

		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>0054908</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>University Nsg Rehab Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1095 University Dr</u> <u>Edwardsville</u> <u>62025</u>																									
Number City Zip Code																									
County: <u>Madison</u>																									
Telephone Number: <u>(618)656-1081</u> Fax # <u>(618)656-7083</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>3/1/2018</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																									
Email Address: _____																									

Facility Name & ID Number University Nsg Rehab Center

0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>122</u>	Skilled (SNF)	<u>122</u>	<u>44,652</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>122</u>	TOTALS	<u>122</u>	<u>44,652</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>18,763</u>	<u>2,611</u>	<u>7,271</u>	<u>28,645</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>18,763</u>	<u>2,611</u>	<u>7,271</u>	<u>28,645</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.15%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 03/01/2018

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 03/01/2018 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 118 and days of care provided 3,460

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 University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	222,093	27,423	9,344	258,860		258,860		258,860			1
2	Food Purchase		176,176		176,176		176,176	(154)	176,022			2
3	Housekeeping	147,167	40,620		187,787		187,787		187,787			3
4	Laundry	99,305	34,689		133,994		133,994		133,994			4
5	Heat and Other Utilities			138,537	138,537		138,537		138,537			5
6	Maintenance	75,794	24,262	80,559	180,615		180,615	(11,675)	168,940			6
7	Other (specify):*											7
8	TOTAL General Services	544,359	303,170	228,440	1,075,969		1,075,969	(11,829)	1,064,140			8
	B. Health Care and Programs											
9	Medical Director			20,125	20,125		20,125		20,125			9
10	Nursing and Medical Records	2,323,460	72,420	29,424	2,425,304		2,425,304	(127)	2,425,177			10
10a	Therapy	19,301			19,301		19,301		19,301			10a
11	Activities	63,371	10,316		73,687		73,687		73,687			11
12	Social Services	61,912		4,030	65,942		65,942		65,942			12
13	CNA Training											13
14	Program Transportation			593	593		593		593			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,468,044	82,736	54,172	2,604,952		2,604,952	(127)	2,604,825			16
	C. General Administration											
17	Administrative	150,028		70,000	220,028		220,028	10,842	230,870			17
18	Directors Fees											18
19	Professional Services			268,476	268,476		268,476	(205,110)	63,366			19
20	Dues, Fees, Subscriptions & Promotions			49,445	49,445		49,445	(10,836)	38,609			20
21	Clerical & General Office Expenses	216,085	10,662	354,434	581,181		581,181	(130,462)	450,719			21
22	Employee Benefits & Payroll Taxes			516,325	516,325		516,325		516,325			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,099	3,099		3,099		3,099			24
25	Other Admin. Staff Transportation			9,390	9,390		9,390	1,964	11,354			25
26	Insurance-Prop.Liab.Malpractice			213,279	213,279		213,279	1,418	214,697			26
27	Other (specify):*							17,879	17,879			27
28	TOTAL General Administration	366,113	10,662	1,484,448	1,861,223		1,861,223	(314,305)	1,546,918			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,378,516	396,568	1,767,060	5,542,144		5,542,144	(326,261)	5,215,883			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			33,393	33,393		33,393	76,580	109,973			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,005	13,005		13,005	91,336	104,341			32
33	Real Estate Taxes			91,547	91,547		91,547	(1,798)	89,749			33
34	Rent-Facility & Grounds			211,054	211,054		211,054	(188,771)	22,283			34
35	Rent-Equipment & Vehicles			23,935	23,935		23,935	1,747	25,682			35
36	Other (specify):*											36
37	TOTAL Ownership			372,934	372,934		372,934	(20,906)	352,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		347,551	572,495	920,046		920,046	(52,911)	867,135			39
40	Barber and Beauty Shops			60	60		60		60			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			237,634	237,634		237,634		237,634			42
43	Other (specify):*	91,543		52,690	144,233		144,233	(144,233)				43
44	TOTAL Special Cost Centers	91,543	347,551	862,879	1,301,973		1,301,973	(197,144)	1,104,829			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,470,059	744,119	3,002,873	7,217,051		7,217,051	(544,311)	6,672,740			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	(12,962)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(63,602)	30		9
10	Interest and Other Investment Income	(1,388)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,950)	21		19
20	Contributions	(4,083)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(223,678)	21		24
25	Fund Raising, Advertising and Promotional	(6,342)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(206,671)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (522,830)		\$	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)	(21,481)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (21,481)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (544,311)		37

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

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

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

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Medical Records Income	\$ (95)	10	1
2	Miscellaneous Income	(852)	21	2
3	Resident Lost Items	(32)	10	3
4	Marketing Salary	(91,543)	43	4
5	Sequestration	(10,236)	21	5
6	Bank Service Charges	(1,761)	21	6
7	Collection Fees/ Cc Fees	(7,736)	21	7
8	Late Fees	(21,581)	21	8
9	Taxes	(26)	21	9
10	Bldg Co - Amortization	(9,398)	36	10
11	Bldg Co - Accounting	(2,163)	19	11
12	Real Estate Taxes	(1,798)	33	12
13	Additional R&M	5,839	06	13
14	Capitalized R&M	(6,300)	06	14
15	Non Allowable Auto Lease	(1,592)	35	15
16	Chamber of Commerce	(476)	20	16
17	Refund	(100)	21	17
18	Non Allowable Expense	(3,000)	43	18
19	Non Allowable Legal	(4,131)	19	19
20	Non Allowable Expense	(49,690)	43	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(206,671)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(154)											(154)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(13,423)		1,748									(11,675)	6
7	Other (specify):*													7
8	TOTAL General Services	(13,577)		1,748									(11,829)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(127)											(127)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(127)											(127)	16
	C. General Administration													
17	Administrative			10,842									10,842	17
18	Directors Fees													18
19	Professional Services	(6,294)	2,163	(200,979)									(205,110)	19
20	Fees, Subscriptions & Promotions	(10,901)		65									(10,836)	20
21	Clerical & General Office Expenses	(269,920)		139,458									(130,462)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			1,964									1,964	25
26	Insurance-Prop.Liab.Malpractice			1,418									1,418	26
27	Other (specify):*			17,879									17,879	27
28	TOTAL General Administration	(287,115)	2,163	(29,353)									(314,305)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(300,819)	2,163	(27,605)									(326,261)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(63,602)	140,182										76,580	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,388)	91,760	964									91,336	32
33	Real Estate Taxes	(1,798)											(1,798)	33
34	Rent-Facility & Grounds		(204,460)	15,689									(188,771)	34
35	Rent-Equipment & Vehicles	(1,592)		3,339									1,747	35
36	Other (specify):*	(9,398)	9,398											36
37	TOTAL Ownership	(77,778)	36,880	19,992									(20,906)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(52,911)								(52,911)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(144,233)											(144,233)	43
44	TOTAL Special Cost Centers	(144,233)			(52,911)								(197,144)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(522,830)	39,043	(7,613)	(52,911)								(544,311)	45

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	\$ 204,460	University Health Properties LLC		\$	(204,460)	1
2	V	36	Amortization Expense - Loan Fee		University Health Properties LLC		9,398	9,398	2
3	V	30	Depreciation Expense		University Health Properties LLC		140,182	140,182	3
4	V	32	Interest Expense		University Health Properties LLC		91,760	91,760	4
5	V	19	Accounting Fees		University Health Properties LLC		2,163	2,163	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 204,460			\$ 243,503	\$ * 39,043	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Mark Suissa	91.00%	CORI MANOR	ST. LOUIS MO.	UNIVERSITY HEALTH PROPER	EDWARDSVILLE	BUILDING CO.	1
2	Lorraine Suissa	9.00%	GRAND MANOR NURSING AND REHAB	ST. LOUIS MO.	HEALTHCARE ACCOUNTING S	ST. LOUIS MO.	BOOKKEEPING/FINANCIAL	2
3			NORTHVIEW VILLAGE	ST. LOUIS MO.	MS HEALTHCARE ACCT.	CHICAGO, IL	ACCOUNTING	3
4			SALEM VILLAGE NURSING AND REHABILITATION CENTER, L.L.C	JOLIET	TOWN AND COUNTRY REHAB	ST. LOUIS MO.	THERAPY	4
5			ELMWOOD NURSING & REHAB CENTER	MARYVILLE				5
6			EDWARDSVILLE CARE CENTER	EDWARDSVILLE, IL				6
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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								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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	\$	HEALTHCARE ACCOUNTING SERVICES, LLC		\$ 1,748	\$ 1,748	15
16	V	19	Professional Fees		HEALTHCARE ACCOUNTING SERVICES, LLC		3,251	3,251	16
17	V	20	Dues, Subscriptions		HEALTHCARE ACCOUNTING SERVICES, LLC		65	65	17
18	V	21	Clerical & General		HEALTHCARE ACCOUNTING SERVICES, LLC		3,686	3,686	18
19	V	24	Seminar		HEALTHCARE ACCOUNTING SERVICES, LLC				19
20	V	25	Travel		HEALTHCARE ACCOUNTING SERVICES, LLC		1,964	1,964	20
21	V	26	Insurance		HEALTHCARE ACCOUNTING SERVICES, LLC		1,418	1,418	21
22	V	30	Depreciation		HEALTHCARE ACCOUNTING SERVICES, LLC				22
23	V	32	Interest		HEALTHCARE ACCOUNTING SERVICES, LLC		964	964	23
24	V	34	Office Space		HEALTHCARE ACCOUNTING SERVICES, LLC		15,689	15,689	24
25	V	35	Auto Rental		HEALTHCARE ACCOUNTING SERVICES, LLC		1,945	1,945	25
26	V	35	Equipment Rental		HEALTHCARE ACCOUNTING SERVICES, LLC		1,394	1,394	26
27	V	21	Clerical Salaries		HEALTHCARE ACCOUNTING SERVICES, LLC		75,301	75,301	27
28	V	27	G&A Employee Benefits		HEALTHCARE ACCOUNTING SERVICES, LLC		9,957	9,957	28
29	V	17	Admin. Salary - M. Suissa		HEALTHCARE ACCOUNTING SERVICES, LLC		10,842	10,842	29
30	V	27	Employee Benefits-M. Suissa		HEALTHCARE ACCOUNTING SERVICES, LLC		929	929	30
31	V								31
32	V	21	Clerical Salaries		HEALTHCARE ACCOUNTING SERVICES, LLC		60,471	60,471	32
33	V	27	G&A Employee Benefits		HEALTHCARE ACCOUNTING SERVICES, LLC		6,993	6,993	33
34	V								34
35	V	12	Social Service		HEALTHCARE ACCOUNTING SERVICES, LLC				35
36	V	15	Health Care Employee Benefits		HEALTHCARE ACCOUNTING SERVICES, LLC				36
37	V								37
38	V	19	Bookkeeping Services	204,230	HEALTHCARE ACCOUNTING SERVICES, LLC			(204,230)	38
39	Total			\$ 204,230			\$ 196,617	\$ * (7,613)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	\$ 546,384	Town and Country Rehab, LLC		\$ 493,473	\$ (52,911)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 546,384			\$ 493,473	\$ * (52,911)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Suissa	Shareholder	Administrative	91.00%	See Attached	5.91	9.85%	MF/Alloc Sal	\$ 80,842	17-3,17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 80,842		13

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

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

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

Facility Name & ID Number University Nsg Rehab Center# 0054908

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

HEALTHCARE ACCOUNTING SERVICES, LI

Street Address

1401 S. BRENTWOOD BOULEVARD

City / State / Zip Code

BRENTWOOD, MO. 63144

Phone Number

(314) 963-7570

Fax Number

(314) 963-9030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Repairs & Maintenance	IL & MO Patient Days	290,630	7	\$ 17,739	\$ 28,645	\$ 1,748	1
2	19	Professional Fees	IL & MO Patient Days	290,630	7	32,987	28,645	3,251	2
3	20	Dues, Subscriptions	IL & MO Patient Days	290,630	7	659	28,645	65	3
4	21	Clerical & General	IL & MO Patient Days	290,630	7	37,397	28,645	3,686	4
5	24	Seminar	IL & MO Patient Days	290,630	7		28,645		5
6	25	Travel	IL & MO Patient Days	290,630	7	19,930	28,645	1,964	6
7	26	Insurance	IL & MO Patient Days	290,630	7	14,386	28,645	1,418	7
8	30	Depreciation	IL & MO Patient Days	290,630	7		28,645		8
9	32	Interest	IL & MO Patient Days	290,630	7	9,786	28,645	964	9
10	34	Office Space	IL & MO Patient Days	290,630	7	159,180	28,645	15,689	10
11	35	Auto Rental	IL & MO Patient Days	290,630	7	19,739	28,645	1,945	11
12	35	Equipment Rental	IL & MO Patient Days	290,630	7	14,145	28,645	1,394	12
13	21	Clerical Salaries	IL & MO Patient Days	290,630	7	763,997	28,645	75,301	13
14	27	G&A Employee Benefits	IL & MO Patient Days	290,630	7	101,021	28,645	9,957	14
15	17	Admin. Salary - M. Suissa	IL & MO Patient Days	290,630	7	110,000	28,645	10,842	15
16	27	Employee Benefits-M. Suissa	IL & MO Patient Days	290,630	7	9,429	28,645	929	16
17									17
18	21	Clerical Salaries	Illinois Patient Days	140,721	4	297,069	28,645	60,471	18
19	27	G&A Employee Benefits	Illinois Patient Days	140,721	4	34,351	28,645	6,993	19
20									20
21	12	Social Service	Specific Facility Days	149,909	3	4,392	4,392		21
22	15	Health Care Employee Benefits	Specific Facility Days	149,909	3	674			22
23									23
24									24
25	TOTALS					\$ 1,646,881	\$ 1,175,458	\$ 196,617	25

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization TOWN AND COUNTRY REHAB, LLC
Street Address 1401 S. BRENTWOOD BOULEVARD
City / State / Zip Code BRENTWOOD, MO. 63144
Phone Number (314) 963-7570
Fax Number (314) 963-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	THERAPY	DIRECT			\$	\$		\$ 493,473	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					\$	\$		\$ 493,473	25

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

Facility Name & ID Number University Nsg Rehab Center # 0054908 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

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	Central Bank of St Louis		X	Mortgage			\$	2,012,740			\$	91,759	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Central Bank of St Louis		X	Line of Credit								6,506	6
7	First Insurance		X	Insurance Financing								6,499	7
8													8
9	TOTAL Facility Related						\$	2,012,740			\$	104,764	9
	B. Non-Facility Related*												
10	Interest Income		X									(1,388)	10
11	Allocated from HAS	X										964	11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(424)	14
15	TOTALS (line 9+line14)						\$	2,012,740			\$	104,340	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME University Nsg Rehab Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0054908

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 14-2-15-15-11-201-002.001	Long Term Care Property	\$ 89,748.92	\$ 89,748.92
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 89,748.92	\$ 89,748.92

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 providecopies of their original second installment tax bill.

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEUniversity Nsg Rehab CenterCOUNTYMadison

FACILITY IDPH LICENSE NUMBER0054908

CONTACT PERSON REGARDING THIS REPORTSteven Lavenda

TELEPHONE ()FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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 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 a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 28,920

B. General Construction Type: Exterior Brick Frame 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	Facility		2018	\$ 245,000	1
2					2
3	TOTALS			\$ 245,000	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	122		2018	1978	\$ 2,205,000	\$ 80,182	35	\$ 63,000	\$ (17,182)	\$ 178,500
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			33,393			(33,393)		69
70	TOTAL (lines 4 thru 69)		\$ 2,205,000	\$ 113,575		\$ 63,000	\$ (50,575)	\$ 178,500	70

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

Facility Name & ID Number University Nsg Rehab Center

0054908

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,205,000	\$ 113,575		\$ 63,000	\$ (50,575)	\$ 178,500	1
2	Amana Digismart Ptac Heating Units X 11	2018	7,307		20	365	365	1,096	2
3	Hvac Rooftops Units X 5	2018	30,775		20	1,539	1,539	4,617	3
4	Demo And Install 2" Copper Piping And Pressure Reducing Valves	2019	3,845		20	192	192	256	4
5	Repair Garbage Disposal	2020	3,788		20	189	189	189	5
6	Installed New Alternator On Generator	2020	2,512		20	126	126	126	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	TOTAL (lines 1 thru 33)		\$ 2,253,227	\$ 113,575		\$ 65,411	\$ (48,164)	\$ 184,784	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,253,227	\$ 113,575		\$ 65,411	\$ (48,164)	\$ 184,784	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	TOTAL (lines 1 thru 33)		\$ 2,253,227	\$ 113,575		\$ 65,411	\$ (48,164)	\$ 184,784	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,253,227	\$ 113,575		\$ 65,411	\$ (48,164)	\$ 184,784	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	TOTAL (lines 1 thru 33)		\$ 2,253,227	\$ 113,575		\$ 65,411	\$ (48,164)	\$ 184,784	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,253,227	\$ 113,575		\$ 65,411	\$ (48,164)	\$ 184,784	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	TOTAL (lines 1 thru 33)		\$ 2,253,227	\$ 113,575		\$ 65,411	\$ (48,164)	\$ 184,784	34

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

Facility Name & ID Number University Nsg Rehab Center

0054908

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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	\$395,862	\$60,000	\$39,588	\$ (20,412)	10	\$105,149	71
72	Current Year Purchases	11,547		1,155	1,155	10	1,155	72
73	Fully Depreciated Assets	13,951		4	4	10	13,951	73
74								74
75	TOTALS	\$421,360	\$60,000	\$40,747	\$ (19,253)		\$120,255	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		Facility Van	2018	\$10,000	\$	\$2,000	\$2,000	5	\$6,000
77		New Engine for Van	2020	9,079		1,816	1,816	5	1,816
78									
79									
80	TOTALS			\$19,079	\$	\$3,816	\$3,816		\$7,816

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)			\$2,938,666	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$173,575	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$109,973	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$(63,602)	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$312,854	

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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				6,594			5
6	Allocated from HAS				15,689			6
7	TOTAL				\$22,283			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$17,467
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Lincoln	\$685	\$6,270	17
18	Allocated from HAS			1,945	18
19					19
20					20
21	TOTAL		\$685	\$8,215	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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	

(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 - 03	hrs	\$		\$ 185,454	\$		\$ 185,454	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			117,804			117,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			243,127			243,127	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				205,184		205,184	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					26,110	142,367		168,477	13
14	TOTAL			\$		\$ 572,495	\$ 347,551		\$ 920,046	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 933,065	\$ 933,162	1
2	Cash-Patient Deposits	42,774	42,774	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,454,588	1,454,588	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,096	58,096	6
7	Other Prepaid Expenses	65,537	65,537	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	475	24,892	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,554,535	\$ 2,579,049	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		245,000	13
14	Buildings, at Historical Cost		2,205,000	14
15	Leasehold Improvements, at Historical Cost	43,664	43,664	15
16	Equipment, at Historical Cost	140,363	440,363	16
17	Accumulated Depreciation (book methods)	(79,701)	(477,330)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	33,276	55,802	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 137,602	\$ 2,512,499	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,692,137	\$ 5,091,548	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 75,494	\$ 75,494	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,273	42,273	28
29	Short-Term Notes Payable		126,344	29
30	Accrued Salaries Payable	228,227	228,227	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,070	12,070	31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,000	90,000	32
33	Accrued Interest Payable	2	2	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,145,797	1,145,797	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,593,863	\$ 1,720,207	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,886,396	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,049,079	683,123	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,049,079	\$ 2,569,519	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,642,942	\$ 4,289,726	46
47	TOTAL EQUITY(page 18, line 24)	\$ 49,195	\$ 801,822	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,692,137	\$ 5,091,548	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (185,325)	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (185,328)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	234,523	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)	\$ 234,523	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)	\$ 49,195	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number University Nsg Rehab Center

0054908

Report Period Beginning: 01/01/20

Ending: 12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,005,941	1
2	Discounts and Allowances for all Levels	488,615	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,494,556	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,022,836	6
7	Oxygen	13,292	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,036,128	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	162,242	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,820	19
20	Radiology and X-Ray	8,961	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 185,023	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,388	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,388	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	734,479	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 734,479	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,451,574	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,075,969	31
32	Health Care	2,604,952	32
33	General Administration	1,861,223	33
	B. Capital Expense		
34	Ownership	372,934	34
	C. Ancillary Expense		
35	Special Cost Centers	1,064,339	35
36	Provider Participation Fee	237,634	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,217,051	40
41	Income before Income Taxes (line 30 minus line 40)**	234,523	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 234,523	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 328,152	44
45	Private Pay - Net Inpatient Revenue	527,816	45
46	Medicare - Net Inpatient Revenue	1,371,101	46
47	Other-(specify) Hospice	492,547	47
48	Other-(specify) Insurance	2,774,940	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,494,556	49

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,618	1,706	\$ 71,763	\$ 42.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,229	10,981	416,796	37.96	3
4	Licensed Practical Nurses	20,801	21,998	681,229	30.97	4
5	CNAs & Orderlies	57,003	62,837	1,121,411	17.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	433	529	19,301	36.49	8
9	Activity Director					9
10	Activity Assistants	3,823	4,614	63,371	13.73	10
11	Social Service Workers	2,494	2,675	61,912	23.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,409	16,868	222,093	13.17	15
16	Dishwashers					16
17	Maintenance Workers	3,481	3,873	75,794	19.57	17
18	Housekeepers	10,858	11,807	147,167	12.46	18
19	Laundry	7,000	7,970	99,305	12.46	19
20	Administrator	2,029	2,229	150,028	67.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,644	7,524	216,085	28.72	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	1,957	2,087	32,261	15.46	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,852	2,080	91,543	44.01	33
34	TOTAL (lines 1 - 33)	145,631	159,778	\$ 3,470,059 *	\$ 21.72	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	169	\$ 9,344	01-03	35
36	Medical Director	Monthly	20,125	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	18,084	10-03	38
39	Pharmacist Consultant	132	9,404	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	65	4,030	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	366	\$ 60,987		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	28	\$ 1,568	10-03	50
51	Licensed Practical Nurses	8	368	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	36	\$ 1,936		53

STATE OF ILLINOIS

Facility Name & ID Number University Nsg Rehab Center

0054908

Report Period Beginning: 01/01/20

Page 21

Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Ruth Hilligoss</u>	<u>Administrator</u>		\$ <u>94,718</u>	<u>Workers' Compensation Insurance</u>	\$ <u>63,723</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
<u>Gina Higgins</u>	<u>Administrator</u>		<u>55,310</u>	<u>Unemployment Compensation Insurance</u>	<u>47,937</u>	<u>Advertising: Employee Recruitment</u>	<u>21,670</u>	
				<u>FICA Taxes</u>	<u>265,460</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>122,830</u>	<u>(Indicate # of checks performed <u>117</u>)</u>	<u>3,540</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks <u>107</u></u>	<u>1,926</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>3,660</u>	
				<u>401K Match/Pension</u>	<u>2,906</u>	<u>Licenses & Fees</u>	<u>5,758</u>	
				<u>Holiday Expense</u>	<u>13,469</u>			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ <u>150,028</u>					
B. Administrative - Other						<u>See Supplemental Schedule</u>	<u>65</u>	
Description			Amount			<u>Less: Public Relations Expense</u>	()	
<u>Management Fees - Mark Suissa</u>			\$ <u>70,000</u>			<u>Non-allowable advertising</u>	()	
						<u>Yellow page advertising</u>	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ <u>70,000</u>	TOTAL (agree to Schedule V, line 22, col.8)		\$ <u>516,325</u>	TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Healthcare Accounting Services</u>	<u>Accounting/Bookkeeping</u>		\$ <u>204,230</u>				<u>Out-of-State Travel</u>	\$
<u>Marcum LLP</u>	<u>Accounting</u>		<u>29,870</u>					
<u>National Datacare Corporation</u>	<u>Data Processing</u>		<u>2,252</u>					
<u>Paycom</u>	<u>Payroll Processing</u>		<u>21,045</u>				<u>In-State Travel</u>	
<u>TASC</u>	<u>Enrollment Services</u>		<u>1,693</u>					
<u>Capital Group Plan</u>	<u>401K Planning</u>		<u>2,003</u>					
<u>Walton Management Services</u>	<u>Tax Consultant</u>		<u>1,827</u>					
							<u>Seminar Expense</u>	<u>3,099</u>
<u>See Attached</u>	<u>Legal</u>		<u>5,556</u>					
							<u>Entertainment Expense</u>	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ <u>268,476</u>	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ <u>3,099</u>

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- | | |
|---|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u>
If YES, give association name and amount. <u>N/A</u></p> <p>(3) Did the nursing home make political contributions or payments to a political organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>10 Years</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>15,857</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? <u>X</u> YES NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>237,634</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Ln 14</u>
d. Have vehicle usage logs been maintained? <u>N/A</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees</p> |
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