

		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: 0053868 Facility Name: Lakefront Nursing Rehab Ctr Address: 7618 N Sheridan Road Chicago 60626 Number City Zip Code County: Cook Telephone Number: (773)743-7711 Fax #: (773)761-3387 HFS ID Number: Date of Initial License for Current Owners: 4/1/2006 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Date) (Type or Print Name) (Title) Paid Preparer (Signed) 05/09/2021 (Date) * Subject to the attached Accountants' Consulting Report (Print Name Steven N. Lavenda, CPA and Title Partner) (Firm Name Marcum, LLP & Address 9 Parkway North, Suite 200 Deerfield, IL 60015) (Telephone) (847) 282-6300 Fax #: (847) 282-6301 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
In the event there are further questions about this report, please contact: Name: Steven N. Lavenda Telephone Number: (847) 282-6300 Email Address:	

Facility Name & ID Number Lakefront Nursing Rehab Ctr

0053868 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

N/A

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234
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	99	TOTALS	99	36,234

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		1,496	1,496	8
9	SNF/PED				9
10	ICF	30,833	135	421	31,389
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	30,833	135	1,917	32,885

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.76%

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

None (Do not include bed reserve days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 4/1/2006

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

YES ☒ Date 4/1/2006 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 99 and days of care provided 1,496

Medicare Intermediary National Government Services

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.

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 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		3,739	614,599	618,338		618,338	1,869	620,207			1
2	Food Purchase		423		423		423	3,555	3,978			2
3	Housekeeping		4,735	351,365	356,100		356,100	1,212	357,312			3
4	Laundry	85,867	9,120		94,987		94,987	82	95,069			4
5	Heat and Other Utilities			116,732	116,732		116,732	(5,198)	111,534			5
6	Maintenance	210,859	6,254	93,351	310,464		310,464	4,199	314,663			6
7	Other (specify):*											7
8	TOTAL General Services	296,726	24,271	1,176,047	1,497,044		1,497,044	5,719	1,502,763			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,990,715	120,550	42,667	2,153,932		2,153,932	53,519	2,207,451			10
10a	Therapy	133,644			133,644		133,644		133,644			10a
11	Activities	77,838	6,166	962	84,966		84,966	5	84,971			11
12	Social Services	193,123		3,201	196,324		196,324	3,246	199,570			12
13	CNA Training											13
14	Program Transportation			1,375	1,375		1,375		1,375			14
15	Other (specify):*							3,367	3,367			15
16	TOTAL Health Care and Programs	2,395,320	126,716	48,205	2,570,241		2,570,241	60,136	2,630,377			16
	C. General Administration											
17	Administrative	215,294			215,294		215,294	36,133	251,427			17
18	Directors Fees											18
19	Professional Services			109,716	109,716	(617)	109,099	(10,431)	98,668			19
20	Dues, Fees, Subscriptions & Promotions			44,349	44,349		44,349	(22,796)	21,553			20
21	Clerical & General Office Expenses	121,021	1,287	256,295	378,603		378,603	2,783	381,386			21
22	Employee Benefits & Payroll Taxes			494,349	494,349		494,349		494,349			22
23	Inservice Training & Education											23
24	Travel and Seminar			568	568		568	81	649			24
25	Other Admin. Staff Transportation			129	129		129	2,701	2,830			25
26	Insurance-Prop.Liab.Malpractice			149,107	149,107		149,107	7,571	156,678			26
27	Other (specify):*							14,482	14,482			27
28	TOTAL General Administration	336,315	1,287	1,054,513	1,392,115	(617)	1,391,498	30,524	1,422,023			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,028,361	152,274	2,278,765	5,459,400	(617)	5,458,783	96,379	5,555,163			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							391,280	391,280			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,265	9,265		9,265	279,215	288,480			32
33	Real Estate Taxes			16,164	16,164	617	16,781	138,376	155,157			33
34	Rent-Facility & Grounds			737,836	737,836		737,836	(737,780)	56			34
35	Rent-Equipment & Vehicles			2,064	2,064		2,064	2,624	4,688			35
36	Other (specify):*							38,509	38,509			36
37	TOTAL Ownership			765,329	765,329	617	765,946	112,225	878,171			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		103,926	373,248	477,174		477,174	(2,608)	474,566			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			250,079	250,079		250,079		250,079			42
43	Other (specify):*			317,886	317,886		317,886	(317,886)				43
44	TOTAL Special Cost Centers		103,926	941,213	1,045,139		1,045,139	(320,494)	724,645			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,028,361	256,200	3,985,307	7,269,868		7,269,868	(111,890)	7,157,978			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,830)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	190,186	30		9
10	Interest and Other Investment Income	(8,031)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(672)	21		18
19	Entertainment	(32)	21		19
20	Contributions	(12,221)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(136,718)	21		24
25	Fund Raising, Advertising and Promotional	(3,750)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,024,479)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,001,547)		\$	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)	889,657		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 889,657		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (111,890)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Allowable Expense	\$ (317,886)	43	1
2	Rebates	(162)	10	2
3	Patient Personal Items	(6,950)	10	3
4	Bank Charges	(6,991)	21	4
5	Sequestration	(9,373)	21	5
6	Bldg Co - Filing Fees	(75)	20	6
7	Bldg Co - Accounting	(17,383)	19	7
8	Bldg Co - Legal Fees	(5,431)	19	8
9	Bldg Co - Amortization	(3,011)	36	9
10	Bldg Co - Prepayment Penalty	(629,420)	21	10
11	Additional R&M	1,050	06	11
12	Capitalized R&M	(3,068)	06	12
13	Marketing Licenses	(620)	20	13
14	Prior Period Dues	(519)	20	14
15	PAC Dues	(7,712)	20	15
16	Non Allowable Legal	(16,928)	19	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,024,479)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakefront Nursing Rehab Ctr# 0053868

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			1,869									1,869	1
2	Food Purchase			3,555									3,555	2
3	Housekeeping			1,212									1,212	3
4	Laundry			82									82	4
5	Heat and Other Utilities	(5,830)				632							(5,198)	5
6	Maintenance	(2,018)		6,074		612		(470)					4,199	6
7	Other (specify):*													7
8	TOTAL General Services	(7,848)		12,793		1,244		(470)					5,719	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(7,112)		62,138					(1,507)				53,519	10
10a	Therapy													10a
11	Activities			5									5	11
12	Social Services			3,246									3,246	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,367								3,367	15
16	TOTAL Health Care and Programs	(7,112)		65,389	3,367				(1,507)				60,136	16
	C. General Administration													
17	Administrative			36,133									36,133	17
18	Directors Fees													18
19	Professional Services	(39,742)	22,814	10,198		266	(3,967)						(10,431)	19
20	Fees, Subscriptions & Promotions	(24,897)	75	2,025		0							(22,796)	20
21	Clerical & General Office Expenses	(783,206)	629,420	156,422		147							2,783	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			81									81	24
25	Other Admin. Staff Transportation			2,701									2,701	25
26	Insurance-Prop.Liab.Malpractice		7,341	71		159							7,571	26
27	Other (specify):*			14,482									14,482	27
28	TOTAL General Administration	(847,845)	659,650	222,115		571	(3,967)						30,524	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(862,805)	659,650	300,296	3,367	1,816	(3,967)	(470)	(1,507)				96,379	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	190,186	197,196			3,898							391,280	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,031)	285,056			2,190							279,215	32
33	Real Estate Taxes		136,386			1,990							138,376	33
34	Rent-Facility & Grounds		(737,836)	18,342		(18,286)							(737,780)	34
35	Rent-Equipment & Vehicles				2,624								2,624	35
36	Other (specify):*	(3,011)	41,520										38,509	36
37	TOTAL Ownership	179,144	(77,678)	18,342	2,624	(10,207)							112,225	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(2,608)			(2,608)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(317,886)											(317,886)	43
44	TOTAL Special Cost Centers	(317,886)								(2,608)			(320,494)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,001,547)	581,972	318,638	5,991	(8,392)	(3,967)	(470)	(1,507)	(2,608)			(111,890)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 737,836	Lakefront Property Holdings, LLC		\$	(737,836)	1
2	V	32	Interest	544	Lakefront Property Holdings, LLC		285,600	285,056	2
3	V	33	Real Estate Taxes		Lakefront Property Holdings, LLC		136,386	136,386	3
4	V	26	Property Insurance		Lakefront Property Holdings, LLC		7,341	7,341	4
5	V	36	MIP Expense		Lakefront Property Holdings, LLC		38,509	38,509	5
6	V	20	Filing Fees		Lakefront Property Holdings, LLC		75	75	6
7	V	19	Accounting		Lakefront Property Holdings, LLC		17,383	17,383	7
8	V	19	Legal Fees		Lakefront Property Holdings, LLC		5,431	5,431	8
9	V	30	Depreciation		Lakefront Property Holdings, LLC		197,196	197,196	9
10	V	36	Amortization		Lakefront Property Holdings, LLC		3,011	3,011	10
11	V	21	Prepayment Penalty		Lakefront Property Holdings, LLC		629,420	629,420	11
12	V				Lakefront Property Holdings, LLC				12
13	V								13
14	Total			\$ 738,380			\$ 1,320,352	\$ * 581,972	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	GPN Family Trust	50.00%	Astoria Place Skilled Nursing Facility LLC	Chicago	Lakefront Property Holdings, LLC		Building Company	1
2	Doros Generation Trust	50.00%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Bethany Terrace	Morton Grove				27
28			Carlton Skilled Nursing Facility LLC	Chicago				28
29			Chalet Skilled Nursing Facility LLC	Chicago				29
30			Clark Skilled Nursing Facility	Chicago				30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Elmbrook Skilled Nursing Facility LLC	Elmhurst				1
2			Evanston Skilled Nursing Facility LLC	Evanston				2
3			Grove at the Lake Skilled Nursing Facility LLC	Zion				3
4			Grove of Berwyn	Berwyn				4
5			Grove of Fox Valley	Aurora				5
6			Grove of St. Charles	St. Charles				6
7			Lagrange Skilled Nursing Facility LLC	Lagrange Park				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

1 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	01 Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 1,859	\$ 1,859	15
16	V	01 Dietary Supplies		Legacy Healthcare Financial Services		10	10	16
17	V	02 Food		Legacy Healthcare Financial Services		3,555	3,555	17
18	V	03 Housekeeping		Legacy Healthcare Financial Services		1,212	1,212	18
19	V	04 Linen Replacement		Legacy Healthcare Financial Services		82	82	19
20	V	06 Maintenance Salary		Legacy Healthcare Financial Services		5,734	5,734	20
21	V	06 Repairs & Maintenance		Legacy Healthcare Financial Services		340	340	21
22	V	10 Nursing Salary		Legacy Healthcare Financial Services		47,462	47,462	22
23	V	10 Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		4,480	4,480	23
24	V	10 Medical Supplies		Legacy Healthcare Financial Services		10,197	10,197	24
25	V	12 Social Service Salary		Legacy Healthcare Financial Services		3,233	3,233	25
26	V	11 Activities Program		Legacy Healthcare Financial Services		5	5	26
27	V	12 Social Service Consultant		Legacy Healthcare Financial Services		13	13	27
28	V	17 COO / Administrative Salary		Legacy Healthcare Financial Services		36,133	36,133	28
29	V	19 Professional Fees	1,664	Legacy Healthcare Financial Services		11,862	10,198	29
30	V	20 Dues / Licenses / Permits		Legacy Healthcare Financial Services		2,025	2,025	30
31	V	21 Clerical & General Wages		Legacy Healthcare Financial Services		145,791	145,791	31
32	V	21 Clerical & Office Expense		Legacy Healthcare Financial Services		10,631	10,631	32
33	V	24 Education & Seminars		Legacy Healthcare Financial Services		81	81	33
34	V	25 Travel		Legacy Healthcare Financial Services		2,701	2,701	34
35	V	26 Insurance - General		Legacy Healthcare Financial Services		71	71	35
36	V	27 Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		14,482	14,482	36
37	V	34 Rent		Legacy Healthcare Financial Services		18,286	18,286	37
38	V	34 Offsite Storage / Parking		Legacy Healthcare Financial Services		56	56	38
39	Total		\$ 1,664			\$ 320,302	\$ * 318,638	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	35	Equipment Rental		Legacy Healthcare Financial Services		244	\$	244
16	V	35	Auto Rental		Legacy Healthcare Financial Services		2,380		2,380
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		3,367		3,367
18	V								
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			\$ 5,991	\$ *	5,991

* 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	5	Utilities	\$	CF St. Louis LLC		\$ 632	\$ 632	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		612	612	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		217	217	17
18	V	19	Accounting Fees		CF St. Louis LLC		49	49	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		0	0	19
20	V	21	Office Expense		CF St. Louis LLC		147	147	20
21	V	26	Insurance		CF St. Louis LLC		159	159	21
22	V	30	Depreciation		CF St. Louis LLC		3,898	3,898	22
23	V	32	Interest Expense		CF St. Louis LLC		2,190	2,190	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		1,990	1,990	24
25	V								25
26	V	34	Rent	18,286	CF St. Louis LLC			(18,286)	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			\$ 18,286			\$ 9,894	\$ * (8,392)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 17,314	ProPay HR LLC		\$ 13,347	\$ (3,967)	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			\$ 17,314			\$ 13,347	\$ * (3,967)	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	06	Maintenance	\$ 19,200	ML Group Design & Development		\$ 18,730	\$ (470)	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			\$ 19,200			\$ 18,730	\$ * (470)	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	Medical Supplies	\$ 5,000	ReMED Services		\$ 3,493	\$ (1,507)	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			\$ 5,000			\$ 3,493	\$ * (1,507)	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	39	Laboratory	\$ 6,407	Lifescan Labs of Illinois		\$ 3,799	\$ (2,608)	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			\$ 6,407			\$ 3,799	\$ * (2,608)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

YESNO

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

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

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

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 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 _____
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 Lakefront Nursing Rehab Ctr# 0053868

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Legacy Healthcare Financial Services

Street Address

3450 Oakton Street

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 679-9797

Fax Number

(847) 683-2900

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	01	Dietician Salary	Available Bed Days	53	\$ 130,303	\$ 130,303	36,234	\$ 1,859	1
2	01	Dietary Supplies	Available Bed Days	53	697		36,234	10	2
3	02	Food	Available Bed Days	53	249,220		36,234	3,555	3
4	03	Housekeeping	Available Bed Days	53	84,952		36,234	1,212	4
5	04	Linen Replacement	Available Bed Days	53	5,771		36,234	82	5
6	06	Maintenance Salary	Available Bed Days	53	401,986	401,986	36,234	5,734	6
7	06	Repairs & Maintenance	Available Bed Days	53	23,857		36,234	340	7
8	10	Nursing Salary	Available Bed Days	53	3,327,223	3,327,223	36,234	47,462	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	53	314,035		36,234	4,480	9
10	10	Medical Supplies	Available Bed Days	53	714,824		36,234	10,197	10
11	12	Social Service Salary	Available Bed Days	53	226,662	226,662	36,234	3,233	11
12	11	Activities Program	Available Bed Days	53	335		36,234	5	12
13	12	Social Service Consultant	Available Bed Days	53	893		36,234	13	13
14	17	COO / Administrative Salary	Available Bed Days	53	2,533,078	2,533,078	36,234	36,133	14
15	19	Professional Fees	Available Bed Days	53	831,592		36,234	11,862	15
16	20	Dues / Licenses / Permits	Available Bed Days	53	141,983		36,234	2,025	16
17	21	Clerical & General Wages	Available Bed Days	53	10,220,453	10,220,453	36,234	145,791	17
18	21	Clerical & Office Expense	Available Bed Days	53	745,293		36,234	10,631	18
19	24	Education & Seminars	Available Bed Days	53	5,655		36,234	81	19
20	25	Travel	Available Bed Days	53	189,364		36,234	2,701	20
21	26	Insurance - General	Available Bed Days	53	4,997		36,234	71	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	53	1,015,274		36,234	14,482	22
23	34	Rent	Available Bed Days	53	1,281,940		36,234	18,286	23
24	34	Offsite Storage / Parking	Available Bed Days	53	3,949		36,234	56	24
25	TOTALS				\$ 22,454,338	\$ 16,839,706		\$ 320,302	25

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 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 Legacy Healthcare Financial Services
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 679-9797
Fax Number (847) 683-2900

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		36,234	244	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		36,234	2,380	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		36,234	3,367	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					\$ 419,973	\$		\$ 5,991	25

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 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 CF St. Louis LLC
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
Fax Number (847) 676-5348

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Available Bed Days	2,540,133	53	\$ 44,301	\$	36,234	\$ 632	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		36,234	612	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		36,234	217	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		36,234	49	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		36,234	0	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		36,234	147	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		36,234	159	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		36,234	3,898	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		36,234	2,190	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		36,234	1,990	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					\$ 693,655	\$		\$ 9,894	25

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 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 ProPay HR LLC
Street Address 2201 W. Main St.
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 3268
Fax Number ()

	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	19	Payroll Services	Direct			\$	\$		\$ 13,347	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					\$	\$		\$ 13,347	25

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 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 ML Group Design and Development
Street Address 3424 Oakton St
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 676-5300
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	6	Maintenance	Direct			\$	\$		\$ 18,730	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					\$	\$		\$ 18,730	25

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 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 ReMED Services LLC
Street Address 3424 Oakton Street, Suite 102
City / State / Zip Code Skokie, IL
Phone Number (847) 440-2600
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	10	Medical Supplies	Direct			\$	\$		\$ 3,493	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					\$	\$		\$ 3,493	25

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 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 Lifescan Labs of Illinois, LLC
Street Address 5255 Golf Road
City / State / Zip Code Skokie, IL 60077
Phone Number ()
Fax Number ()

	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	39	Laboratory	Direct			\$	\$		\$ 3,799	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					\$	\$		\$ 3,799	25

Ending: 12/31/20

Facility Name & ID Number Lakefront Nursing Rehab Ctr # 0053868 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 _____
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
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12										12
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	CIBC		X	Mortgage			\$		\$ 6,916,060			\$ 285,600	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CIBC		X	Note Payable					1,902,419			9,265	6
7													7
8													8
9	TOTAL Facility Related						\$		\$ 8,818,479			\$ 294,865	9
	B. Non-Facility Related*												
10	Interest Income		X									(8,031)	10
11	Interest Income - Bldg Co		X									(544)	11
12	Allocated from CF St. Louis	X										2,190	12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ (6,385)	14
15	TOTALS (line 9+line14)						\$		\$ 8,818,479			\$ 288,480	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 38,509 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.)

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.			\$	154,751	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.)			\$	151,893	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(2,858)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	157,398	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.)			\$	617	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.			\$	155,157	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	116,302	8	
		2016	127,119	9	
		2017	136,627	10	
		2018	147,382	11	
		2019	149,903	12	
2020 Accrual = \$149,903 x 1.05 = \$157,398					
Allocated from CF St. Louis \$1,990					

		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 Lakefront Nursing Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053868

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 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. 11-29-108-011-0000	Long Term Care Property	\$ 74,951.56	\$ 74,951.56
2. 11-29-108-012-0000	Long Term Care Property	\$ 74,951.56	\$ 74,951.56
3. 10-23-406-034-0000	Home Office Allocation	\$ 459,532.44	\$ 1,990.25
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 609,435.56	\$ 151,893.37

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.

IMPORTANT NOTICE

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

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

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

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

FACILITY NAME Lakefront Nursing Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053868

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation**. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

A. Square Feet: 23,691

B. General Construction Type: Exterior BrickFrameNumber of Stories

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			\$ 500,000	1
2	Allocated from CF St. Louis, LLC			2,815	2
3	TOTALS			\$ 502,815	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99		2015	1971	\$ 8,113,576	\$ 197,196	35	\$ 231,816	\$ 34,620	\$ 1,390,898
5										
6										
7										
8										
	Improvement Type**									
9	Various		2006		55,269		20	2,763	2,763	41,452
10	Various		2007		100,655		20	5,033	5,033	70,459
11	Various		2008		15,300		20	765	765	9,945
12	Various		2009		116,571		20	5,829	5,829	69,943
13	Various		2010		4,600		20	230	230	2,530
14	Various		2011		21,240		20	1,062	1,062	10,620
15	Various		2012		100,258		20	5,013	5,013	45,116
16	Various		2013		45,809		20	2,290	2,290	18,324
17	Various		2014		16,946		20	847	847	5,931
18	Various		2016		44,334		20	2,217	2,217	8,867
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	132,495	3,594		6,300	2,706	28,184	68
69	Financial Statement Depreciation							69
70	TOTAL (lines 4 thru 69)	\$ 8,767,053	\$ 200,790		\$ 264,165	\$ 63,376	\$ 1,702,268	70

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

Facility Name & ID Number Lakefront Nursing Rehab Ctr

0053868

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,767,053	\$ 200,790		\$ 264,165	\$ 63,376	\$ 1,702,268	1
2	Electrical Work For Transfer Switch Replacement	2017	3,475		20	174	174	522	2
3	Replacement Of Actuator, And Installation Of Additional Damper	2017	4,500		20	225	225	2,250	3
4	Furnish And Installation Of New Door Operator	2017	5,200		20	260	260	1,214	4
5	Tested Connectivity To New Lines For Computers	2017	2,615		20	131	131	698	5
6	Install Temp Chiller	2017	3,128		20	156	156	626	6
7	Install. Of New Magn Lock & Alarm In Dining Room 1St Fl	2017	3,304		20	165	165	661	7
8	Elevator Repair	2017	3,250		20	163	163	650	8
9	Door Handles, Hardware, And Sink Insulation-Bathroom	2018	3,193		20	160	160	607	9
10	Faucet And Shut Off Valves/Install Supply Lines	2018	3,610		20	180	180	621	10
11	Resident Bathroom Mirrors	2018	2,549		20	127	127	714	11
12	Hall Doors At Ground Level, 2Nd Floor, And 3Rd Floor	2018	2,754		20	138	138	413	12
13	Primed All Doors And Frames On 1St-3Rd Floors	2018	3,841		20	192	192	576	13
14	Electrical And Lighting Repair On 1St&3Rd Floor/South Side/We	2018	2,407		20	120	120	361	14
15	Plumbing Repairs And Installed New Valves	2018	9,913		20	496	496	1,487	15
16	Walk In Cooler Repair	2018	4,258		20	213	213	639	16
17	Hot Water Boiler Replacement	2018	14,363		20	718	718	2,154	17
18	Installed Two Tankless Water Heaters	2018	5,345		20	267	267	823	18
19	Installed Light Fixtures In Front Of Building (\$3750)	2019	3,634		20	182	182	557	19
20	Installed New Steps And Ramp - Concrete (\$17530)	2019	16,988		20	849	849	1,434	20
21	Installation Of New Delayed Egress Mag Lock On Dining Room (\$	2019	2,657		20	133	133	270	21
22	Install New Front Door (8,500)	2020	8,292		20	415	415	415	22
23	Front Reception Built In Custom Cabinets & Countertop (4,800)	2020	4,682		20	234	234	234	23
24	Repair 2Nd Fl Shower Room Piping (3,647)	2020	3,558		20	178	178	178	24
25	Flooring In Rm 315, 2Nd Fl Bathroom Tiling, Elevator Vinyl (8,20	2020	7,999		20	400	400	400	25
26	Transfer Switch (2,800)	2020	2,731		20	137	137	137	26
27	Fire Sprinkler Repair (3,238)	2020	3,158		20	158	158	158	27
28	Repair Elevator Cables (3,068)	2020	2,993		20	150	150	150	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,901,450	\$ 200,790		\$ 270,885	\$ 70,096	\$ 1,721,214	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 12B, Carried Forward		\$ 8,901,450	\$ 200,790		\$ 270,885	\$ 70,096	\$ 1,721,214	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,901,450	\$ 200,790		\$ 270,885	\$ 70,096	\$ 1,721,214	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		\$ 8,901,450	\$ 200,790		\$ 270,885	\$ 70,096	\$ 1,721,214	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,901,450	\$ 200,790		\$ 270,885	\$ 70,096	\$ 1,721,214	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		\$ 8,901,450	\$ 200,790		\$ 270,885	\$ 70,096	\$ 1,721,214	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 8,901,450	\$ 200,790		\$ 270,885	\$ 70,096	\$ 1,721,214	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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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)		\$	\$		\$	\$	\$	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		\$	\$		\$	\$	\$	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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19									19
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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)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Lakefront Nursing Rehab Ctr

0053868

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	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	15,159	704	35	433	(271)	2,166	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	94,114	2,322	20	4,706	2,384	23,528	9
10	Allocated from CF St. Louis, LLC	2017	2,184	54	20	109	55	437	10
11	Allocated from CF St. Louis, LLC	2019	19,799	488	20	990	502	1,980	11
12	Allocated from CF St. Louis, LLC	2019	1,041	26	20	52	26	52	12
13									13
14	Allocated from Legacy HC	2018	112		20	6	6	17	14
15	Allocated from Legacy HC	2020	85		20	4	4	4	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)		\$ 132,495	\$ 3,594		\$ 6,300	\$ 2,706	\$ 28,184	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		\$132,495	\$3,594		\$6,300	\$2,706	\$28,184	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$132,495	\$3,594		\$6,300	\$2,706	\$28,184	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	\$1,203,929	\$303	\$120,393	\$120,090	10	\$718,784	71
72	Current Year Purchases	20	1	2	1	10	2	72
73	Fully Depreciated Assets	133,314				10	133,314	73
74								74
75	TOTALS	\$1,337,264	\$304	\$120,395	\$120,091		\$852,100	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$10,741,529	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$201,094	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$391,280	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$190,186	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,573,314	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 Legacy Healthcare				56			5
6								6
7	TOTAL				\$ 56			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: \$ 2,308
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy Healthcare		\$	\$ 2,380	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,380	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 EndingAnnual 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.
- (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.

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	

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 158,125	\$		\$ 158,125	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			39,725			39,725	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			156,500			156,500	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				71,433		71,433	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					18,898	32,493		51,391	13
14	TOTAL			\$		\$ 373,248	\$ 103,926		\$ 477,174	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	\$ 57,848	\$ 452,739	1
2	Cash-Patient Deposits	7,304	7,304	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	561,826	561,826	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	187,831	209,383	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	112,665	223,160	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 927,474	\$ 1,454,412	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	13,300	484,995	13
14	Buildings, at Historical Cost		4,245,251	14
15	Leasehold Improvements, at Historical Cost	256,859	256,859	15
16	Equipment, at Historical Cost	73,855	603,909	16
17	Accumulated Depreciation (book methods)	(83,431)	(1,171,355)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	1,418,010	1,500,187	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,678,593	\$ 5,919,846	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,606,067	\$ 7,374,258	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 416,647	\$ 418,290	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,902,419	2,039,476	29
30	Accrued Salaries Payable	144,173	144,173	30
31	Accrued Taxes Payable (excluding real estate taxes)	131,897	131,897	31
32	Accrued Real Estate Taxes(Sch.IX-B)		157,398	32
33	Accrued Interest Payable		22,477	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	237,583	301,583	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,832,719	\$ 3,215,294	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,779,003	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	458,160	1,149,570	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 458,160	\$ 7,928,573	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,290,879	\$ 11,143,867	46
47	TOTAL EQUITY (page 18, line 24)	\$ (684,812)	\$ (3,769,609)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,606,067	\$ 7,374,258	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (158,402)	1
2	Restatements (describe):		2
3	Bad Debts	21,497	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (136,905)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(142,740)	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	(405,167)	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)	\$ (547,907)	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)	\$ (684,812)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lakefront Nursing Rehab Ctr

0053868

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	\$ 10,718,964	1
2	Discounts and Allowances for all Levels	(5,339,202)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,379,762	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	894,500	6
7	Oxygen	16	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 894,516	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	58,018	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,325	19
20	Radiology and X-Ray		20
21	Other Medical Services	10,960	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 82,303	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,031	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,031	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	762,516	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 762,516	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,127,128	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,497,044	31
32	Health Care	2,570,241	32
33	General Administration	1,392,115	33
	B. Capital Expense		
34	Ownership	765,329	34
	C. Ancillary Expense		
35	Special Cost Centers	795,060	35
36	Provider Participation Fee	250,079	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,269,868	40
41	Income before Income Taxes (line 30 minus line 40)**	(142,740)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (142,740)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,775,056	44
45	Private Pay - Net Inpatient Revenue	56,564	45
46	Medicare - Net Inpatient Revenue	444,768	46
47	Other-(specify) Insurance/Veterans	103,374	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,379,762	49

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,048	2,160	\$ 115,364	\$ 53.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,006	9,171	330,612	36.05	3
4	Licensed Practical Nurses	20,748	23,285	695,056	29.85	4
5	CNAs & Orderlies	44,319	50,965	849,683	16.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,792	6,580	133,644	20.31	8
9	Activity Director					9
10	Activity Assistants	4,818	5,340	77,838	14.58	10
11	Social Service Workers	8,136	8,784	193,123	21.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	12,268	13,546	210,859	15.57	17
18	Housekeepers					18
19	Laundry	5,197	5,741	85,867	14.96	19
20	Administrator	2,024	2,200	147,766	67.17	20
21	Assistant Administrator	2,096	2,304	67,528	29.31	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,442	6,927	121,021	17.47	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(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,894	137,002	\$ 3,028,361 *	\$ 22.10	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	\$ 614,599	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	39,746	10-03	38
39	Pharmacist Consultant	Monthly	2,921	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	962	11-03	44
45	Social Service Consultant	52	3,201	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	73	\$ 661,429		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Eliyahu Barnett	Administrator	0	\$ 147,766	Workers' Compensation Insurance	\$	31,484	IDPH License Fee	\$ 1,990	
Magdalena de Anda	Asst. Admin.	0	67,528	Unemployment Compensation Insurance		17,272	Advertising: Employee Recruitment	468	
				FICA Taxes		231,670	Health Care Worker Background Check		
				Employee Health Insurance		161,930	(Indicate # of checks performed 721)	7,218	
				Employee Meals			Patient Background Checks	225	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	8,943	
				Union Pension		20,708	Licenses & Fees	683	
				Employee Benefits		17,953			
				401K Expense		4,157			
				Voluntary Benefit Contributions		6,894			
				Employee Physical Exams		2,281			
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 215,294						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	568	
							See Supplemental Schedule	81	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			(agree to Sch. V, line 24, col. 8)		
(Attach a copy of any management service agreement)							TOTAL		
C. Professional Services									
Vendor/Payee	Type		Amount						
Marcum LLP	Accounting	\$	24,000						
ProPay HR	Payroll Processing		17,314						
Onyx Procurement Solutions	Procurement Services		7,770						
Legacy Healthcare	Bookkeeping		1,664						
2401 Incorporated	Architectural Services		2,410						
Compliagent	Compliance		3,843						
Cortex Health	Data Processing		7,829						
MTS Consulting	Tax Consulting		989						
Personnel Planners	Unemployment Tax Consult		870						
Prospect Resources Inc	Energy Procurement		600						
See Attached	Legal		35,019						
See Supplemental Schedule			7,408						
TOTAL (agree to Schedule V, line 19, column 3)									
(For legal fee disclosure, see page 39 of instructions)			\$ 109,715						

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number <u>Lakefront Nursing Rehab Ctr</u>	STATE OF ILLINOIS # <u>0053868</u>	Report Period Beginning: <u>01/01/20</u>	Ending: <u>12/31/20</u>
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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?
If YES, give association name and amount. HCCI \$15,424

(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?
What was the average life used for new equipment added during this period? Yes
10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,080 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. \$ 250,079
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

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

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