

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0055384

Facility Name: LOFT REHAB NURSING OF CANTON

Address: 2081 NORTH MAIN ST CANTON 61520
Number City Zip Code

County: FULTON

Telephone Number: (309) 647-6135 Fax # (309) 647-6141

HFS ID Number:

Date of Initial License for Current Owners: 12/4/18

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: KATHLEEN MCNAMARA Telephone Number: (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 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) DANIEL AARON
(Title) CFO

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____
(Print Name and Title) KATHLEEN MCNAMARA VICE-PRESIDENT
(Firm Name & Address) KBKB, LTD 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-3585

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

#REF!

Facility Name & ID Number LOFT REHAB NURSING OF CANTON

0055384 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,940</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>90</u>	TOTALS	<u>90</u>	<u>32940</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>3,122</u>	<u>3,122</u>	8
9	SNF/PED					9
10	ICF	<u>12,330</u>	<u>4,099</u>	<u>969</u>	<u>17,398</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,330</u>	<u>4,099</u>	<u>4,091</u>	<u>20,520</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.30 %

#REF!

D. How many bed reserve days during this year were paid by the Department? 0 (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 11/30/18

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/30/18 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 90 and days of care provided 3,122

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **LOFT REHAB NURSING OF CANTON** # **0055384** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	197,167	4,491	8,910	210,568		210,568		210,568			1
2	Food Purchase		131,294		131,294		131,294		131,294			2
3	Housekeeping	83,968	21,447		105,415		105,415		105,415			3
4	Laundry	23,890	9,796		33,686		33,686		33,686			4
5	Heat and Other Utilities			114,599	114,599		114,599		114,599			5
6	Maintenance	61,541	11,870	63,482	136,893		136,893		136,893			6
7	Other (specify):*			10,437	10,437		10,437		10,437			7
8	TOTAL General Services	366,566	178,898	197,428	742,892		742,892		742,892			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,711,871	136,648	68,997	1,917,516		1,917,516		1,917,516			10
10a	Therapy	48,497			48,497		48,497		48,497			10a
11	Activities	68,223	4,918	1,652	74,793		74,793		74,793			11
12	Social Services			1,402	1,402		1,402		1,402			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,828,591	141,566	84,051	2,054,208		2,054,208		2,054,208			16
	C. General Administration											
17	Administrative	99,362		185,569	284,931		284,931	(80,912)	204,019			17
18	Directors Fees											18
19	Professional Services			128,768	128,768		128,768	193	128,961			19
20	Dues, Fees, Subscriptions & Promotions			13,322	13,322		13,322	(11,077)	2,245			20
21	Clerical & General Office Expenses	146,083	24,517	135,820	306,420		306,420	(116,621)	189,799			21
22	Employee Benefits & Payroll Taxes			319,444	319,444		319,444		319,444			22
23	Inservice Training & Education			175	175		175		175			23
24	Travel and Seminar			11,619	11,619		11,619		11,619			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			133,700	133,700		133,700		133,700			26
27	Other (specify):*			22,903	22,903		22,903	(4,376)	18,527			27
28	TOTAL General Administration	245,445	24,517	951,320	1,221,282		1,221,282	(212,793)	1,008,489			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,440,602	344,981	1,232,799	4,018,382		4,018,382	(212,793)	3,805,589			29

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

#REF!

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		PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF	TOTAL	LINE
1	DIETARY		
	DIETITIAN CONSULTANT XVIII B 35-2	8,910	
	REPAIRS & MAINTENANCE	0	
	CONTRACTED DIETARY SERVICES	0	
		8,910	
3	HOUSEKEEPING		
	CONTRACTED HOUSEKEEPING SERVICES	0	
		0	
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE	0	
	CONTRACTED LAUNDRY SERVICES	0	
		0	
5	HEAT & OTHER UTILITIES		
	GAS HEAT	29,942	
	ELECTRICITY	43,340	
	WATER	32,490	
	CABLE TV - LOBBY	8,827	
		114,599	
6	MAINTENANCE		
	GROUNDS MAINTENANCE	7,747	
	PAINTING & DECORATING	0	
	BUILDING REPAIRS	0	
	MAINTENANCE TRAVEL	0	
	EQUIPMENT MAINTENANCE & REPAIR	54,789	
	ELEVATOR MAINTENANCE & REPAIR	0	
	OUTSIDE LABOR	0	
	EXTERMINATING SERVICE	946	
	FIRE SERVICE	0	
		63,482	
7	OTHER		
	SCAVENGER	10,437	
	SECURITY SERVICE	0	
		10,437	
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	12,000	12,000

SCHED REF	TOTAL	LINE
NURSING		10
CONTRACT NURSING XVIII C 53-2		
LABORATORY & XRAY EXPENSE	5,711	
PURCHASED SERVICES	0	
PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0	
RESTORATIVE NURSING CONSULTANT XVIII B 38-2	53,855	
MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,765	
PHARMACY CONSULTANT XVIII B 39-2	7,666	
UTILIZATION REVIEW FEES XVIII B __-2	0	
PHYSICIANS XVIII B __-2	0	
PSYCHIATRIC XVIII B __-2	0	
RN CONSULTANT XVIII B 38-2		
	68,997	
THERAPY		10a
PHYSICAL THERAPY SERVICES	0	
SPEECH THERAPY SERVICES	0	
OCCUPATIONAL THERAPY SERVICES	0	
REHABILITATION CONSULTANT XVIII B __-2	0	
PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0	
OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0	
RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0	
SPEECH THERAPY CONSULTANT XVIII B 43-2	0	
	0	
ACTIVITIES		11
CABLE TV - PATIENT ROOMS	0	
ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,652	
	1,652	
SOCIAL SERVICES		12
SOCIAL REHABILITATION SERVICES	0	
SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0	
SOCIAL WORKER XVIII B 45-2	1,402	
	1,402	
NURSE AIDE TRAINING		13
NURSE AIDE TRAINING COSTS XIII	0	0

LINE	V.COST CENTER EXPENSES	PAGE 3 COLUMN 3 OTHER	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		0	
				0
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	185,569	185,569
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	91,509	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	37,259	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0	
				128,768
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	11,077	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	0	
	LICENSES & PERMITS	XIX F	2,245	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	0	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				13,322
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		355	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		116,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	621	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,844	
	MESSENGER SERVICE		0	
				135,820

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	181,628
	UNEMPLOYMENT COMPENSATION XIX D	36,315
	WORKERS COMPENSATION INSURANCE XIX D	47,318
	HOSPITALIZATION INSURANCE XIX D	46,822
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	7,361
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
		319,444
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	175
		175
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	11,619
		11,619
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	0
		0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	133,700
		133,700
27	OTHER	
	BAD DEBTS VI 24	22,903
		22,903

GRAND TOTAL COLUMN 3 OTHER **1,232,799**

LOFT REHAB NURSING OF CANTON
SCHEDULES
12/31/2020

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	131,294	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	131,294	
TOTAL PATIENT CENSUS	20,520	
TIMES 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	61,560	
ADD # EMPLOYEE MEALS/DAY		
TIMES # DAYS	<u>32,940</u>	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	61,560	
ADD EMPLOYEE MEALS	<u>0</u>	
TOTAL MEALS/YEAR	0	
NET FOOD	<u>131,294</u>	
DIVIDE TOTAL MEALS/YEAR	<u>0</u>	
COST PER MEAL	#DIV/0!	
TIMES EMPLOYEE MEALS	<u>0</u>	
EMPLOYEE MEAL RECLASSIFICATION	<u><u>#DIV/0!</u></u>	

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							1,249	1,249			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,207	82,207		82,207	(71)	82,136			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			394,609	394,609		394,609		394,609			34
35	Rent-Equipment & Vehicles			17,946	17,946		17,946	506	18,452			35
36	Other (specify):*											36
37	TOTAL Ownership			494,762	494,762		494,762	1,684	496,446			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,374	486,110	593,484		593,484		593,484			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,376	148,376		148,376		148,376			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		107,374	634,486	741,860		741,860		741,860			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,440,602	452,355	2,362,047	5,255,004		5,255,004	(211,109)	5,043,895			45

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

#REF!

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
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,249	30		9
10	Interest and Other Investment Income	(71)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(621)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,903)	27		24
25	Fund Raising, Advertising and Promotional	(11,077)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A		22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,423)		\$	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)	(177,686)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (177,686)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (211,109)		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

ID#0055384

Report Period Beginning:1/1/2020

Ending:12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LOFT REHAB NURSING OF CANTON# 0055384

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(80,912)	0	0	0	0	0	0	0	0	0	(80,912)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	193	0	0	0	0	0	0	0	0	0	193	19
20	Fees, Subscriptions & Promotions	(11,077)	0	0	0	0	0	0	0	0	0	0	(11,077)	20
21	Clerical & General Office Expenses	(621)	(116,000)	0	0	0	0	0	0	0	0	0	(116,621)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(22,903)	18,527	0	0	0	0	0	0	0	0	0	(4,376)	27
28	TOTAL General Administration	(34,601)	(178,192)	0	0	0	0	0	0	0	0	0	(212,793)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,601)	(178,192)	0	0	0	0	0	0	0	0	0	(212,793)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LOFT REHAB NURSING OF CANTON # 0055384 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,249	0	0	0	0	0	0	0	0	0	0	1,249	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(71)	0	0	0	0	0	0	0	0	0	0	(71)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	506	0	0	0	0	0	0	0	0	0	506	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,178	506	0	0	0	0	0	0	0	0	0	1,684	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(33,423)	(177,686)	0	0	0	0	0	0	0	0	0	(211,109)	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

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	21	OUTSIDE CLERICAL SVC	\$ 116,000	SELECT HEALTHCARE CONSULTANTS INC	100.00%	\$	\$ (116,000)	1
2	V	17	MANAGEMENT FEES	185,569				(185,569)	2
3	V								3
4	V	17	ADMIN COMP-D AARON				28,766	28,766	4
5	V	17	ADMIN COMP-R AARON				28,766	28,766	5
6	V	17	ADMIN COMP-A AARON				11,626	11,626	6
7	V	17	ADMIN COMP-C ROW				35,499	35,499	7
8	V	19	DATA PROCESSING				193	193	8
9	V	27	HEALTH INSURANCE				11,520	11,520	9
10	V	27	PAYROLL TAXES				7,007	7,007	10
11	V	35	AUTO LEASE				506	506	11
12	V								12
13	V								13
14	Total			\$ 301,569			\$ 123,883	\$ * (177,686)	14

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

###

Facility Name & ID Number

LOFT REHAB NURSING OF CANTON

0055384

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	DANIEL AARON	22.6	THE LOFT REHABILITATION & NURSING	EUREKA	SELECT POST ACUTE CARE REALTY LLC		BUILDING	1
2	ROBERT AARON	22.6	THE LOFT REHABILITATION & NURSING	NORMAL	SELECT HEALTHCARE CONSULTANTS INC		MANAGEMENT	2
3	ADAM AARON	22.6			MISTY MEADOWS ESTATES		SENIOR APTS	3
4	MICHAEL AARON	22.6						4
5	CORY ROW	4.9						5
6	DIANA KUFTA	2.35						6
7	DENNIS NEHMER	2.35						7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

###

Facility Name & ID Number LOFT REHAB NURSING OF CANTON # 0055384 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DANIEL AARON	MEMBER	ADMINISTRATIV	22.60	SCHEDULE	15	30.00	SALARY	\$ 28,766	17-7	1
2	ROBERT AARON	MEMBER	ADMINISTRATIV	22.60	ATTACHED	15	30.00	SALARY	28,766	17-7	2
3	ADAM AARON	MEMBER	ADMINISTRATIV	22.60		10	28.00	SALARY	11,626	17-7	3
4	CORY ROW	MEMBER	ADMINISTRATIV	4.90		15	33.00	SALARY	35,499	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 104,657		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.

#REF!

Facility Name & ID Number LOFT REHAB NURSING OF CANTON # 0055384 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization SELECT HEALTHCARE CONSULTANTS
Street Address 3359 W MAIN STREET
City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 679-8219
Fax Number (847) 679-7377

	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	17	ADMIN COMP-D AARON	HOURS	50	3	\$ 95,885	\$ 95,885	15	\$ 28,766	1
2	17	ADMIN COMP-R AARON	HOURS	50	3	95,885	95,885	15	28,766	2
3	17	ADMIN COMP-A AARON	HOURS	35	3	40,692	40,692	10	11,626	3
4	17	ADMIN COMP-C ROW	HOURS	45	3	106,498	106,498	15	35,499	4
5	19	DATA PROCESSING	PATIENT DAYS	77,366	3	726		20,520	193	5
6	27	HEALTH INSURANCE	PATIENT DAYS	77,366	3	43,434		20,520	11,520	6
7	27	PAYROLL TAXES	PATIENT DAYS	77,366	3	26,417		20,520	7,007	7
8	35	AUTO LEASE	PATIENT DAYS	77,366	3	1,907		20,520	506	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					\$ 411,444	\$ 338,960		\$ 123,883	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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CONGRESSIONAL BANK		X	WORKING CAPITAL		4/19	472,942	386,339	4/22	7.5000	42,131	6	
7	R ROTHNER		X	WORKING CAPITAL		11/18	591,800	278,562	4/22	7.0000	26,855	7	
8	LOAN COSTS		X	AMORT OF LOAN COSTS			39,664	15,425			13,221	8	
9	TOTAL Facility Related						\$ 1,104,406	\$ 680,326			\$ 82,207	9	
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,104,406	\$ 680,326			\$ 82,207	15	

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

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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. 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.

HFS 3745 (N-4-99)

IL478-2471

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LOFT REHAB NURSING OF CANTON COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0055384

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 09-08-15-205-007	NURSING HOME	\$ 54,407.80	\$ 54,407.80
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 54,407.80	\$ 54,407.80

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

A. Square Feet: 28,361

B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
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				\$	1
2					2
3	TOTALS			\$	3

#REF!

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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18						N/A				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

*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

#REF!

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	\$ 12,491	\$	\$ 1,249	\$ 1,249	10 YRS	\$ 2,498	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 12,491	\$	\$ 1,249	\$ 1,249		\$ 2,498	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	12,491
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	1,249
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	1,249
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,498

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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.

#REF!

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:PARADOX CANTON PROPERTY LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		90	11/30/2018	\$ 394,609	10		3
4	Additions							4
5								5
6								6
7	TOTAL		90		\$ 394,609			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: 5 YEARS *

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: \$ 7,062 Description: SEE ATTACHED SCHEDULE
(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			\$ 907.00	\$ 10,884	17
18					18
19					19
20					20
21	TOTAL		\$ 907.00	\$ 10,884	21

10. Effective dates of current rental agreement:
Beginning 11/30/2018
Ending 11/30/2028

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2021	\$ 316,534
13.	12/31/2022	\$ 324,863
14.	12/31/2023	\$ 333,191

* 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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

C. CONTRACTUAL INCOME

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)	\$			

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

###

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 174,768	\$		\$ 174,768	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			25,998			25,998	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			285,344			285,344	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				93,678		93,678	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	LABORATORY	39-2					9,796		9,796	13
	Other (specify): TRANSPORTATION	39-2					3,900		3,900	
14	TOTAL			\$		\$ 486,110	\$ 107,374		\$ 593,484	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.

#REF!

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	\$ 586,811	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	705,181		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,263		6
7	Other Prepaid Expenses	75,000		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,397,255	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,491		16
17	Accumulated Depreciation (book methods)	(12,491)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	39,664		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(24,239)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>OPTION DEPOSIT</u>	226,600		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 242,025	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,639,280	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 397,407	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	386,339		29
30	Accrued Salaries Payable	128,573		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,807		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 919,126	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	278,562		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 278,562	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,197,688	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 441,592	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,639,280	\$	48

#REF!

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (509,016)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (509,016)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	950,608	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 950,608	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)	\$ 441,592	24 *

* This must agree with page 17, line 47.

#REF!

Facility Name & ID Number LOFT REHAB NURSING OF CANTON

0055384

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,830,464	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,830,464	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	182,043	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 182,043	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	71	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 71	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STIMULUS PAYMENT	1,189,624	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,189,624	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,202,202	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	742,892	31
32	Health Care	2,054,208	32
33	General Administration	1,221,282	33
	B. Capital Expense		
34	Ownership	494,762	34
	C. Ancillary Expense		
35	Special Cost Centers	593,484	35
36	Provider Participation Fee	148,376	36
	D. Other Expenses (specify):		
37	OUT OF PERIOD INCOME/EXPENSE	(3,410)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,251,594	40
41	Income before Income Taxes (line 30 minus line 40)**	950,608	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 950,608	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,068,539	44
45	Private Pay - Net Inpatient Revenue	727,653	45
46	Medicare - Net Inpatient Revenue	1,589,875	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	444,397	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,830,464	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **YES** 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.

#REF!

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	2,874	3,123	\$ 88,240	\$ 28.25	1
2	Assistant Director of Nursing	200	246	6,226	25.31	2
3	Registered Nurses	15,040	15,933	439,945	27.61	3
4	Licensed Practical Nurses	12,536	13,122	367,617	28.02	4
5	CNAs & Orderlies	35,189	37,929	544,880	14.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,048	2,136	48,497	22.70	8
9	Activity Director	1,984	2,162	29,243	13.53	9
10	Activity Assistants	4,255	4,255	38,980	9.16	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,856	2,080	57,088	27.45	13
14	Head Cook	8,073	8,737	100,732	11.53	14
15	Cook Helpers/Assistants	3,635	3,999	39,347	9.84	15
16	Dishwashers					16
17	Maintenance Workers	3,616	4,195	61,541	14.67	17
18	Housekeepers	5,456	5,705	83,968	14.72	18
19	Laundry	965	1,100	23,890	21.72	19
20	Administrator	2,136	2,331	99,362	42.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,767	3,953	146,083	36.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,733	1,950	29,439	15.10	31
32	Other Health C: CARE PLAN/RES	3,892	4,326	159,405	36.85	32
33	Other(specify) Amissions DIR	1,896	2,080	76,119	36.60	33
34	TOTAL (lines 1 - 33)	111,151	119,362	\$ 2,440,602 *	\$ 20.45	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	M	\$ 8,910	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	1,765	10-3	37
38	Nurse Consultant	T	53,855	10-3	38
39	Pharmacist Consultant	H	7,666	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,652	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 85,848		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

###

LOFT REHAB NURSING OF CANTON
SCHEDULE - LEGAL

12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
7/1/2020	MUCH SHELIST	GENERAL SERVICES	340.76
1/31/2020	STONE POGRUND & KOREY LLC	VARIOUS COLLECTIONS AND GUARDIANSHIPS	130.69
10/31/2020	STONE POGRUND & KOREY LLC	VARIOUS COLLECTIONS AND GUARDIANSHIPS	1,851.23
11/30/2020	STONE POGRUND & KOREY LLC	VARIOUS COLLECTIONS AND GUARDIANSHIPS	100.00
12/31/2020		LEGAL FEES FOR AUDIT	3,641.00
3/15/2020	CARD SERVICES		1,257.00
TOTAL			<u>7,320.68</u>

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____

(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? _____

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,791 Line 10-2

(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. _____

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 148,376
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____

(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. \$ _____

c. What percent of all travel expense relates to transportation of nurses and patients? 5%

d. Have vehicle usage logs been maintained? NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES

g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____

(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.

#REF!