

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0050088</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Niles Nrsg Rehab Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>9777 Greenwood Ave</u> <u>Niles</u> <u>60714</u> Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>708-449-1900</u> Fax # <u>708-449-1500</u>																																																	
HFS ID Number: _____																																																	
Date of Initial License for Current Owners: <u>06/20/08</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Paresh Vipani</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) <u>3/5/2021</u></td></tr><tr><td>(Print Name and Title) <u>Aaron Mauer</u> <u>President</u></td></tr><tr><td>(Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimtz Parkway South Bend IN 46628</u></td></tr><tr><td>(Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Paresh Vipani</u>	(Title) <u>CFO</u>	(Signed) _____	Paid Preparer	(Date) <u>3/5/2021</u>	(Print Name and Title) <u>Aaron Mauer</u> <u>President</u>	(Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimtz Parkway South Bend IN 46628</u>	(Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u>																																				
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		☐	Trust																																														
		☐	Other _____																																														
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																															
Name: <u>Aaron Mauer</u> Telephone Number: <u>773-747-4506</u> Email Address: _____																																																	

Facility Name & ID Number Niles Nrsrg Rehab Center

0050088 Report Period Beginning: 1/1/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	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>304</u>	Skilled (SNF)	<u>304</u>	<u>110,960</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>304</u>	TOTALS	<u>304</u>	<u>110,960</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>70,152</u>	<u>2,069</u>	<u>12,672</u>	<u>84,893</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>70,152</u>	<u>2,069</u>	<u>12,672</u>	<u>84,893</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.51%

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 06/20/08

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 06/20/08 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 304 and days of care provided 8,308

Medicare Intermediary National Government Services

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 Niles Nrsrg Rehab Center # 0050088 Report Period Beginning: 1/1/20 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	821,277	83,190	19,700	924,167		924,167	(94)	924,073			1
2	Food Purchase		782,338		782,338		782,338		782,338			2
3	Housekeeping	793,233	106,861		900,094		900,094		900,094			3
4	Laundry	68,505	35,713		104,218		104,218		104,218			4
5	Heat and Other Utilities			358,364	358,364		358,364	3,574	361,938			5
6	Maintenance	150,580	41,148	118,082	309,810		309,810	(112)	309,698			6
7	Other (specify):*											7
8	TOTAL General Services	1,833,595	1,049,250	496,146	3,378,991		3,378,991	3,368	3,382,359			8
	B. Health Care and Programs											
9	Medical Director			51,000	51,000		51,000		51,000			9
10	Nursing and Medical Records	6,786,906	440,044	124,621	7,351,571		7,351,571	(301,688)	7,049,883			10
10a	Therapy			1,461,989	1,461,989		1,461,989		1,461,989			10a
11	Activities	450,587	36,946		487,533		487,533	(1,000)	486,533			11
12	Social Services	205,019		5,435	210,454		210,454		210,454			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			24,705	24,705		24,705	(596)	24,109			15
16	TOTAL Health Care and Programs	7,442,512	476,990	1,667,750	9,587,252		9,587,252	(303,284)	9,283,968			16
	C. General Administration											
17	Administrative	172,790		3,793	176,583		176,583	97,755	274,338			17
18	Directors Fees											18
19	Professional Services			1,155,194	1,155,194		1,155,194	23,056	1,178,250			19
20	Dues, Fees, Subscriptions & Promotions			3,913	3,913		3,913	255	4,168			20
21	Clerical & General Office Expenses	351,664	105,026	838,742	1,295,432		1,295,432	113,799	1,409,231			21
22	Employee Benefits & Payroll Taxes			1,681,073	1,681,073		1,681,073	71,385	1,752,458			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,734	25,734		25,734	19,082	44,816			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,890,819	1,890,819		1,890,819	134,653	2,025,472			26
27	Other (specify):*											27
28	TOTAL General Administration	524,454	105,026	5,599,268	6,228,748		6,228,748	459,984	6,688,732			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,800,561	1,631,266	7,763,164	19,194,991		19,194,991	160,069	19,355,060			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			210,256	210,256		210,256	38,634	248,890			30
31	Amortization of Pre-Op. & Org.			13,638	13,638		13,638	1,212,336	1,225,974			31
32	Interest			182	182		182	457,310	457,492			32
33	Real Estate Taxes			925,675	925,675		925,675		925,675			33
34	Rent-Facility & Grounds			2,063,915	2,063,915		2,063,915	(2,055,275)	8,640			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			2,821	2,821		2,821	(2,821)				36
37	TOTAL Ownership			3,216,487	3,216,487		3,216,487	(349,816)	2,866,671			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			684	684		684		684			38
39	Ancillary Service Centers		620,885		620,885		620,885	(5,647)	615,238			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			628,793	628,793		628,793		628,793			42
43	Other (specify):*			363,389	363,389		363,389	(363,389)				43
44	TOTAL Special Cost Centers		620,885	992,866	1,613,751		1,613,751	(369,036)	1,244,715			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,800,561	2,252,151	11,972,517	24,025,229		24,025,229	(558,784)	23,466,445			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
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(115,326)	30		9
10	Interest and Other Investment Income	(263,368)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(94)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment				19
20	Contributions	(3,040)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(363,389)	43		24
25	Fund Raising, Advertising and Promotional	(37,464)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,821)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,758)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (796,690)		\$	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)			34
35	Other- Attach Schedule	237,906	Various	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 237,906		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (558,784)		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	RP Profit	\$ (150)	10	1
2	RP Profit	(596)	15	2
3	RP Profit	(5,647)	39	3
4	Misc Income - Vendor Rebate	(2,146)	6	4
5	Misc Income - Med Records	(219)	10	5
6	Misc Income - Acitivity Donation	(1,000)	11	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,758)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Niles Nrsg Rehab Center# 0050088

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(94)	0	0	0	0	0	0	0	0	0	0	(94)	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	3,574	0	0	0	0	0	0	0	0	0	3,574	5
6	Maintenance	(2,146)	2,034	0	0	0	0	0	0	0	0	0	(112)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,240)	5,608	0	0	0	0	0	0	0	0	0	3,368	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	(369)	(301,319)	0	0	0	0	0	0	0	0	0	(301,688)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,000)	0	0	0	0	0	0	0	0	0	0	(1,000)	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):*	(596)	0	0	0	0	0	0	0	0	0	0	(596)	15
16	TOTAL Health Care and Programs	(1,965)	(301,319)	0	0	0	0	0	0	0	0	0	(303,284)	16
	C. General Administration													
17	Administrative	0	97,755	0	0	0	0	0	0	0	0	0	97,755	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,670	3,386	0	0	0	0	0	0	0	0	23,056	19
20	Fees, Subscriptions & Promotions	0	255	0	0	0	0	0	0	0	0	0	255	20
21	Clerical & General Office Expenses	(41,934)	155,733	0	0	0	0	0	0	0	0	0	113,799	21
22	Employee Benefits & Payroll Taxes	0	71,385	0	0	0	0	0	0	0	0	0	71,385	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	19,082	0	0	0	0	0	0	0	0	0	19,082	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	3,789	130,864	0	0	0	0	0	0	0	0	134,653	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(41,934)	367,668	134,250	0	0	0	0	0	0	0	0	459,984	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,139)	71,958	134,250	0	0	0	0	0	0	0	0	160,069	29

Summary B

12/31/20

[illegible]

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
Michael Blisko	40	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
GELP	40	Belhaven Nursing & Rehab Center	Chicago	Niles Nursing Realty		Realty Co.
A & F Realty, LLC	20	Citi View Multicare Center	Cicero	United Rx		Pharmacy Co.
		Continental Nursing & Rehab Center	Chicago			
		Forest View Nursing & Rehab Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	5	Heat and Other Utilities	\$	Infinity Healthcare Management of IL LLC		\$ 3,574	\$ 3,574	1
2	V	6	Maintenance	1	Infinity Healthcare Management of IL LLC		2,035	2,034	2
3	V	10	Nursing and Medical Records	405,691	Infinity Healthcare Management of IL LLC		104,372	(301,319)	3
4	V	17	Administrative	1,182	Infinity Healthcare Management of IL LLC		98,937	97,755	4
5	V	19	Professional Services	1,043,414	Infinity Healthcare Management of IL LLC		1,063,084	19,670	5
6	V	20	Dues, Fees, Subscriptions & Promotions		Infinity Healthcare Management of IL LLC		255	255	6
7	V	21	Clerical & General Office Expenses	209,257	Infinity Healthcare Management of IL LLC		364,990	155,733	7
8	V	22	Employee Benefits & Payroll Taxes	9	Infinity Healthcare Management of IL LLC		71,394	71,385	8
9	V	24	Travel and Seminar	5,423	Infinity Healthcare Management of IL LLC		24,505	19,082	9
10	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		3,789	3,789	10
11	V	30	Depreciation		Infinity Healthcare Management of IL LLC		114	114	11
12	V	32	Interest		Infinity Healthcare Management of IL LLC		9,516	9,516	12
13	V	34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		8,640	8,640	13
14	Total			\$ 1,664,977			\$ 1,755,204	\$ * 90,227	14

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

VII. RELATED PARTIES (continued)

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

☒ 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	34	Rent	\$ 2,063,915	Niles Nursing Realty		\$	(2,063,915)	15
16	V	31	Amortization		Niles Nursing Realty		1,212,336	1,212,336	16
17	V	30	Depreciation		Niles Nursing Realty		153,846	153,846	17
18	V	19	Professional Services		Niles Nursing Realty		3,386	3,386	18
19	V	26	Insurance		Niles Nursing Realty		130,864	130,864	19
20	V	32	Interest		Niles Nursing Realty		711,162	711,162	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			\$ 2,063,915			\$ 2,211,594	\$ * 147,679	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Oak Lawn Respiratory & Rehab Center	Oak Lawn				2
3			Parker Nursing & Rehab Center	Streater				3
4			Parkshore Estates Nursing & Rehab Ctr	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomington				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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									\$		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.

Ending: 12/31/20

	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						\$	\$		\$	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

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	HUD		X	Mortgage	\$91,487.00	7/31/14	\$ 22,000,000	\$ 19,882,891	9/1/49	3.5000	\$ 716,763	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Infinity Funding	X		Working Capital	None	Various	Various	Various	None	Various	182	6	
7												7	
8												8	
9	TOTAL Facility Related				\$91,487.00		\$ 22,000,000	\$ 19,882,891			\$ 716,945	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 22,000,000	\$ 19,882,891			\$ 716,945	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 130,864 Line # 26

* 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.			\$	(839,449)	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.)			\$	885,812	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,725,261	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	(799,586)	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
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.			\$	925,675	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	808,182	8	
		2016	786,432	9	
		2017	883,625	10	
		2018	898,714	11	
		2019	885,812	12	
				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 Niles Nrsg Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050088

CONTACT PERSON REGARDING THIS REPORT Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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. 09-11-306-005-0000	Nursing Home	\$ 337,774.46	\$ 337,774.46
2. 09-11-306-006-0000	Nursing Home	\$ 337,601.81	\$ 337,601.81
3. 09-11-306-013-0000	Nursing Home	\$ 210,436.16	\$ 210,436.16
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 885,812.43	\$ 885,812.43

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:

17,850

B. General Construction Type:

Exterior

Concrete

Frame

Steel

Number of Stories

6

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).

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:

18,185,064

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

15

3. Current Period Amortization:

1,212,336

4. Dates Incurred:

Prior to 8/31/12

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		2012	\$ 500,000	1
2					2
3	TOTALS			\$ 500,000	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	304		2012		\$ 6,000,000	\$ 153,846	39	\$ 153,846	\$	\$ 1,148,263
5										
6										
7										
8										
	Improvement Type**									
9	2008 TOTAL		2008		92,845	2,381	39	2,381		29,390
10										
11	2009 TOTAL		2009		235,600	6,041	39	6,041		71,038
12										
13	2010 TOTAL		2010		102,029	1,828	39	1,828		24,593
14										
15	2011 TOTAL		2011		525,233	13,468	39	13,468		131,415
16										
17	2012 TOTAL		2012		352,840	9,047	39	9,047		79,228
18										
19	2013 TOTALS		2013		193,030	4,949	39	4,949		38,388
20										
21	2014 TOTALS		2014		173,386	5,234	39	5,234		27,829
22										
23	2015 TOTALS		2015		346,257	8,878	39	8,878		51,131
24										
25	Paint 5th Floor Hallway		2016		9,250	237	39	237		1,238
26	Paint 4th Floor Hallway		2016		12,026	308	39	308		1,610
27	Paint 4th Floor Hallway		2016		17,186	441	39	441		2,302
28	3rd, 4th, 5th Floor Handrails		2016		12,245	314	39	314		1,640
29	Condor Conversion for Astroslide		2016		3,593	92	39	92		480
30	Parking Lot Lights		2016		3,846	99	39	99		516
31	Pit Ladder		2016		4,261	109	39	109		570
32	Small Walk-in Freezer		2016		4,650	119	39	119		621
33	Remove & Replace Wheel Stops-North Lot		2016		4,694	120	39	120		628
34	Remove & Replace Wheel Stops-South Lot		2016		4,694	120	39	120		628
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

Facility Name & ID Number Niles Nrsrg Rehab Center

0050088

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Flooring for 6 Resident Rooms	2016	\$ 5,570	\$ 143	39	\$ 143	\$	\$ 747	37
38	Mechanical Room Air Handler	2016	12,500	321	39	321		1,675	38
39	Install New Floors Rooms 523,524,525	2016	4,392	113	39	113		589	39
40	Repair Room & Bathroom Walls Rooms 526,527,528	2016	4,058	104	39	104		543	40
41	New Flooring for 6 Rooms	2016	5,570	143	39	143		747	41
42	Kitchen/Laundry Water Heater Boiler	2016	14,715	377	39	377		1,970	42
43	Electrical Supply for the Steamer & Coffee Maker	2016	3,530	91	39	91		474	43
44	Repair Walls in Rooms 529,530,531	2016	5,000	128	39	128		668	44
45									45
46	Replace Heat Exchanger on Boiler #2	2017	2,536	65	39	65		228	46
47	Replace Faulty Bearing for Main Building Air Handler	2017	2,037	52	39	52		182	47
48	Zero Plenum Light fixtures throughout Building	2017	10,173	261	39	261		913	48
49	Repair Walls in Rooms 520, 521, 522	2017	4,037	104	39	104		363	49
50	New Flooring for 1st Floor Game Room	2017	9,054	232	39	232		812	50
51	New Water Treatment Station	2017	2,059	53	39	53		185	51
52	Repair & Paint Walls in Rooms 517, 518	2017	2,905	74	39	74		260	52
53	Patient Wanderer Systems	2017	11,482	294	39	294		1,030	53
54	Repipe Sprinkler System	2017	6,185	159	39	159		555	54
55	Remodel 5th floor Central Supply Room	2017	2,800	72	39	72		252	55
56	Replace Hydronic Pipe in Dining Room	2017	4,031	103	39	103		362	56
57									57
58	New exhaust for bathroom and heat pump for boiler room and	2018	22,954	589	39	589		1,471	58
59	kitchen AH coil report								59
60	Bypass Piping for Water Treatment System and shower filters	2018	52,972	1,358	39	1,358		3,396	60
61	New circulating pump and replace faulty bearing on pump	2018	5,077	130	39	130		325	61
62	New flooring, doors, paint for rooms 516,517,513	2018	3,980	102	39	102		255	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,295,282	\$ 212,699		\$ 212,699	\$	\$ 1,629,509	70

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

Facility Name & ID Number Niles Nrsrg Rehab Center

0050088

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	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		\$ 8,295,282	\$ 212,699		\$ 212,699	\$	\$ 1,629,509	1
2	Plumbing Upgrade/ Instillation Heating cooling	2018	32,918	844	39	844		2,110	2
3	New Feed Valve for Water Main / DPH Plumbing Upgrades	2018	8,019	206	39	206		514	3
4	New Circulating Pump	2018	4,186	107	39	107		269	4
5	New Hot & Cold Back Flow Lines for Laundry Room	2018	4,000	103	39	103		256	5
6	Mill & Resurface Driveway	2018	7,560	194	39	194		485	6
7	Paint & Repair Walls in Rooms 507, 509, 511	2018	4,750	122	39	122		305	7
8	Paint & Repair Kitchen Wall	2018	2,800	72	39	72		180	8
9	New Flooring for Kitchen	2018	3,023	78	39	78		194	9
10	New Entrance Door	2018	4,186	107	39	107		269	10
11	New Chemical Pump	2018	2,785	71	39	71		179	11
12	Reinsulate Dietary Room	2018	2,770	71	39	71		178	12
13	Reinsulate Barber Shop Room	2018	3,646	93	39	93		234	13
14	Reinsulate NE Crnr Office/Kitchen Ceiling	2018	8,779	225	39	225		562	14
15	Remodel Rooms 510, 514, 515	2018	4,920	126	39	126		315	15
16	Replace Old Valves/Rmv Faulty Piping/ New Floor/Reinsulate	2018	15,010	385	39	385		962	16
17	Convert Walk-In Freezer to Cooler	2018	5,975	153	39	153		383	17
18	Remodel Rooms 423, 424, 501	2018	4,920	126	39	126		315	18
19	Medical Tap Filters	2018	3,480	89	39	89		223	19
20	Remodel Rooms 406, 408, 410	2018	4,590	118	39	118		294	20
21	Replace Cracked Heat Exchanger in Basement / New Floor	2018	6,799	174	39	174		436	21
22	Remodel Rooms 431, 412, 410 / New Motors Roof Fan	2018	7,206	185	39	185		462	22
23	Remodel Rooms 406, 412, 414	2018	4,590	118	39	118		294	23
24	New Flooring	2018	3,149	81	39	81		201	24
25	Replace Spark Board & Transformer on Boiler 1	2018	3,463	89	39	89		222	25
26	Remodel Rooms 409, 411, 413 / Patient Wandering System	2018	9,887	254	39	254		634	26
27	New Flooring	2018	3,417	88	39	88		219	27
28	Remodel Rooms 405, 407, 418	2018	4,750	122	39	122		305	28
29									29
30	Replace Isolation Valves on Left Hand Circulating Pump	2019	3,467	89	39	89		38	30
31	Remove tile & flooring in Rooms 414, 419, 420. Install new floorin	2019	4,750	122	39	122		103	31
32	Remove tile & flooring in Rooms 221, 422, 431. Install new floorin	2019	4,750	122	39	122		103	32
33	Flooring tile & flooing for Rooms 416, 421, 429, 425, 428.	2019	3,417	88	39	88		35	33
34	TOTAL (lines 1 thru 33)		\$ 8,483,244	\$ 217,519		\$ 217,519	\$	\$ 1,640,789	34

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

Facility Name & ID Number Niles Nrsrg Rehab Center

0050088

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	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 12B, Carried Forward		\$ 8,483,244	\$ 217,519		\$ 217,519	\$	\$ 1,640,789	1
2	Replace Roof Top Exhaust Fans	2019	5,452	140	39	140		139	2
3	Remove tile & flooring in Rooms 423, 424, 425. Install new floorin	2019	4,590	118	39	118		95	3
4	Upgrades to Fire Alarm System	2019	2,785	71	39	71		3	4
5	Upgrades to Fire Alarm System (down payment)	2019	6,708	172	39	172		204	5
6	Replace OEM Burners on Boiler 1	2019	2,265	58	39	58		116	6
7	Upgrades to Fire Alarm System (final payment)	2019	6,708	172	39	172		344	7
8	Boiler Room Combustion Air In-Forcer	2019	6,875	176	39	176		353	8
9	Service to Front Lobby RTU	2019	1,958	50	39	50		100	9
10	Repair Water Leak in Main Air Handler Hot Water Coil	2019	2,364	61	39	61		121	10
11	New Hanging Unit Heater in Generator Room	2019	2,975	76	39	76		146	11
12	New Back Door Convector for Basement	2019	3,450	88	39	88		170	12
13	Install New Heater in Main Air Handler Room	2019	3,762	96	39	96		185	13
14	Install New Hydronic Unit Heater in Main Air Handler Room	2019	5,406	139	39	139		266	14
15	Flooring for Rooms 416, 421, 429, 425, 428	2019	3,417	88	39	88		168	15
16	Flooring for Rooms 416, 421, 429, 425, 428	2019	3,417	88	39	88		168	16
17	Remove tile & Flooring in Rooms 417, 415, 401. Install new floori	2019	5,858	150	39	150		288	17
18	Remove tile & flooring in Rooms 416, 421, 429. Install new floorin	2019	4,650	119	39	119		219	18
19	Remove tile & flooring in Rooms 425, 426, 428. Install new floorin	2019	4,590	118	39	118		216	19
20	Flooring for 230, 211, 209	2019	3,417	88	39	88		161	20
21	Remove tile & flooring in Rooms 230, 211, 209. Install new floorin	2019	5,020	129	39	129		225	21
22	Flooring for Rooms 215, 205, 207	2019	3,417	88	39	88		153	22
23	Remove & install flooring in Rooms 215, 205, 207. Install new floo	2019	5,020	129	39	129		225	23
24	Rebuilt Starter and New Batteries for Alarm System	2019	3,768	97	39	97		169	24
25	Remove Tile & Flooring in Rooms 204, 209, 211. Install new floori	2019	4,700	121	39	121		201	25
26	New Building Booster Pump	2019	6,344	163	39	163		271	26
27	Remove flooring in Korean Main Dining Room. Install new floorin	2019	6,650	171	39	171		284	27
28	Replace Blower Motor on Main Air Handler	2019	4,376	112	39	112		187	28
29	Flooring for Rooms 204, 209, 211	2019	3,417	88	39	88		146	29
30	New Centrifugal Building Booster Pump	2019	3,394	87	39	87		145	30
31	Remove & Strip existing floor tiles in Rooms 206, 208, 210 & bath	2019	4,600	118	39	118		187	31
32	Tile for Rooms 206, 208 & 210	2019	4,556	117	39	117		185	32
33	Vinyl tile for 1st Floor Conference Room	2019	3,417	88	39	88		139	33
34	TOTAL (lines 1 thru 33)		\$ 8,622,570	\$ 221,091		\$ 221,091	\$	\$ 1,646,766	34

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

Facility Name & ID Number Niles Nrsrg Rehab Center

0050088

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	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 12C, Carried Forward		\$ 8,622,570	\$ 221,091		\$ 221,091	\$	\$ 1,646,766	1
2	Remove & Strip existing floor tiles in 1st Floor Conference Room;	2019	7,600	195	39	195		309	2
3	Remove & Strip existing floor tiles in Room 212, 216 & 217 & bath	2019	4,750	122	39	122		193	3
4	Remove & Strip floor tile in Group Room & Activity Department	2019	6,300	162	39	162		256	4
5	Tile for Group Room & Activity Department Office	2019	5,786	148	39	148		235	5
6	New Delay Egress Emlock on 5th Floor; Replace Magnetic Lock o	2019	2,013	52	39	52		77	6
7	Install New Flooring in Kitchen	2019	2,800	72	39	72		96	7
8	New Surveillance Cameras	2019	5,967	153	39	153		204	8
9	Install New Flooring in 329 Rest Room	2019	2,600	67	39	67		83	9
10	Remove Existing Flooring & Install New Flooring in 1st Floor Hu	2019	3,400	87	39	87		109	10
11	Replace Kitchen Air Handler Shaft & Bearing, Winterize Chiller	2019	2,295	59	39	59		74	11
12	Remove Existing Flooring & Install New Flooring in Room 216 Re	2019	2,600	67	39	67		83	12
13	Remove Existing Flooring & Install New Flooring in Room 428 Ba	2019	2,600	67	39	67		83	13
14	Remove Existing Flooring & Install New Flooring in Room 525 Re	2019	2,600	67	39	67		83	14
15	Flooring for Rooms 216, 428, 525	2019	4,456	114	39	114		143	15
16	New Refractory for Heating Boiler #1	2019	4,441	114	39	114		133	16
17	Install New Vinyl Plank Flooring, Patch & Paint Walls in DON's C	2019	4,400	113	39	113		132	17
18	Install New Vinyl Plank Flooring, Patch & Paint Walls in BOM's C	2019	3,400	87	39	87		102	18
19	Install New Aluminum Siding in Kitchen Walk-in Cooler	2019	2,800	72	39	72		84	19
20	Replace Freezer, Cooler & Overhang Sprinkler System	2019	3,121	80	39	80		93	20
21		2019	4,200	108	39	108		126	21
22	Install New Porcelain Tile, Paint & Patch Walls in 4th Floor Nursi	2019	2,800	72	39	72		84	22
23	Install New Porcelain Tile, Paint & Patch Walls in 1st Floor Activi	2019	2,800	72	39	72		84	23
24	Install New Vinyl Plank Flooring, Patch & Paint Walls in 1st Floor	2019	4,200	108	39	108		126	24
25	Install New Porcelain Tile, New Toilet, Paint & Patch Walls in Ro	2019	2,800	72	39	72		78	25
26	Remove Damaged Floor & Base, Patch & Level Floors, Install Nev	2019	1,530	39	39	39		43	26
27	Install New Conduit & Ran New Electrical Wire for Outlet in Med	2019	2,200	56	39	56		61	27
28	Remove Existing Floor & Wall Tile, Install New Tiles on Floor &	2019	2,800	72	39	72		78	28
29	Remove Damaged Floor & Base, Install New Flooring in Room 31.	2019	1,900	49	39	49		53	29
30	Remove Existing Floor & Wall Tile, Install New Tiles on Floor &	2019	2,800	72	39	72		78	30
31	Remove Damaged Floor, Wall & Base, Install New Tiles on Floor	2019	2,800	72	39	72		78	31
32	Remove Damaged Floor, Wall & Base, Install New Tiles on Floor	2019	1,800	46	39	46		50	32
33	Remove Damaged Floor, Wall & Base, Install New Tiles on Floor	2019	8,400	215	39	215		233	33
34	TOTAL (lines 1 thru 33)		\$ 8,737,529	\$ 224,039		\$ 224,039	\$	\$ 1,650,507	34

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

Facility Name & ID Number Niles Nrsrg Rehab Center

0050088

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	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 12D, Carried Forward		\$ 8,737,529	\$ 224,039		\$ 224,039	\$	\$ 1,650,507	1
2	Replace Leaking Pipes in Generator Room in Basement	2019	2,685	69	39	69		75	2
3	Remove Damaged Floor, Wall & Base, Install New Tiles on Floor	2019	8,400	215	39	215		233	3
4	Remove Damaged Floor, Wall & Base, Install New Tiles on Floor	2019	2,800	72	39	72		78	4
5									5
6	Inventory of Sprinkler System Heads	2020	3,577	92	39	92		92	6
7	Install New Tiles on the Bathroom Walls & Floors in Rooms 510,	2020	8,400	215	39	215		215	7
8	Install New Tiles on the Floor & Wall in Room 224	2020	4,700	121	39	121		121	8
9	Install New Tiles on the Bathroom Walls & Floors in Rooms 513,	2020	8,400	215	39	215		215	9
10	Install New Tiles on the Bathroom Walls & Floors in Rooms 516,	2020	8,400	215	39	215		215	10
11	Install New Tiles on the Bathroom Walls & Floors in Rooms 523,	2020	8,400	215	39	215		215	11
12	Install New Tiles on the 2nd, 3rd, 4th, 5th Men's Showers on the E	2020	22,400	574	39	574		574	12
13	Replace Corroded Pipes in Kitchen for State Inspector Piping Viol	2020	7,314	188	39	172	(16)	188	13
14	Replace 3 Exhaust Fans on Lower Roof	2020	2,785	71	39	60	(12)	71	14
15	New Circulating Pump for Building RH	2020	6,496	167	39	125	(42)	167	15
16	Install New Isolation Valve and Replace Pipe in Kitchen	2020	2,657	68	39	40	(28)	68	16
17	Repair Leaking Pipes in Kitchen	2020	3,189	82	39	48	(34)	82	17
18	Repair Leaking Cold Water Pipe on West Side of Building	2020	3,529	90	39	53	(38)	90	18
19	Repair Basement Injector Pumps	2020	3,168	81	39	47	(34)	81	19
20	Test RPZ and Rebuild Kitchen Sink	2020	2,942	75	39	38	(38)	75	20
21	Replace shaft and Bearings in Kitchen Air Handler	2020	2,983	76	39	32	(45)	76	21
22	Surveillance Cameras for Stairwells Outside Employee Parking Lot	2020	2,700	69	39	23	(46)	69	22
23	Repair Water Leak in 1st Floor HR Office	2020	3,380	87	39	29	(58)	87	23
24	New 119 Gallon Storage Tanks for Kitchen/Laundry	2020	16,200	415	39	104	(312)	415	24
25	Replace Hot Water Mixing Valve	2020	7,802	200	39	50	(150)	200	25
26	Medical Shower Filters, Medical Tap Filters & Faucet Aerator Ad	2020	3,867	99	39	25	(74)	99	26
27	Booster Pump for Rooms 501 & 502	2020	3,175	81	39	20	(61)	81	27
28	Replace Return Line Pump for the Domestic Hot Water Heater	2020	5,344	137	39	23	(114)	137	28
29	Medical Shower Filters, Medical Tap Filters for Bathrooms	2020	3,120	80	39	13	(67)	80	29
30	New Boiler for Building	2020	32,545	834	39	139	(695)	834	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,928,887	\$ 228,946		\$ 227,083	\$ (1,863)	\$ 1,655,443	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	\$53,266	\$1,900	\$1,900	\$	5	\$53,266	71
72	Current Year Purchases	199,074	133,370	19,907	(113,463)	5	199,074	72
73	Fully Depreciated Assets	1,783,139				5	1,783,139	73
74								74
75	TOTALS	\$2,035,479	\$135,270	\$21,807	\$(113,463)		\$2,035,479	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)	\$11,464,366	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$364,216	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$248,890	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(115,326)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,690,922	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.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: YES NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* 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.)

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			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	10a-3	hrs	\$	7,222	\$ 538,972	\$	7,222	\$	538,972
2	Licensed Speech and Language Development Therapist	10a-3	hrs		3,015	296,772		3,015		296,772
3	Licensed Recreational Therapist		hrs							
4	Licensed Physical Therapist	10a-3	hrs		6,520	626,245		6,520		626,245
5	Physician Care		visits							
6	Dental Care		visits							
7	Work Related Program		hrs							
8	Habilitation		hrs							
9	Pharmacy	39-2	# of prescrpts				234,113			234,113
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
11	Academic Education		hrs							
12	Other (specify): X-Ray	39-2					14,744			14,744
13	Other (specify): Lab	39-2					372,028			372,028
14	TOTAL			\$	16,757	\$ 1,461,989	\$ 620,885	16,757	\$	2,082,874

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (273,185)	\$ (272,117)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,267,308	7,267,308	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	425,140	425,140	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		676,054	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,419,263	\$ 8,096,385	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		6,000,000	14
15	Leasehold Improvements, at Historical Cost	2,928,886	2,928,886	15
16	Equipment, at Historical Cost	1,427,480	19,369,161	16
17	Accumulated Depreciation (book methods)	(1,881,114)	(13,250,499)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	197,434	440,817	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(25,003)	(160,639)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	385,011	385,011	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,032,694	\$ 16,212,737	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,451,957	\$ 24,309,122	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,456,462	\$ 3,879,592	26
27	Officer's Accounts Payable	(10,060)		27
28	Accounts Payable-Patient Deposits		(10,060)	28
29	Short-Term Notes Payable		410,314	29
30	Accrued Salaries Payable	317,935	317,935	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,882	32,882	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)	\$ 3,797,219	\$ 4,630,663	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,472,577	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)	\$	\$ 19,472,577	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,797,219	\$ 24,103,240	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,654,738	\$ 205,882	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,451,957	\$ 24,309,122	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,699,796	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,699,796	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(45,058)	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) Rounding Error	1	15
16	Other (describe) Rounding	(1)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (45,058)	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)	\$ 6,654,738	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Niles Nrsg Rehab Center

0050088

Report Period Beginning: 1/1/20

Ending: 12/31/20

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 19,806,259	1
2	Discounts and Allowances for all Levels	(63,536)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,742,723	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	733,329	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 733,329	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	3,016,526	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	23,073	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	163,784	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,203,383	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	263,368	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 263,368	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	381	28
28a	Misc Income	36,987	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 37,368	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,980,171	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,378,991	31
32	Health Care	9,587,252	32
33	General Administration	6,228,748	33
	B. Capital Expense		
34	Ownership	3,216,487	34
	C. Ancillary Expense		
35	Special Cost Centers	1,613,751	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 24,025,229	40
41	Income before Income Taxes (line 30 minus line 40)**	(45,058)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (45,058)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 13,279,312	44
45	Private Pay - Net Inpatient Revenue	512,400	45
46	Medicare - Net Inpatient Revenue	4,979,409	46
47	Other-(specify) NET PATIENT REVENUE	971,602	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 19,742,723	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.

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	2,000	2,272	\$ 125,763	\$ 55.35	1
2	Assistant Director of Nursing	7,226	8,315	317,049	38.13	2
3	Registered Nurses	49,094	56,647	2,145,978	37.88	3
4	Licensed Practical Nurses	27,753	34,513	1,109,947	32.16	4
5	CNAs & Orderlies	124,626	156,513	3,014,640	19.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	21,236	23,679	450,587	19.03	10
11	Social Service Workers	8,373	9,127	205,019	22.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,998	48,459	821,277	16.95	15
16	Dishwashers					16
17	Maintenance Workers	5,620	6,480	150,580	23.24	17
18	Housekeepers	41,681	46,774	746,519	15.96	18
19	Laundry	3,720	4,175	62,672	15.01	19
20	Administrator	3,151	3,663	172,790	47.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,686	17,070	351,664	20.60	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	3,477	3,865	126,078	32.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	354,641	421,552	\$ 9,800,563 *	\$ 23.25	34

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

** See instructions.

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	410	\$ 19,700	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,299	69,351	10-3	38
39	Pharmacist Consultant	494	24,705	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	81	5,265	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,284	\$ 119,021		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			10-2	51
52	Certified Nurse Assistants/Aides	458	55,270	10-2	52
53	TOTAL (lines 50 - 52)	458	\$ 55,270		53

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	
Panganiban, Bryan	Administrators	0	\$ 13,477	Workers' Compensation Insurance	\$	191,023	IDPH License Fee	\$ 1,990	
Sianghio, John Marc	Administrators	0	72,013	Unemployment Compensation Insurance		31,623	Advertising: Employee Recruitment		
Ricana, Ralph R	Administrators	0	52,860	FICA Taxes		801,752	Health Care Worker Background Check		
Eugenio, Ronron	Administrators	0	5,721	Employee Health Insurance		602,258	(Indicate # of checks performed _____)		
Laurea, Russell	Administrators	0	28,719	Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Management and network services	750	
				Uniforms		1,403	Niles chamber of commerce	275	
				Pension		92,727	Village of Niles	600	
				Employee backround check		1,943	Clia Laborotory	180	
				Other Employee Expense		29,729	Other Licenses and dues	373	
							Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,		\$ 1,752,458	TOTAL (agree to Sch. V,		
(List each licensed administrator separately.)			\$ 172,790	line 22, col.8)			line 20, col. 8)		
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	\$	
							Travel Reimbursement	2,720	
							In-State Travel		
							Travel Reimbursement	19,082	
							Travel Reimbursement	19,457	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Seminar Expense		
(Attach a copy of any management service agreement)							Education and Seminars	3,558	
C. Professional Services									
Vendor/Payee	Type		Amount						
Infinity Healthcare Management of I	Managfement fees	\$	1,027,220						
Empire Risk Management Services, I	Professionla fees		12,000						
Genex Services, LLC.	Professionla fees		100						
Global Fiscal Midwest LLC	Professionla fees		14,032						
Infinity Healthcare Management of I	Professionla fees		1,759						
PROFESSIONAL SEARCH NETWC	Professionla fees		20,250						
USA Risk Management Inc	Professionla fees		2,048						
Premier Destine Inc	Professionla fees		704						
People Powered LLC	Professionla fees		2,000						
Infinity H Funding	Professionla fees		423						
See attached schedule			74,659						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,		
(For legal fee disclosure, see page 39 of instructions)			\$ 1,155,194				line 24, col. 8)		
							TOTAL	\$ 44,816	

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number <u>Niles Nrsg Rehab Center</u>	STATE OF ILLINOIS # <u>0050088</u>	Report Period Beginning: <u>1/1/20</u>	Ending: <u>12/31/20</u>
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XX. GENERAL INFORMATION:

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(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? NO
If YES, give association name and amount. N/A

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 136,385 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 628,793
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. \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
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.