		20	30	30	457	35
36	Gutters & Down Spouts		2003		10,759		20	538		9,505	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 Franklin Grove Living Rehab

0051599

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	
37	Aluminum Soffit	2003	\$ 1,864	\$	20	\$ 93	\$ 93	\$ 1,631	37
38	Painting (24 Rooms)	2004	5,520		20	276	276	4,554	38
39	Nurses station	2004	18,750		20	938	938	15,474	39
40	Dining Area	2004	2,400		20	120	120	1,980	40
41	New Windows	2004	6,335		20	317	317	5,229	41
42	Bathroom Plumbing and Electrical	2004	12,600		20	630	630	10,395	42
43	Kitchen and Dining Room	2004	16,369		20	818	818	13,499	43
44	Remodel Shower and Flooring	2004	10,595		20	530	530	8,744	44
45	Display Case - Nurses Station	2004	3,800		20	190	190	3,135	45
46	Dining Room Windows	2004	9,614		20	481	481	7,935	46
47	Glass Block Shower Windows	2004	1,427		20	71	71	1,174	47
48	Remodel Glass and Shower	2004	3,100		20	155	155	2,558	48
49	Carpet	2004	2,660		20	133	133	2,195	49
50	Windows	2005	34,060		20	1,703	1,703	26,397	50
51	Remodel Wall	2005	6,518		20	326	326	5,053	51
52	Outside Soffit	2005	6,268		20	313	313	4,854	52
53	Install Valves	2005	4,500		20	225	225	3,488	53
54	Tiles and Flooring	2006	15,604		20	780	780	11,311	54
55	Exterior and Resident Doors	2006	21,725		20	1,086	1,086	15,748	55
56	Kick Plates	2006	5,533		20	277	277	4,015	56
57	Windows	2006	58,240		20	2,912	2,912	42,224	57
58	Siding	2006	2,080		20	104	104	1,508	58
59	Paving	2006	7,517		20	376	376	5,451	59
60	Wallpaper	2006	3,078		20	154	154	2,233	60
61	Air Conditioners	2006	20,183		20	1,009	1,009	14,631	61
62	Water Heater	2006	9,984		20	499	499	7,236	62
63									63
64	Glue Down Carpet	2007	3,036		20	152	152	2,052	64
65									65
66	New Doors	2008	41,645		20	2,082	2,082	26,028	66
67	Wiring-Kitchen Ansul System to Fire Alarm	2008	5,571		20	279	279	3,482	67
68	Lighting Insulation	2008	12,804		20	640	640	8,003	68
69	New Ceiling-Laundry	2008	3,755		20	188	188	2,347	69
70	TOTAL (lines 4 thru 69)		\$ 2,096,293	\$		\$ 64,344	\$ 63,806	\$ 1,907,519	70

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

Facility Name & ID Number Franklin Grove Living Rehab

0051599

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 12A, Carried Forward		\$ 2,096,293	\$		\$ 64,344	\$ 64,344	\$ 1,907,519	1
2	South Porch Remodel	2008	4,175		20	209	209	2,610	2
3	Wallpaper & Installation	2008	8,467		20	423	423	5,291	3
4	Steel studs & drywall on outside walls, retrim windows, and	2008	101,179		20	5,059	5,059	63,236	4
5	extend electrical boxes in 36 rooms								5
6	Gas Water heater	2008	4,399		20	220	220	2,750	6
7	Painting	2008	9,395		20	470	470	5,872	7
8	Replace Boiler Sections	2008	12,164		20	608	608	7,603	8
9	Vinyl Flooring	2008	83,058		20	4,153	4,153	51,911	9
10	Landscaping	2008	14,896		15	993	993	12,414	10
11	New Sprinkler System	2009	155,270		20	7,764	7,764	89,286	11
12	New Water Line for Sprinkler System	2009	14,936		20	747	747	8,590	12
13	Fire Alarm Interface-Sprinkler System	2009	3,000		20	150	150	1,725	13
14	Laminate Flooring	2009	2,946		20	147	147	1,691	14
15	Repave parking lots	2010	36,093		20	1,805	1,805	18,949	15
16	Replace concrete for front sidewalk	2010	4,653		20	233	233	2,443	16
17	Water heater	2010	8,047		20	402	402	4,221	17
18	Remodel Kitchen: Install Wall Cabinets, Flooring,	2011	25,348		20	1,267	1,267	12,037	18
19	- Countertops, Backsplash & Drywalls								19
20	Remodel Laundry Room: Install Wall Panels, Plumbing,	2011	11,100		20	555	555	5,273	20
21	- Tiles/Flooring, Shelving and Cabinets								21
22	Dining Room Floor	2011	9,658		20	483	483	4,587	22
23	Carpet & Installation	2011	3,705		20	185	185	1,758	23
24	Front Entrance Soffit	2011	2,100		20	105	105	998	24
25	Parking lot Seal coating	2011	8,400		20	420	420	4,993	25
26									26
27	Drywall Rooms & Ceilings (Rooms: 409, 501, 502, 504, 505 & 515)	2012	6,865	250	20	343	93	3,032	27
28	Drywall Rooms & Ceilings (Rooms: 409, 501, 502, 504, 505 & 515)	2012	3,433	125	20	172	47	1,403	28
29	Hot Water Tank: Boiler Room off the 100 Hall	2012	7,914	288	20	396	108	3,531	29
30	FGA: Repave Driveway	2012	10,000		15	667	667	5,666	30
31									31
32	Grab Bars in Bathrooms	2013	2,589	94	10	259	165	1,942	32
33	2 PTAC Units	2013	2,508		10	251	251	1,882	33
34	TOTAL (lines 1 thru 33)		\$ 2,652,591	\$ 757		\$ 92,829	\$ 92,072	\$ 2,233,212	34

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

Facility Name & ID Number Franklin Grove Living Rehab

0051599

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		\$ 2,652,591	\$ 757		\$ 92,829	\$ 92,072	\$ 2,233,212	1
2	Water Heater - services 400 & 500 Hall	2014	3,250		15	217	217	1,410	2
3	Telephone System Upgrade - Throughout Entire Facility	2014	15,316		10	1,532	1,532	9,958	3
4									4
5	Storm Drain and Drainage	2015	13,209		20	660	660	3,632	5
6	Installing new cabling for 6 rooms	2015	4,054		20	203	203	1,115	6
7	Installing surveillance camera system throughout the building	2015	27,195		5	2,720	2,720	27,195	7
8	Seal Coating parking lot for the entire parking	2015	4,420		20	221	221	1,216	8
9	Installing soft water system throughout the building	2015	3,482		5	348	348	3,482	9
10									10
11	RPZ connection - 400& 500 Hall	2015	4,266		20	213	213	1,173	11
12	Replace Roof of nc storage - garage outside/kitchen	2015	2,740		10	274	274	1,507	12
13	Install Insulation above resident rooms 19,420sq	2015	14,245		15	950	950	5,223	13
14	- 100, 200 & 300 halls								14
15	Side Entry Whirlpool Tub - New Spa 400 & 500 wing	2015	8,045		10	805	805	4,427	15
16									16
17	Generator 125k - RC outside & New dinning room	2016	97,479		20	4,874	4,874	21,933	17
18	Spinkler head relocating - remodel - rooms 400	2016	4,874		20	244	244	1,097	18
19	Landscaping - bushes, lawn, and flowers - around new therapy	2016	40,667	1,738	15	2,711	973	12,200	19
20	and new patio								20
21	Drop Ceiling Replacement -rooms 401, 402, 403, 404, 406 & 502	2016	12,775		20	639	639	2,874	21
22	Fire Alarm & Nurse Call System (2 hall lights, 2 horn strobes		2,651	96	20	133	37	596	22
23	in dining room, nurse call annunaiator to new area)	2016	-						23
24	Installation of Code Alert Door Alarm System- Therapy Door	2016	10,545	1,012	5	2,109	1,097	9,491	24
25	Sealcoat	2016	4,200		15	280	280	1,260	25
26	Backup lines, valve, install tub - Spa in New addition	2016	3,407		20	170	170	767	26
27	Door/Fire/Nurse Call Alarm System Repairs	2016	4,160		20	208	208	936	27
28	15 PTAC units - 400-500 Wing	2016	8,461		5	1,692	1,692	7,615	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,942,032	\$ 3,603		\$ 114,031	\$ 110,428	\$ 2,352,317	34

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

Facility Name & ID Number Franklin Grove Living Rehab

0051599

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 12C, Carried Forward		\$ 2,942,032	\$ 3,603		\$ 114,031	\$ 110,428	\$ 2,352,317	1
2									2
3	Construction Draws 1 through 10:	2016	30,000		20	1,500	1,500	6,750	3
4	Site Improvements- Lighting	2016	24,000		20	1,200	1,200	5,400	4
5	New Outdoor Patio(s)	2016	477,756		20	23,888	23,888	107,495	5
6	New P.T. Addition	2016	5,000		20	250	250	1,125	6
7	Office/admin. Room	2016	9,520		20	476	476	2,142	7
8	New Servery	2016	329,931		20	16,497	16,497	74,234	8
9	New Dining/Office Addition	2016	52,000		20	2,600	2,600	11,700	9
10	New Bistro Area & Reading Lounge	2016	38,000		20	1,900	1,900	8,550	10
11	Lounge Area(s) Conversion	2016	6,400		20	320	320	1,440	11
12	Clean Utility Room	2016	10,290		20	515	515	2,315	12
13	Beauty Shop Relocation	2016	32,355		20	1,618	1,618	7,280	13
14	Spa Room Renovation & Expansion	2016	49,800		20	2,490	2,490	11,205	14
15	SNF Portion Entry Renovation	2016	545,025		20	27,251	27,251	122,631	15
16	6 Bed Addition- Option	2016	10,000	733	20	500	(233)	2,250	16
17	Electrical upgrades to emergency power	2016	-						17
18	Insulation	2016	14,245		20	712	712	3,205	18
19	Water Service Increase & Misc	2016	11,312		20	566	566	2,545	19
20	2401 Inc Corp - architects - architect fees	2016	70,190		20	3,510	3,510	15,793	20
21	KDI Design Inc - architect fees	2016	9,450		20	473	473	2,126	21
22	(Draw #1 - \$97,449, Draw #2 - \$113,670, Draw #3 - \$121,400,								22
23	Draw #4 - \$161,231, Draw #5 - \$198,606, Draw #6 - \$209,899,								23
24	Draw #7 - \$293,567, Draw #8 - \$204,538, Draw #9 - \$119,709								24
25	Draw #10 - \$100,009)								25
26			-						26
27	Cabling-Throughout Facility	2017	4,000	160	20	200	40	500	27
28	Additional Load on new generator-Outside Dining Room	2017	5,881	214	20	294	80	516	28
29	Voice Announcer/Door Alarm System-Main Panel	2017	5,770	210	20	289	79	505	29
30	Regasket all sections on boiler pipe-Boiler Room	2017	6,264	228	20	313	85	391	30
31	Oak Flooring- 400 & 500 Wings	2017	8,574	1,372	20	429	(943)	858	31
32	Cabinets-DON/ADON & Wound Care Offices	2017	3,914	142	20	196	54	490	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,701,710	\$ 6,662		\$ 202,015	\$ 195,353	\$ 2,743,763	34

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

Facility Name & ID Number Franklin Grove Living Rehab

0051599

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		\$ 4,701,710	\$ 6,662		\$ 202,015	\$ 195,353	\$ 2,743,763	1
2	<u>Cabling-Throughout Facility</u>	2017	4,000		20	200	200	800	2
3	<u>Roofing-Nursing Side</u>	2017	4,519		20	226	226	864	3
4	<u>RCSI - Pergola - New Patio Area</u>	2017	7,840		15	523	523	1,045	4
5	<u>RFP & Handrail Installation-Dining Room</u>	2017	4,670		20	234	234	468	5
6	<u>Shutters of Front Elevation</u>	2017	2,880		20	144	144	180	6
7	<u>Water Heater-Services Kitchen</u>	2017	9,860		20	493	493	1,357	7
8	<u>Flooring, Plumbing, Electrical, Carpentry, Faucets, Lighting</u>	2017	46,940		20	2,347	2,347	2,935	8
9	<u>Remodel-Room #412, 505 and 513</u>								9
10	<u>Led Overhead bed lights -Room #412, 505 and 513</u>	2017	2,980	477	5	596	119	1,193	10
11	<u>15 PTAC Units-400 & 500 Halls</u>	2017	8,175	1,308	5	1,635	327	3,270	11
12	<u>Signage-Throughout Facility</u>	2017	8,319		5	1,664	1,664	6,239	12
13									13
14	<u>Plumbing, Electrical, Drywall, Shower Floor - Rooms 512 & 514</u>	2018	17,543		20	877	877	3,070	14
15	<u>Drywall, Flooring, Shower Floor, Electrical - Rooms 508 & 510</u>	2018	10,090		20	505	505	1,639	15
16	<u>RE Entity: Electrical, Flooring & Drywall - Rooms 508 & 510</u>	2018	22,440		20	1,122	1,122	2,805	16
17	<u>RE Entity: Boiler upgrades - Mechanical Room</u>	2018	7,200		20	360	360	900	17
18									18
19	<u>Furnish and install 2 water heaters with mixing valve-400 & 500 Ha</u>	2019	16,750	533	20	1,536	1,003	2,304	19
20	<u>20 PTAC Units-400 & 500 Halls</u>	2019	12,342		5	4,526	4,526	6,789	20
21									21
22	<u>Driveway curtain replacement - Repair Asphalt Areas</u>	2020	9,795		15	327	327	327	22
23	<u>Sealcoat - Seal Blacktop, Crack Filling and Striping</u>	2020	5,450		15	182	182	182	23
24	<u>Install 2 units of 399k BTU Boilers, Boiler Pumps, Water</u>	2020	38,250		15	1,275	1,275	1,275	24
25	<u>Cutoffs and 1 unit of Boiler bladder expansion tank</u>								25
26									26
27	<u>15 units of PTAC Units</u>	2020	9,597		7	686	686	686	27
28	<u>Mansard section of roof</u>	2020	25,750		15	858	858	858	28
29									29
30	<u>To tie current book depreciation</u>			(1,582)			1,582		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,977,100	\$ 7,398		\$ 222,329	\$ 214,931	\$ 2,782,947	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 12E, Carried Forward		\$ 4,977,100	\$ 7,398		\$ 222,329	\$ 214,931	\$ 2,782,947	1
2	Allocated from SW Financial Services Co. - Leasehold Improvemen	1995	3,452					3,451	2
3	Allocated from SW Financial Services Co. - Leasehold Improvemen	1996	575					575	3
4	Allocated from SW Financial Services Co. - Leasehold Improvemen	1997	666					666	4
5	Allocated from SW Financial Services Co. - Leasehold Improvemen	1998	570					570	5
6	Allocated from SW Financial Services Co. - Leasehold Improvemen	1999	1,581					1,581	6
7	Allocated from SW Financial Services Co. - Leasehold Improvemen	2005	3,272			164	164	2,535	7
8	Allocated from SW Financial Services Co. - Leasehold Improvemen	2007	1,852			93	93	1,250	8
9	Allocated from SW Financial Services Co. - Leasehold Improvemen	2009	3,867			193	193	2,223	9
10	Allocated from SW Financial Services Co. - Leasehold Improvemen	2013	2,064			103	103	774	10
11	Allocated from SW Financial Services Co. - Leasehold Improvemen	2014	2,082			104	104	677	11
12	Allocated from SW Financial Services Co. - Leasehold Improvemen	2015	427			28	28	157	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,997,508	\$ 7,398		\$ 223,014	\$ 215,616	\$ 2,797,406	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,993,946	\$2,593	\$105,141	\$102,548	5	\$1,828,665	71
72	Current Year Purchases	16,331		1,553	1,553	7	1,553	72
73	Fully Depreciated Assets							73
74	Allocation from Management Co.	13,711		707	707		10,688	74
75	TOTALS	\$2,023,988	\$2,593	\$107,401	\$104,808		\$1,840,906	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	Facility	Ford 2002	2012	\$20,328	\$-	\$-		5	\$20,328	76
77	Facility	2001 Chevy Van	2014	15,700	-	1,570	1,570	10	10,990	77
78					-	-				78
79	Allocation from Management	2017 Land Rover Evoque	2010	7,552	-	1,510	1,510	5	5,286	79
80	TOTALS			\$43,580	\$	\$3,080	\$3,080		\$36,604	80

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)	\$7,101,281	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$9,991	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$333,495	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$323,504	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,674,916	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$1,462,063	92
93			93
94			94
95		\$1,462,063	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.

		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?
16. Rental Amount for movable equipment: \$104 Description: Medical Supplies - \$104
(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	Allocated from Management Co.		\$	\$912	17
18	Facility Use	2019 Lexus RX	701.57	15,979	18
19					19
20					20
21	TOTAL		\$701.57	\$16,891	21

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
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)	\$			

(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.

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	

(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.

HFS 3745 (N-4-99)

IL478-2471

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	L39, C3	hrs	\$	4,172	\$ 300,420	\$	4,172	\$ 300,420	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,182	85,078		1,182	85,078	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		4,269	307,401		4,269	307,401	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				199,138		199,138	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	9,623	\$ 692,899	\$ 199,138	9,623	\$ 892,037	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,502,583	\$ 1,564,915	1
2	Cash-Patient Deposits	24,761	24,761	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,808)	2,171,292	2,171,292	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	37,870	107,757	6
7	Other Prepaid Expenses	-	-	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): See Schedule 17A	531,694	869,559	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,268,200	\$ 4,738,284	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	36,205	13
14	Buildings, at Historical Cost	-	1,364,934	14
15	Leasehold Improvements, at Historical Cost	154,986	3,632,574	15
16	Equipment, at Historical Cost	252,723	2,067,568	16
17	Accumulated Depreciation (book methods)	(296,453)	(4,674,916)	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 (spe See Schedule 17A	680,678	2,247,795	22
23	Other(specify):	-	-	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 791,934	\$ 4,674,160	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,060,134	\$ 9,412,444	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 147,511	\$ 147,511	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	31,083	31,083	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	44,491	44,491	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,561	6,561	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	56,825	32
33	Accrued Interest Payable	34,251	50,008	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,882,181	937,893	36
37		-	-	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,146,078	\$ 1,274,372	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	740,379	6,280,631	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	-	-	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43		-	-	43
44		-	-	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 740,379	\$ 6,280,631	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,886,457	\$ 7,555,003	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,173,677	\$ 1,857,441	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,060,134	\$ 9,412,444	48

*(See instructions.)

Facility Name:Franklin Grove Living Rehab

IDPH License ID Number:0051599

Fiscal Year End:12/31/20

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

		After	
Description		Operating	Consolidation
8811	Due To/From Property	231,221	231,221
4050	Due From Fr. Gr. Associates	223,344	223,344
2900	Escrow - Replacement Reserve	-	162,667
3029	Reimbursement Due	(130,662)	(130,662)
2073	Due From State - Interest	129,983	129,983
3030	Short Term Loan Exchange	76,806	76,806
3025	Rent Receivable - F	-	56,107
2903	Escrow - Insurance	-	40,209
2904	Escrow - Re Taxes	-	28,989
2905	Excrow - Mip	-	28,367
4600	Deposits - Hud	-	21,526
7680	Due To Public Aid	1,002	1,002
Total - Line 9		531,694	869,559
		-	-

XV. Balance Sheet

Line 22 Long-Term Assets Other (specify):

		After	
Description		Operating	Consolidation
6040	Intangible Asset - Goodwill	1,458,598	1,468,000
5050	Cip	-	1,462,063
6041	Accum. Amort. - Goodwill	(777,920)	(777,920)
6044	Mortgage Costs	-	105,485
6045	Accum Amort - Mortgage Costs	-	(9,833)
Total - Line 22		680,678	2,247,795
		-	-

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

		After	
Description		Operating	Consolidation
7310	Accrued Expenses	370,573	370,573
8810	Due From Franklin Grove Inc.	-	242,608
2070	Due From State	122,000	122,000
2075	Due To State Per Audit	97,800	97,800
8812	Due To/From Franklin Gr Ass	5,233	43,609
7610	Short Term Loan Exchange	1,260,605	35,333
7055	Insurance Premiums Payable	24,696	24,696
7145	Acc. Retirement (From P/R)	1,274	1,274
Total - Line 36		1,882,181	937,893
		-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 479,145	1
2	Restatements (describe):		2
3	Prior Period Adjustment	796	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 479,941	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,694,450	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	(714)	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)	\$ 1,693,736	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,173,677	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Franklin Grove Living Rehab

0051599

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	\$ 7,946,045	1
2	Discounts and Allowances for all Levels	(-)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,946,045	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	231,365	6
7	Oxygen	5,131	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 236,496	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	778,177	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	-	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	-	19
20	Radiology and X-Ray	-	20
21	Other Medical Services	-	21
22	Laundry	-	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 778,177	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	1,434	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,434	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		-	28
28a	Transportation and Misc. Income	24,538	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,538	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,986,690	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,265,505	31
32	Health Care	2,682,557	32
33	General Administration	1,173,898	33
	B. Capital Expense		
34	Ownership	990,496	34
	C. Ancillary Expense		
35	Special Cost Centers	957,357	35
36	Provider Participation Fee	222,427	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,292,240	40
41	Income before Income Taxes (line 30 minus line 40)**	1,694,450	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,694,450	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,816,727	44
45	Private Pay - Net Inpatient Revenue	1,790,446	45
46	Medicare - Net Inpatient Revenue	3,338,961	46
47	Other-(specify) Hospice	(89)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,946,045	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.

^Entity is a cash basis taxpayer.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,048	2,160	\$ 85,543	\$ 39.60	1
2	Assistant Director of Nursing	2,116	2,160	72,893	33.75	2
3	Registered Nurses	10,014	10,380	333,907	32.17	3
4	Licensed Practical Nurses	20,051	21,413	633,578	29.59	4
5	CNAs & Orderlies	72,080	75,029	1,181,567	15.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,623	12,113	131,250	10.84	10
11	Social Service Workers	4,223	4,330	89,234	20.61	11
12	Dietician					12
13	Food Service Supervisor	1,919	2,007	58,462	29.13	13
14	Head Cook	5,263	5,531	63,719	11.52	14
15	Cook Helpers/Assistants	21,451	22,355	223,885	10.02	15
16	Dishwashers					16
17	Maintenance Workers	6,303	6,577	100,906	15.34	17
18	Housekeepers	15,506	16,157	165,465	10.24	18
19	Laundry	6,289	6,553	67,112	10.24	19
20	Administrator	2,064	2,160	95,274	44.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,258	8,741	230,852	26.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,207	197,664	\$ 3,533,647 *	\$ 17.88	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,213	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,213		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	111	\$ 5,831	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	111	\$ 5,831		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
Carolyn McBride	Administrator	0	\$95,274	Workers' Compensation Insurance	\$64,517	IDPH License Fee	\$3,980
				Unemployment Compensation Insurance	28,260	Advertising: Employee Recruitment	
				FICA Taxes	268,308	Health Care Worker Background Check (Indicate # of checks performed <u>755</u>)	9,056
				Employee Health Insurance	65,770	Patient Background Checks	
				Employee Meals	6,375	Health Care Council of IL	18,355
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Permits	864
				Other Employee Benefits	19,197	Miscellaneous Inspections & Licenses	7,917
TOTAL (agree to Schedule V, line 17, col. 1)				Holiday Expense	(155)	Allocated from Management Co. & RE	2,504
(List each licensed administrator separately.)			\$95,274	Life Insurance	(17)	Lobbying expense and Chamber of Commerce	(9,592)
B. Administrative - Other						Less: Public Relations Expense	()
Description			Amount			Non-allowable advertising	()
SW Financial Services Co. Fees (Eliminated on Sch V. Col 7.) (Eliminated on Sch. V. Col. 7)			\$107,328			Yellow page advertising	()
Moshe Herman/Momentum Healthcare, LLC			126,000	TOTAL (agree to Schedule V, line 22, col.8)	\$452,255	TOTAL (agree to Sch. V, line 20, col. 8)	\$33,084
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$233,328	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
C. Professional Services	Type		Amount	Description	Line #	Amount	
Nathan Kamionski Llp	Legal		\$1,673	N/A			Out-of-State Travel \$
RSM US LLP	Accounting		23,545				
Personnel Planners Inc.	Unemployment Consultant		1,900				In-State Travel
							Seminar Expense 879
							Allocated from Mgmt Co 352
							Entertainment Expense ()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$27,118	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8) \$1,231

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Franklin Grove Living Rehab
IDPH License ID Number: 0051599
Fiscal Year End: 12/31/20

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Balance brought forward from schedule 21F		27,118
Total (agree to Schedule V, line 19, column 3)		27,118
Allocated from Management Company Legal Fees		2,106
Allocated from Management Company Professional Services		1,760
Allocated from Real Estate Professional Services		10,215
Total (agree to Schedule V, line 19, column 8)		41,199

Facility Name & ID Number <u>Franklin Grove Living Rehab</u>	STATE OF ILLINOIS # <u>0051599</u>	Report Period Beginning: <u>01/01/20</u>	Ending: <u>12/31/20</u>	Page 22
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. Health Care Council of Illinois - \$18,355

(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? 5 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,026 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. \$ 222,427
 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. \$ 6,375 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 d. Have vehicle usage logs been maintained? Adequate records have been maintained
 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 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.