

		FOR BHF USE					

LL1

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>0052712</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Kensington Place Nrsg Rehab</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/20</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>3405 S Michigan Ave</u> <u>Chicago</u> <u>60616</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>(312) 791-0035</u> Fax # <u>(312) 791-0626</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>2/1/2014</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Joshua S. Banach</u>		Telephone Number: <u>(847) 628 - 8784</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) <u>Denise A Leonard, CPA</u> <u>Partner</u>	
		(Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>1111 Superior Ave, Suite 1250 Cleveland, OH 44114</u>	
		(Telephone) <u>(216) 274-6514</u> Fax # <u>(248) 233-7349</u>	
		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	

Facility Name & ID Number Kensington Place Nrsng Rehab

0052712 Report Period Beginning: 1/1/20 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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>155</u>	Skilled (SNF)	<u>155</u>	<u>56,730</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>155</u>	TOTALS	<u>155</u>	<u>56,730</u>	7

B. Census-For the entire report period.					
	1	2	3	4	5
	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF	<u>38,912</u>	<u>169</u>	<u>6,412</u>	<u>45,493</u>
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	<u>38,912</u>	<u>169</u>	<u>6,412</u>	<u>45,493</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.19%

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)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 05/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/01/87 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 155 and days of care provided 5,393

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

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

	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	327,817	60,792	14,827	403,436		403,436	149	403,585			1
2	Food Purchase		294,182		294,182		294,182	109	294,291			2
3	Housekeeping	208,447	32,620		241,067		241,067	1,300	242,367			3
4	Laundry	95,167	15,447		110,614		110,614		110,614			4
5	Heat and Other Utilities			190,034	190,034		190,034	(21,053)	168,981			5
6	Maintenance	123,617	144,827	13,273	281,717		281,717	6,340	288,057			6
7	Other (specify):*	43,805		35,632	79,437		79,437	3,916	83,353			7
8	TOTAL General Services	798,853	547,868	253,766	1,600,487		1,600,487	(9,239)	1,591,248			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	3,101,023	190,091	14,122	3,305,236		3,305,236	(1,395)	3,303,841			10
10a	Therapy	107,515		939,180	1,046,695		1,046,695		1,046,695			10a
11	Activities	116,344	3,303	1,771	121,418		121,418		121,418			11
12	Social Services	429,419	4,554	3,126	437,099		437,099		437,099			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,754,301	197,948	967,199	4,919,448		4,919,448	(1,395)	4,918,053			16
	C. General Administration											
17	Administrative	346,000			346,000		346,000	18,616	364,616			17
18	Directors Fees											18
19	Professional Services			340,782	340,782		340,782	(160,875)	179,907			19
20	Dues, Fees, Subscriptions & Promotions			65,338	65,338		65,338	(9,096)	56,242			20
21	Clerical & General Office Expenses	194,269	157,248	20,730	372,247		372,247	42,812	415,059			21
22	Employee Benefits & Payroll Taxes			841,211	841,211		841,211		841,211			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,246	1,246		1,246	395	1,641			24
25	Other Admin. Staff Transportation			17,571	17,571		17,571	745	18,316			25
26	Insurance-Prop.Liab.Malpractice			251,746	251,746		251,746	1,597	253,343			26
27	Other (specify):*			26,804	26,804		26,804	593	27,397			27
28	TOTAL General Administration	540,269	157,248	1,565,428	2,262,945		2,262,945	(105,213)	2,157,732			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,093,423	903,064	2,786,393	8,782,880		8,782,880	(115,847)	8,667,033			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			54,410	54,410		54,410	89,220	143,630			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,708	13,708		13,708	(13,708)				32
33	Real Estate Taxes			335,298	335,298		335,298	4,986	340,284			33
34	Rent-Facility & Grounds			926,416	926,416		926,416	(919,129)	7,287			34
35	Rent-Equipment & Vehicles			48,510	48,510		48,510	(14,267)	34,243			35
36	Other (specify):*			8,130	8,130		8,130	(8,130)				36
37	TOTAL Ownership			1,386,472	1,386,472		1,386,472	(861,028)	525,444			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,374	82,435	85,809		85,809	(6,989)	78,820			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			335,398	335,398		335,398		335,398			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		3,374	417,833	421,207		421,207	(6,989)	414,218			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,093,423	906,438	4,590,698	10,590,559		10,590,559	(983,864)	9,606,695			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	(22,477)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	86,714	30		9
10	Interest and Other Investment Income	(22,666)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,598)	36		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,167)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(24,637)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,532)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(195,873)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (189,236)		\$	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)	(794,628)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (794,628)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (983,864)		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		Sch. V Line	
	Amount	Reference	
1	Boulevard Property LLC- Management Fees	\$ (11,625) 17	1
2	Boulevard Property LLC- Accounting Fees	(3,550) 19	2
3	Boulevard Property LLC- Bank and Filing Fees	(1,178) 21	3
4	Boulevard Property LLC- Amortization	(19,774) 31	4
5	Bank Charges	(1,674) 21	5
6	Collections Expense	(9,117) 21	6
7	Website Expenses	(535) 19	7
8	PAC Dues	(11,520) 20	8
9	Non-Allowable Auto Lease	(14,539) 35	9
10	Non-Allowable Expense	(91,256) 21	10
11	Capitalized R&M	(17,970) 06	11
12	Non- Allowable Legal	(13,135) 19	12
13		0	13
14		0	14
15		0	15
16		0	16
17		0	17
18		0	18
19		0	19
20		0	20
21		0	21
22		0	22
23		0	23
24		0	24
25		0	25
26		0	26
27		0	27
28		0	28
29		0	29
30		0	30
31		0	31
32		0	32
33		0	33
34		0	34
35		0	35
36		0	36
37		0	37
38		0	38
39		0	39
40		0	40
41		0	41
42		0	42
43		0	43
44		0	44
45		0	45
46		0	46
47		0	47
48		0	48
49	Total	(195,873)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Kensington Place Nrsg Rehab# 0052712

Report Period Beginning:

1/1/20

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	0	0	149	0	0	0	0	0	0	0	0	149	1
2	Food Purchase	0	0	109	0	0	0	0	0	0	0	0	109	2
3	Housekeeping	0	0	1,300	0	0	0	0	0	0	0	0	1,300	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(22,477)	0	1,424	0	0	0	0	0	0	0	0	(21,053)	5
6	Maintenance	(17,970)	0	2,836	21,474	0	0	0	0	0	0	0	6,340	6
7	Other (specify):*	0	0	0	3,916	0	0	0	0	0	0	0	3,916	7
8	TOTAL General Services	(40,447)	0	5,816	25,391	0	0	0	0	0	0	0	(9,240)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(1,395)	0	0	0	0	0	(1,395)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	(1,395)	0	0	0	0	0	(1,395)	16
	C. General Administration													
17	Administrative	(11,625)	11,625	0	18,616	0	0	0	0	0	0	0	18,616	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,220)	3,550	(147,757)	0	0	0	552	0	0	0	0	(160,875)	19
20	Fees, Subscriptions & Promotions	(11,520)	0	2,424	0	0	0	0	0	0	0	0	(9,096)	20
21	Clerical & General Office Expenses	(103,225)	1,178	12,763	131,610	0	0	486	0	0	0	0	42,812	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	395	0	0	0	0	0	0	0	0	395	24
25	Other Admin. Staff Transportation	0	0	745	0	0	0	0	0	0	0	0	745	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,597	0	0	0	0	0	0	0	0	1,597	26
27	Other (specify):*	(26,804)	0	0	27,397	0	0	0	0	0	0	0	593	27
28	TOTAL General Administration	(170,394)	16,353	(129,832)	177,623	0	0	1,038	0	0	0	0	(105,212)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(210,841)	16,353	(124,016)	203,013	0	(1,395)	1,038	0	0	0	0	(115,847)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	86,714	0	2,506	0	0	0	0	0	0	0	0	89,220	30
31	Amortization of Pre-Op. & Org.	(19,774)	19,774	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,666)	0	8,958	0	0	0	0	0	0	0	0	(13,708)	32
33	Real Estate Taxes	0	0	4,986	0	0	0	0	0	0	0	0	4,986	33
34	Rent-Facility & Grounds	0	(926,416)	0	0	0	0	7,287	0	0	0	0	(919,129)	34
35	Rent-Equipment & Vehicles	(14,539)	0	272	0	0	0	0	0	0	0	0	(14,267)	35
36	Other (specify):*	(8,130)	0	0	0	0	0	0	0	0	0	0	(8,130)	36
37	TOTAL Ownership	21,605	(906,642)	16,722	0	0	0	7,287	0	0	0	0	(861,028)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(6,989)	0	0	0	0	0	(6,989)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	(6,989)	0	0	0	0	0	(6,989)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(189,236)	(890,289)	(107,293)	203,013	0	(8,384)	8,325	0	0	0	0	(983,864)	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 - Supp		See Page 6 - Supp		See Page 6 - 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	34	Rent	\$ 926,416	Boulevard Property, LLC	100.00%	\$	\$ (926,416)	1
2	V	33	Real Estate Taxes	317,852	Boulevard Property, LLC	100.00%	317,852		2
3	V	32	Interest	273,046	Boulevard Property, LLC	100.00%	273,046		3
4	V	17	Management Fees		Boulevard Property, LLC	100.00%	11,625	11,625	4
5	V	19	Legal & Accounting		Boulevard Property, LLC	100.00%	3,550	3,550	5
6	V	21	Misc Fees & Charges		Boulevard Property, LLC	100.00%	1,178	1,178	6
7	V	31	Amortization		Boulevard Property, LLC	100.00%	19,774	19,774	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,517,314			\$ 627,025	\$ * (890,289)	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	Yechiel Mashiach	15.20%	BEECHER MANOR NURSING AND REHABIL	BEECHER	Ex Care Consulting	Evanston, IL	Home Office	1
2	Emilelch Ray	7.40%	BURBANK REHABILITATION CENTER	BURBANK	Ex . Care Clinical	Evanston, IL	Administrative	2
3	Chaim Ray	7.40%	CHATEAU NURSING AND REHABILITATION	WILLOWBROOK	2201 Main Street	Evanston, IL	Bldg. Company	3
4	Devorah Ray - Engel	7.40%	COUNTRYSIDE NURSING AND REHABILITAD	DOLTON	CCS VEBA	Evanston, IL	Health Insurance	4
5	Nechama Ray	7.40%	GRASMERE PLACE, LLC	CHICAGO	Vent Lease	Evanston, IL	Vent. Rental	5
6	Malkara Ray - Mashiach	15.20%	ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	Mac RX, LLC	Des Plaines, IL	Pharmacy	6
7	Atied Assoc.	40.00%	LAKEWOOD NURSING & REHABILITATION	PLAINFIELD	Boulevard Property	Chicago, IL	Bldg. Company	7
8			LEMONT NURSING AND REHABILITATION	LEMONT	Jade Financial	Chicago, IL	Consulting Co	8
9			MAJOR HOSPITAL DYER	DYER, IN				9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH (	MERRIVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE MANOR NURSING & REHABILITA	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER,	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			RUSHVILLE NURSING & REHABILITATION	RUSHVILLE				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SOUTH HOLLAND MANOR HEALTH & REH	SOUTH HOLLAND				21
22			SOUTH SUBURBAN REHABILITATION CENT	HOMEWOOD				22
23			ST. JAMES WELLNESS REHAB VILLAS	CRETE				23
24			THE ESTATES OF HYDE PARK	CHICAGO				24
25			TIMBER POINT HEALTHCARE CENTER, INC	CAMP POINT				25
26			WESTMONT MANOR HEALTH & REHAB CE	WESTMONT				26
27			WHEATON VILLAGE NURSING AND REHAB	WHEATON				27
28			LITTLE VILLAGE NURSING & REHAB	CHCAGO				28
29			SHERIDAN VILLAGE NURSING & REHAB	CHICAGO				29
30			TRI STATE VILLAGE NURSING & REHAB	LANSING				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	100.00%	\$ 149	\$ 149	15
16	V	02	Food		Extended Care Consulting	100.00%	109	109	16
17	V	03	Housekeeping		Extended Care Consulting	100.00%	1,300	1,300	17
18	V	05	Utilities		Extended Care Consulting	100.00%	1,424	1,424	18
19	V	06	Maintenance		Extended Care Consulting	100.00%	2,836	2,836	19
20	V	17	Administrative		Extended Care Consulting	100.00%	0		20
21	V	19	Professional Fees		Extended Care Consulting	100.00%	5,795	5,795	21
22	V	20	Dues and Subscriptions		Extended Care Consulting	100.00%	2,424	2,424	22
23	V	21	Office and Clerical		Extended Care Consulting	100.00%	12,763	12,763	23
24	V	24	Seminar and Travel		Extended Care Consulting	100.00%	395	395	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting	100.00%	745	745	25
26	V	26	Insurance		Extended Care Consulting	100.00%	1,597	1,597	26
27	V	30	Depreciation		Extended Care Consulting	100.00%	2,506	2,506	27
28	V	32	Interest		Extended Care Consulting	100.00%	8,958	8,958	28
29	V	33	Real Estate Taxes		Extended Care Consulting	100.00%	4,986	4,986	29
30	V	34	Rent - Building		Extended Care Consulting	100.00%	0		30
31	V	35	Rent - Equipment		Extended Care Consulting	100.00%	272	272	31
32	V	19	Consulting Fees	153,552	Extended Care Consulting	100.00%		(153,552)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 153,552			\$ 46,259	\$ * (107,293)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	06 Maintenance Salaries	\$	Extended Care Consulting	100.00%	\$ 21,474	\$ 21,474	15
16	V	06 Maintenance (Direct)		Extended Care Consulting	100.00%			16
17	V	07 Emp. Ben. - Gen. Serv.		Extended Care Consulting	100.00%	3,916	3,916	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting	100.00%			18
19	V	12 Admission (Direct)		Extended Care Consulting	100.00%			19
20	V	15 Emp. Ben. - Nursing (Direct)		Extended Care Consulting	100.00%			20
21	V	17 Administrative Salaries		Extended Care Consulting	100.00%	18,616	18,616	21
22	V	21 Office and Clerical Salaries		Extended Care Consulting	100.00%	131,610	131,610	22
23	V	21 Office and Clerical (Direct)		Extended Care Consulting	100.00%			23
24	V	27 Emp. Ben. - Gen. Admin.		Extended Care Consulting	100.00%	27,397	27,397	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting	100.00%			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		\$			\$ 203,013	\$ * 203,013	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 Benefits	\$ 246,812	CCS VEBA	100.00%	\$ 246,812	\$	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			\$ 246,812			\$ 246,812	\$ *	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	\$ 14,922	MAC Rx, LLC	100.00%	\$ 13,527	\$ (1,395)	15
16	V	39	Ancillary	74,776	MAC Rx, LLC	100.00%	67,787	(6,989)	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			\$ 89,698			\$ 81,314	\$ * (8,384)	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	4	5	6	7	8	
Schedule V			Cost Per General Ledger		Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
	Line	Item	Amount	Name of Related Organization					
15	V	21	A&G Expenses	\$	Jade Financial	100.00%	\$ 486	\$ 486	15
16	V	19	Professional Fees		Jade Financial	100.00%	552	552	16
17	V	34	Rent Expense		Jade Financial	100.00%	7,287	7,287	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		\$				\$ 8,325	\$ * 8,325	39

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

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	0.00%	See Attached	1.23	3.08%	Alloc Salary	\$ 2,194	22-07	1
2	Yechiel Mashiach	Owner	Administration	15.20%	See Attached	38.04	95.10%	Salary	190,201	17-01	2
3	Yaacov Mashiach	Relative	Admin/Admission	0.00%	See Attached	7.46	18.46%	Salary	20,172	17-1; 12-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 212,567		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 Kensington Place Nrsg Rehab # 0052712 Report Period Beginning: 1/1/20 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
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

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

Facility Name & ID Number Kensington Place Nrsrg Rehab# 0052712

Report Period Beginning:

1/1/20Ending: 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 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 491-9565

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Resident Days	36	\$ 3,992	\$	45,493	\$ 149	1
2	02	Food	Resident Days	36	2,910		45,493	109	2
3	03	Housekeeping	Resident Days	36	34,856		45,493	1,300	3
4	05	Utilities	Resident Days	36	38,173		45,493	1,424	4
5	06	Maintenance	Resident Days	36	76,040		45,493	2,836	5
6	17	Administrative	Resident Days	36			45,493		6
7	19	Professional Fees	Resident Days	36	155,408		45,493	5,795	7
8	20	Dues and Subscriptions	Resident Days	36	64,998		45,493	2,424	8
9	21	Office and Clerical	Resident Days	36	342,251		45,493	12,763	9
10	24	Seminar and Travel	Resident Days	36	10,602		45,493	395	10
11	25	Other Staff Admin. Trans.	Resident Days	36	19,988		45,493	745	11
12	26	Insurance	Resident Days	36	42,836		45,493	1,597	12
13	30	Depreciation	Resident Days	36	67,209		45,493	2,506	13
14	32	Interest	Resident Days	36	240,208		45,493	8,958	14
15	33	Real Estate Taxes	Resident Days	36	133,701		45,493	4,986	15
16	34	Rent - Building	Resident Days	36			45,493		16
17	35	Rent - Equipment	Resident Days	36	7,304		45,493	272	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,240,476	\$		\$ 46,259	25

Facility Name & ID Number Kensington Place Nrsg Rehab# 0052712

Report Period Beginning:

1/1/20Ending: 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 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 491-9565

	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	06	Maintenance Salaries	Resident Days	1,219,947	36	\$ 575,856	\$ 575,856	45,493	\$ 21,474	1
2	06	Maintenance (Direct)								2
3	07	Emp. Ben. - Gen. Serv.	Resident Days	1,219,947	36	105,021		45,493	3,916	3
4	07	Emp. Ben. - Gen. Serv. (Direct)								4
5	12	Admission (Direct)								5
6	15	Emp. Ben. - Nursing (Direct)								6
7	17	Administrative Salaries	Resident Days	1,219,947	36	499,202	499,202	45,493	18,616	7
8	21	Office and Clerical Salaries	Resident Days	1,219,947	36	3,529,267	3,529,267	45,493	131,610	8
9	21	Office and Clerical (Direct)								9
10	27	Emp. Ben. - Gen. Admin.	Resident Days	1,219,947	36	734,685		45,493	27,397	10
11	27	Emp. Ben. - Gen. Admin. (Direct)								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,444,030	\$ 4,604,325		\$ 203,013	25

Facility Name & ID Number Kensington Place Nrsg Rehab # 0052712 Report Period Beginning: 1/1/20 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 CCS VEBA
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 491-9565

	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	22	Employee Benefits	Direct Allocation	8,032,049		\$ 8,032,049	\$	246,812	\$ 246,812	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 8,032,049	\$		\$ 246,812	25

Facility Name & ID Number Kensington Place Nrsg Rehab# 0052712

Report Period Beginning:

1/1/20Ending: 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

MAC Rx LLC

Street Address

2307 S. Mount Prospect Road

City / State / Zip Code

Des Plaines, Illinois 60018

Phone Number

(224) 220-2700

Fax Number

(224) 220-2730

	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	10	Nursing	Profit Margin	690,072	26	\$ 690,072	\$	13,527	\$ 13,527	1
2	39	Ancillary	Profit Margin	4,277,990	26	4,277,990		67,787	67,787	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,968,062	\$		\$ 81,314	25

Facility Name & ID Number Kensington Place Nrsg Rehab # 0052712 Report Period Beginning: 1/1/20 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 Jade Financial Services LLC
Street Address 2320 S. Lawndale Ave
City / State / Zip Code Chicago, IL 60623
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	A&G Expenses	Resident Days	200,733	5	\$ 2,146	\$	45,493	\$ 486	1
2	19	Professional Fees	Resident Days	200,733	5	2,435		45,493	552	2
3	34	Rent Expense	Resident Days	200,733	5	32,153		45,493	7,287	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 36,734	\$		\$ 8,325	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	CIBC		X	Mortgage			\$	4,410,000			\$ 273,046	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG		X	Line of Credit							12,814	6
7	Allocated From ECC		X								8,958	7
8	Equipment Loan		X					3,497				8
9	TOTAL Facility Related						\$	4,413,497			\$ 294,818	9
	B. Non-Facility Related*											
10	Interest Income		X								(22,666)	10
11	Interest Income- Building		X								(273,046)	11
12	Other Long Term Debt		X					58,150				12
13	Misc. Interest Expense		X								894	13
14	TOTAL Non-Facility Related						\$	58,150			\$ (294,818)	14
15	TOTALS (line 9+line14)						\$	4,471,647			\$	15

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

		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.		\$	322,439	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.)		\$	317,308	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(5,131)	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	345,400	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.)		\$	15	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.		\$	340,284	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	224,149	8	
		2016	244,996	9	
		2017	263,322	10	
		2018	307,084	11	
		2019	312,337	12	
2020 Accrual: \$312,337 X 1.11 = \$345,400					
Allocated From ECC: \$4,986					

		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 Kensington Place Nrsg Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052712

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (847) 628 - 8784 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 17-34-119-001-0000	Long Term Care Facility	\$ 92,254.96	\$ 92,254.96
2. 17-34-119-002-0000	Long Term Care Facility	\$ 15,616.53	\$ 15,616.53
3. 17-34-119-003-0000	Long Term Care Facility	\$ 153,999.56	\$ 153,999.56
4. 17-34-119-004-0000	Long Term Care Facility	\$ 14,893.22	\$ 14,893.22
5. 17-34-119-005-0000	Long Term Care Facility	\$ 17,786.40	\$ 17,786.40
6. 17-34-119-006-0000	Long Term Care Facility	\$ 17,786.40	\$ 17,786.40
7. Allocated Fom ECC	Home Office Allocation	\$ 197,162.69	\$ 4,985.85
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 509,499.76	\$ 317,322.92

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: 42,293

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	51,000	1995	\$ 100,000	1
2	Allocated From ECC			20,736	2
3	TOTALS	51,000		\$ 120,736	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		1989		\$ 1,209,350	\$	40	\$ 30,234	\$ 30,234	\$ 967,480	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	8,296		20			8,296	9
10	Various			1988	11,646		20			11,646	10
11	Various			1989	5,250		20			5,250	11
12	Various			1990	7,780		20			7,780	12
13	Various			1991	16,578		20			16,578	13
14	Various			1992	17,269		20			17,269	14
15	Various			1993	21,968		20			21,968	15
16	Various			1994	13,356		20			13,356	16
17	Various			1995	12,270		20			12,270	17
18	Various			1996	15,797		20			15,797	18
19	Various			1997	7,187		20			7,187	19
20	Various			1998	17,815		20			17,815	20
21	Various			1999	6,043		20			6,043	21
22	Various			2000	235,020		20			235,020	22
23	Various			2001	61,023		20	3,051	3,051	61,023	23
24	Various			2002	236,588		20	11,829	11,829	224,759	24
25	Various			2003	110,588		20	5,529	5,529	99,529	25
26	Various			2004	98,820		20	4,941	4,941	83,997	26
27	Various			2005	1,500		20	75	75	1,200	27
28	Various			2006	18,167		20	908	908	13,625	28
29	Various			2007	7,963		20	398	398	5,574	29
30	Various			2008	12,185		20	609	609	7,920	30
31	Various			2009	10,849		20	542	542	6,509	31
32	Various			2010	87,696		20	4,385	4,385	48,233	32
33	Various			2011	66,198		20	3,310	3,310	33,099	33
34	Various			2012	162,288		20	8,114	8,114	73,030	34
35	Various			2013	55,948		20	2,797	2,797	22,379	35
36	Various			2014	50,487		20	2,524	2,524	17,670	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 Kensington Place Nrsg Rehab

0052712

Report Period Beginning:

1/1/20

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	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 Elevator - Remove and Replace Casings	2016	\$ 27,200	\$	20	\$ 1,360	\$ 1,360	\$ 6,800	37
38 Elevator - Control System Board	2016	4,488		20	224	224	1,122	38
39 Painting - Group, Therapy, Dishwasher, Basement,								39
40 Basement, Dining, Recreation, Kitchen, Storage,								40
41 2nd and 3rd Floors	2016	22,845		20	1,142	1,142	5,711	41
42 Nurse Call System	2016	12,094		20	605	605	3,024	42
43 Elevator - Two Door Opener	2016	9,500		20	475	475	2,375	43
44 Elevator - Hydraulic Cylinder	2016	33,000		20	1,650	1,650	8,250	44
45 Flooring - Dishwashing Room	2016	4,590		20	230	230	1,148	45
46 Facility Renovations								46
47 Structural Engineering, Permits, and Project Management	2016	12,239		20	612	612	3,060	47
48 Guest Bathroom - New Tile, Cove Base, Drywall, and Fixture	2016	2,569		20	128	128	642	48
49 Vestibule - Electric Doors, Electric Signs, Fire Alarm Switch,								49
50 Carpet Tile, Millwork, and Painting	2016	18,977		20	949	949	4,744	50
51 Therapy Room - Cornices	2016	317		20	16	16	79	51
52 Offices - Carpet Tile, Cove Base, Window Treatments, Painting	2016	8,828		20	441	441	2,207	52
53 Elevator - Wallcovering, Handrail, Bumper, and Flooring	2016	10,990		20	550	550	2,748	53
54 Dayroom - Fireplace, Cove Base, Wallcovering, and Window Tr	2016	18,259		20	913	913	4,565	54
55 Conference Room - Carpet Tile, Cove Base, Wallcoverings,								55
56 Lighting, and Painting	2016	10,091		20	505	505	2,523	56
57 Corridors - Cove Base, Signage, Lights, Wallcoverings, and Han	2016	55,317		20	2,766	2,766	13,829	57
58 Administrator Bathroom - Tile, Drywall, Lights, and Fixtures	2016	3,062		20	153	153	766	58
59 Lobby - Cove Base, New Wall, Drop Ceiling, Wallcoverings,								59
60 Electrical Fixtures, Double Doors and Framing, Signs,								60
61 Cornices, and Sheers	2016	29,625		20	1,481	1,481	7,406	61
62 Facility Renovations								62
63 Resident Rooms - Cove Base, Overbed Lights, Cubicle								63
64 Curtains, Window Treatments, Bumper Guards and								64
65 End Caps, and Painting	2016	52,481		20	2,624	2,624	13,120	65
66 1st Floor Corridors, Dining Room, and Lobby - Ceiling Tiles	2016	18,557		20	928	928	4,639	66
67 1st Floor - New Doors, Hardward, and Installation	2016	34,496		20	1,725	1,725	8,624	67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,975,450	\$		\$ 98,725	\$ 98,725	\$ 2,159,684	70

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

Facility Name & ID Number Kensington Place Nrsg Rehab

0052712

Report Period Beginning:

1/1/20

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		\$ 2,975,450	\$		\$ 98,725	\$ 98,725	\$ 2,159,684	1
2									2
3	<u>Elevators- Shunt Trip, Heat Exchangers & Spinkler Heads</u>	2017	14,980		20	749	749	2,996	3
4	<u>Resident Rooms- Repair Walls & Repaint, Including Doors</u>								4
5	<u>Trim, Radiator Covers & Ceilings (As Necessary)</u>	2017	46,000		20	2,300	2,300	9,200	5
6	<u>Signage- Resident Rooms & Common Areas</u>	2017	4,695		20	235	235	939	6
7	<u>Resident Rooms- Relpace Rotted Framing & Drywall</u>	2017	8,350		20	418	418	1,670	7
8	<u>Vinyl Cove Base- 2,650 Sq Ft Remove & Replace</u>	2017	4,650		20	233	233	930	8
9	<u>Elevator- Car Top Safety Handrail & Mounting Unit</u>	2017	2,578		20	129	129	516	9
10	<u>Elevator- Component Replacements For Modernization</u>	2017	31,310		20	1,566	1,566	6,262	10
11	<u>Fire Pump</u>	2017	4,081		20	204	204	816	11
12	<u>Roof Repair</u>	2018	4,800		20	240	240	720	12
13	<u>Flooring- Vinyl Planks- Basement, 2nd, 3rd Fl Coves</u>	2018	42,986		20	2,149	2,149	6,448	13
14	<u>Painting- Basement, 2nd and 3rd Floors</u>	2018	16,239		20	812	812	2,436	14
15	<u>Elevator Services</u>	2019	5,289		20	264	264	529	15
16	<u>Backflow Prevention Work</u>	2019	8,250		20	413	413	825	16
17	<u>Upgrade Refrigeration</u>	2019	6,313		20	316	316	631	17
18	<u>Electrical Work- Replace Breaker</u>	2019	3,300		20	165	165	330	18
19	<u>Electrical Work Install New Breaker</u>	2019	8,500		20	425	425	850	19
20	<u>New Sprinkler System</u>	2019	11,554		20	578	578	1,155	20
21	<u>Roofing Repair- Rubber & Membrane</u>	2019	5,200		20	260	260	520	21
22	<u>Broken Sink Line Piping Repair- Kitchen/Greasetrap</u>	2019	3,500		20	175	175	350	22
23	<u>Repair and Welding on Elevator #2</u>	2019	3,692		20	185	185	369	23
24	<u>Nursing Station Built in Cabinets- Panels and Tops</u>	2020	21,748		20	1,087	1,087	1,087	24
25	<u>New Hot Water Tank- Boiler Room</u>	2020	7,900		20	395	395	395	25
26	<u>Generator Repairs-Engine/Thermostat/Radiator/Cooling Syst</u>	2020	2,739		20	137	137	137	26
27	<u>Generator Repair- Exhaust Insulation</u>	2020	3,908		20	195	195	195	27
28	<u>Hydro Jet System-Branch Line/Pipe Fittings-Across Facility</u>	2020	2,800		20	140	140	140	28
29	<u>Fire Alarm Panel-Annunciator/Communicator (Whole Fac.)</u>	2020	3,458		20	173	173	173	29
30									30
31	<u>Financial Statement Depreciation- Kensington Place Nursing & Rehab</u>			54,410			(54,410)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,254,271	\$ 54,410		\$ 112,666	\$ 58,256	\$ 2,200,304	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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 3,254,271	\$ 54,410		\$ 112,666	\$ 58,256	\$ 2,200,304	1
2								2
3 Related Party Allocations								3
4								4
5 Dyer Building Allocation	2007	8,950	198	40	198		2,676	5
6 Allocated From ECC/2201 Main	2002	28,575	733	40	733		13,402	6
7								7
8								8
9 Allocated From ECC/2201 Main	2002	23,606		20			23,606	9
10 Allocated From ECC/2201 Main	2003	27,818		20			27,818	10
11 Allocated From ECC/2201 Main	2005	1,382		20			1,382	11
12 Allocated From ECC/2201 Main	2009	249	12	20	12		150	12
13 Allocated From ECC/2201 Main	2014	2,394	120	20	120		838	13
14 Allocated From ECC/2201 Main	2015	393	20	20	20		254	14
15 Allocated From ECC/2201 Main	2016	1,553	78	20	78		388	15
16 Allocated From ECC/2201 Main	2017	2,694	135	20	135		539	16
17 Allocated From ECC/2201 Main	2018	1,235	62	20	62		185	17
18 Allocated From ECC/2201 Main	2019	465	23	20	23		47	18
19 Allocated From ECC/2201 Main	2020	124	6	20	6		6	19
20								20
21 Allocated From ECC	2007	172	9	20	9		120	21
22 Allocated From ECC	2009	103	5	20	5		62	22
23 Allocated From ECC	2010	1,006	50	20	50		553	23
24 Allocated From ECC	2011	362	18	20	18		181	24
25 Allocated From ECC	2012	119	6	20	6		54	25
26 Allocated From ECC	2014	1,654	83	20	83		579	26
27 Allocated From ECC	2016	1,983	99	20	99		496	27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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)		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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 12D, Carried Forward		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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
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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)		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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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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)		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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 12F, Carried Forward		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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 12G, Carried Forward		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	1
2									2
3									3
4									4
5									5
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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)		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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 12H, Carried Forward		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,359,108	\$ 56,067		\$ 114,323	\$ 58,256	\$ 2,273,640	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	\$190,536	\$	\$19,054	\$19,054	10	\$114,322	71
72	Current Year Purchases	94,042		9,404	9,404	10	9,404	72
73	Fully Depreciated Assets	4,346				10	4,346	73
74	See Attached	277,112	850	850		10	276,381	74
75	TOTALS	\$566,036	\$850	\$29,308	\$28,458		\$404,453	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	Allocated From ECC		2014	\$949	\$	\$	\$		\$949	76
77										77
78										78
79										79
80	TOTALS			\$949	\$	\$	\$		\$949	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)	\$4,046,829	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$56,917	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$143,631	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$86,714	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,679,042	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	Allocated From Jade Financial				7,287			5
6								6
7	TOTAL				\$ 7,287			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: \$ 17,909
- Description: \$12,325 Copier; \$775 Postage Machine; \$4,536 Other Office Rental; \$272 Allocated From ECC
- (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	Facility	Lexus	\$ 1,361.17	\$ 16,334	17
18					18
19					19
20					20
21	TOTAL		\$ 1,361.17	\$ 16,334	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)	\$			

(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	V10A	hrs	\$	5,428	\$ 407,067	\$	5,428	\$ 407,067	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,394	104,513		1,394	104,513	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		5,701	427,600		5,701	427,600	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	107,515					107,515	8
9	Pharmacy	V39	# of prescripts				79,070		79,070	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					3,365		3,365	12
13	Other (specify): BILLABLE SUPPLIES	V39					3,374		3,374	13
14	TOTAL			\$ 107,515	12,522	\$ 939,180	\$ 85,809	12,522	\$ 1,132,504	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	\$ 3,033,927	\$ 3,091,880	1
2	Cash-Patient Deposits	148,428	148,428	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,120,419	3,120,419	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,183	80,183	6
7	Other Prepaid Expenses	2,985	2,985	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	609,933	609,933	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,995,875	\$ 7,053,828	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		3,624,354	14
15	Leasehold Improvements, at Historical Cost	802,473	802,473	15
16	Equipment, at Historical Cost	208,499	363,499	16
17	Accumulated Depreciation (book methods)	(283,106)	(4,062,460)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		21,572	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(19,774)	20
21	Restricted Funds	210,201	210,201	21
22	Other Long-Term Assets (spe See Attached			22
23	Other(specify): See Attached	1,185,648	5,895,648	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,123,715	\$ 6,935,513	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,119,590	\$ 13,989,341	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,226,210	\$ 1,226,209	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	152,057	152,057	28
29	Short-Term Notes Payable	3,497	3,497	29
30	Accrued Salaries Payable	522,054	522,054	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,215	28,215	31
32	Accrued Real Estate Taxes(Sch.IX-B)	345,400	345,400	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	2,361,431	2,571,632	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,638,864	\$ 4,849,064	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	58,150	58,150	39
40	Mortgage Payable		4,410,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	775,000	1,677,429	43
44	See Attached			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 833,150	\$ 6,145,579	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,472,014	\$ 10,994,644	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,647,576	\$ 2,994,698	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,119,590	\$ 13,989,341	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,663,290	1
2	Restatements (describe):		2
3	Prior Year Bad Debt Expense	(67,642)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,595,648	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,880,672	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	(828,744)	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)	\$ 2,051,928	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)	\$ 3,647,576	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Kensington Place Nrsg Rehab

0052712

Report Period Beginning: 1/1/20

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	\$ 12,096,855	1
2	Discounts and Allowances for all Levels	(2,827,551)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,269,304	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,839,687	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,839,687	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	91,727	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,314	19
20	Radiology and X-Ray	2,270	20
21	Other Medical Services	4,877	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 114,188	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	37,075	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 37,075	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		1,210,977	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,210,977	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,471,231	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,600,487	31
32	Health Care	4,919,448	32
33	General Administration	2,262,945	33
	B. Capital Expense		
34	Ownership	1,386,472	34
	C. Ancillary Expense		
35	Special Cost Centers	85,809	35
36	Provider Participation Fee	335,398	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,590,559	40
41	Income before Income Taxes (line 30 minus line 40)**	2,880,672	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,880,672	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,054,626	44
45	Private Pay - Net Inpatient Revenue	34,881	45
46	Medicare - Net Inpatient Revenue	1,543,061	46
47	Other-(specify) <u>ALL OTHER SNF/SCF IP REVENUE</u>	188,247	47
48	Other-(specify) <u>C/A ANCILLARY ACCOUNTS</u>	(551,511)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,269,304	49

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,804	2,104	\$ 141,541	\$ 67.27	1
2	Assistant Director of Nursing	1,979	2,181	103,888	47.63	2
3	Registered Nurses	12,876	14,235	636,565	44.72	3
4	Licensed Practical Nurses	30,926	33,428	1,045,151	31.27	4
5	CNAs & Orderlies	60,493	67,205	1,138,608	16.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,189	5,984	107,515	17.97	8
9	Activity Director	1,778	1,995	34,418	17.25	9
10	Activity Assistants	4,486	5,127	81,926	15.98	10
11	Social Service Workers	14,619	16,103	429,419	26.67	11
12	Dietician					12
13	Food Service Supervisor	1,924	2,096	51,967	24.79	13
14	Head Cook	15,609	17,573	275,850	15.70	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,826	6,481	123,617	19.07	17
18	Housekeepers	11,604	13,237	208,447	15.75	18
19	Laundry	5,715	6,196	95,167	15.36	19
20	Administrator	1,666	1,840	199,200	108.26	20
21	Assistant Administrator	1,540	1,745	146,800	84.13	21
22	Other Administrative	7,081	7,679	194,269	25.30	22
23	Office Manager					23
24	Clerical					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	1,849	2,032	35,270	17.36	31
32	Other Health Care(specify)	2,331	2,468	43,805	17.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,295	209,709	\$ 5,093,423 *	\$ 24.29	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	287	\$ 14,827	V01-03	35
36	Medical Director	Monthly Fees	9,000	V09-03	36
37	Medical Records Consultant	Monthly Fees	3,639	V10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fees	10,483	V10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly Fees	1,771	V11-03	44
45	Social Service Consultant	Monthly Fees	3,126	V12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	287	\$ 42,846		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.

STATE OF ILLINOIS

Facility Name & ID NumberKensington Place Nrsg Rehab

0052712

Report Period Beginning:1/1/20

Page 21

Ending:12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Extended Care Consulting

Consulting Fees

\$ 153,552

Terrill Consulting Services

AR Consulting Services

54,369

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 207,921

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$

Unemployment Compensation Insurance

FICA Taxes

Employee Health Insurance

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

TOTAL (agree to Schedule V, line 22, col.8)

\$

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

(Indicate # of checks performed)

Patient Background Checks

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>Kensington Place Nrsg Rehab</u>	STATE OF ILLINOIS # <u>0052712</u>	Report Period Beginning: <u>1/1/20</u>	Ending: <u>12/31/20</u>
---	--	---	--------------------------------

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. Healthcare Council of IL \$23,041

(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? 5-10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A

(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. \$ 335,398
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 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? Ln 14
 d. Have vehicle usage logs been maintained? Yes
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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.