

		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>0055525</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																				
Facility Name: <u>University Rehab</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>500 S Art Bartell Rd</u> <u>Urbana</u> <u>61802</u>																																																																																						
Number City Zip Code																																																																																						
County: <u>Champaign</u>																																																																																						
Telephone Number: <u>(217) 384-3784</u> Fax # <u>(217) 337-0120</u>																																																																																						
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____ <u>04/12/2021</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td><i>* Subject to the attached Accountants' Consulting Report</i> (Date)</td></tr><tr><td>(Print Name <u>Steven N. Lavenda, CPA</u></td></tr><tr><td>and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Marcum, LLP</u></td></tr><tr><td>& Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>4/1/2019</u></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u></td><td colspan="2">Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ <u>04/12/2021</u>	Paid Preparer	<i>* Subject to the attached Accountants' Consulting Report</i> (Date)	(Print Name <u>Steven N. Lavenda, CPA</u>	and Title) <u>Partner</u>	(Firm Name <u>Marcum, LLP</u>	& Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	Date of Initial License for Current Owners: <u>4/1/2019</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Type of Ownership:		MAIL TO: BUREAU OF HEALTH FINANCE		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></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 _____					In the event there are further questions about this report, please contact:				Name: <u>Steven N. Lavenda</u>		Telephone Number: <u>(847) 282-6300</u>		Email Address: _____			
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Facility Name & ID Number University Rehab

0055525 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>243</u>	Skilled (SNF)	<u>243</u>	<u>88,938</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>243</u>	TOTALS	<u>243</u>	<u>88,938</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>1,153</u>		<u>2,395</u>	<u>3,548</u>	8
9	SNF/PED					9
10	ICF	<u>36,505</u>	<u>6,852</u>	<u>4,414</u>	<u>47,771</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>37,658</u>	<u>6,852</u>	<u>6,809</u>	<u>51,319</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.70%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 4/1/2019

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

YES ☒ Date 4/1/2019 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 243 and days of care provided 2,017

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number University Rehab # 0055525 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	671,501	87,328	460	759,289		759,289		759,289			1
2	Food Purchase		453,016		453,016		453,016	(411)	452,605			2
3	Housekeeping	435,787	87,841	4,808	528,436		528,436	723	529,159			3
4	Laundry	63,773	24,442	1,096	89,311		89,311		89,311			4
5	Heat and Other Utilities			352,883	352,883		352,883	702	353,585			5
6	Maintenance	284,230		269,750	553,980		553,980	(4,695)	549,285			6
7	Other (specify):*											7
8	TOTAL General Services	1,455,291	652,627	628,997	2,736,915		2,736,915	(3,681)	2,733,234			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,339,243	514,310	896,689	5,750,242		5,750,242	14,418	5,764,660			10
10a	Therapy	26,628		8,461	35,089		35,089		35,089			10a
11	Activities	164,071	29,781	1,239	195,091		195,091		195,091			11
12	Social Services	297,461		1,239	298,700		298,700		298,700			12
13	CNA Training											13
14	Program Transportation	43,355			43,355		43,355		43,355			14
15	Other (specify):*							1,182	1,182			15
16	TOTAL Health Care and Programs	4,870,758	544,091	907,628	6,322,477		6,322,477	15,599	6,338,076			16
	C. General Administration											
17	Administrative	130,153			130,153		130,153	63,251	193,404			17
18	Directors Fees											18
19	Professional Services			723,557	723,557	(50,008)	673,549	(510,996)	162,553			19
20	Dues, Fees, Subscriptions & Promotions			18,491	18,491		18,491	(9,529)	8,962			20
21	Clerical & General Office Expenses	308,323	30,164	393,391	731,878		731,878	(179,281)	552,597			21
22	Employee Benefits & Payroll Taxes			1,617,326	1,617,326		1,617,326		1,617,326			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,074	2,074		2,074		2,074			24
25	Other Admin. Staff Transportation			14,199	14,199		14,199	779	14,978			25
26	Insurance-Prop.Liab.Malpractice			265,971	265,971		265,971	908	266,879			26
27	Other (specify):*							30,000	30,000			27
28	TOTAL General Administration	438,476	30,164	3,035,009	3,503,649	(50,008)	3,453,641	(604,868)	2,848,773			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,764,525	1,226,882	4,571,634	12,563,041	(50,008)	12,513,033	(592,950)	11,920,083			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			18,182	18,182		18,182	359,951	378,133			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,087	45,087		45,087	543,069	588,156			32
33	Real Estate Taxes			358,314	358,314	50,008	408,322	2,741	411,063			33
34	Rent-Facility & Grounds			726,000	726,000		726,000	(726,000)				34
35	Rent-Equipment & Vehicles			13,143	13,143		13,143	2,171	15,314			35
36	Other (specify):*											36
37	TOTAL Ownership			1,160,726	1,160,726	50,008	1,210,734	181,931	1,392,665			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		276,423	417,121	693,544		693,544	(22,345)	671,199			39
40	Barber and Beauty Shops			4,095	4,095		4,095		4,095			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			423,373	423,373		423,373		423,373			42
43	Other (specify):*	32,093		99,962	132,055		132,055	(132,055)				43
44	TOTAL Special Cost Centers	32,093	276,423	944,551	1,253,067		1,253,067	(154,400)	1,098,667			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,796,618	1,503,305	6,676,911	14,976,834		14,976,834	(565,419)	14,411,415			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	(120,577)	30		9
10	Interest and Other Investment Income	(104)	32		10
11	Discounts, Allowances, Rebates & Refunds	(22,345)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(605)	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	(43,798)	21		18
19	Entertainment	(655)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(311,730)	21		24
25	Fund Raising, Advertising and Promotional	(10,171)	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	(217,008)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (726,993)		\$	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)	161,574		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 161,574		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (565,419)		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	Misc. Income	\$ (730)	21	1
2	Patient Income	(1,630)	10	2
3	Bank Charges	(10,162)	21	3
4	Theft Loss	(7,380)	21	4
5	Collection Expense	(36)	21	5
6	Building Company - Professional Fees	(7,000)	19	6
7	Building Company - Misc. Admin. Expense	(274)	21	7
8	Building Company - Bank Charges	(800)	21	8
9	Building Company - Amortization	(22,620)	36	9
10	Building Company - Interest (Intercompany)	(29,835)	32	10
11	Capitalized R&M	(5,700)	06	11
12	Additional Nursing Equipment	7,195	10	12
13	Marketing Consultant	(95,000)	43	13
14	Marketing Salaries	(32,093)	43	14
15	Non-Allowable Legal	64	19	15
16	Prior Year Professional Fee	(6,045)	19	16
17	Website Design	(4,962)	43	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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44				44
45				45
46				46
47				47
48				48
49	Total	(217,008)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number University Rehab # 0055525 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	(605)		194									(411)	2
3	Housekeeping			723									723	3
4	Laundry													4
5	Heat and Other Utilities			702									702	5
6	Maintenance	(5,700)		1,005									(4,695)	6
7	Other (specify):*													7
8	TOTAL General Services	(6,305)		2,624									(3,681)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	5,565		8,853									14,418	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,182									1,182	15
16	TOTAL Health Care and Programs	5,565		10,034									15,599	16
	C. General Administration													
17	Administrative			63,251									63,251	17
18	Directors Fees													18
19	Professional Services	(12,981)	7,000	(505,015)									(510,996)	19
20	Fees, Subscriptions & Promotions	(10,171)		642									(9,529)	20
21	Clerical & General Office Expenses	(375,565)	1,074	195,210									(179,281)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			779									779	25
26	Insurance-Prop.Liab.Malpractice			908									908	26
27	Other (specify):*			30,000									30,000	27
28	TOTAL General Administration	(398,717)	8,074	(214,225)									(604,868)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(399,457)	8,074	(201,567)									(592,950)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number University Rehab # 0055525 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	(120,577)	473,395	7,133									359,951	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(29,939)	572,414	594									543,069	32
33	Real Estate Taxes			2,741									2,741	33
34	Rent-Facility & Grounds		(726,000)										(726,000)	34
35	Rent-Equipment & Vehicles			2,171									2,171	35
36	Other (specify):*	(22,620)	22,620											36
37	TOTAL Ownership	(173,136)	342,429	12,638									181,931	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(22,345)											(22,345)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(132,055)											(132,055)	43
44	TOTAL Special Cost Centers	(154,400)											(154,400)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(726,993)	350,503	(188,929)									(565,419)	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	\$ 726,000	University Rehab Real Estate, LLC		\$	(726,000)	1
2	V	33	Real Estate Tax	358,314	University Rehab Real Estate, LLC		358,314		2
3	V	19	Professional Fees		University Rehab Real Estate, LLC		7,000	7,000	3
4	V	21	Misc Admin Expense		University Rehab Real Estate, LLC		274	274	4
5	V	21	Bank Charges		University Rehab Real Estate, LLC		800	800	5
6	V	30	Depreciation		University Rehab Real Estate, LLC		473,395	473,395	6
7	V	36	Amortization		University Rehab Real Estate, LLC		22,620	22,620	7
8	V	32	Interest		University Rehab Real Estate, LLC		572,414	572,414	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,084,314			\$ 1,434,817	\$ * 350,503	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	Atied Associates	50%	Devon Gables Rehabilitation Center	Tucson, AZ	University Rehab Real Estate, LLC	Urbana	Building Company	1
2	William Rothner	50%	Foothills Rehabilitation Center	Tucson, AZ	Altitude Health Services	Evanston	Financial Services	2
3			Palos Heights Rehabilitation Center	Crestwood	Care Centers Building	Evanston	Building Company	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

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	2	<u>Food</u>	\$	<u>Altitude Health Service, Inc.</u>		\$ 194	\$ 194	15
16	V	3	<u>Housekeeping</u>		<u>Altitude Health Service, Inc.</u>		723	723	16
17	V	5	<u>Utilities</u>		<u>Altitude Health Service, Inc.</u>		702	702	17
18	V	6	<u>Maintenance</u>		<u>Altitude Health Service, Inc.</u>		1,005	1,005	18
19	V	10	<u>Nursing - Salaries</u>		<u>Altitude Health Service, Inc.</u>		8,782	8,782	19
20	V	10	<u>Nursing - Other Expense</u>		<u>Altitude Health Service, Inc.</u>		70	70	20
21	V	15	<u>Employee Benefits-Nursing</u>		<u>Altitude Health Service, Inc.</u>		1,182	1,182	21
22	V	17	<u>Administrative Salaries</u>		<u>Altitude Health Service, Inc.</u>		34,992	34,992	22
23	V	17	<u>Management Fees</u>		<u>Altitude Health Service, Inc.</u>		28,259	28,259	23
24	V	19	<u>Professional Fees</u>		<u>Altitude Health Service, Inc.</u>		7,277	7,277	24
25	V	19	<u>Professional Fees - Direct Allocation</u>		<u>Altitude Health Service, Inc.</u>				25
26	V	19	<u>Professional Fees - Tax Appeal</u>		<u>Altitude Health Service, Inc.</u>		8	8	26
27	V	20	<u>Due, Fees, Subscriptions</u>		<u>Altitude Health Service, Inc.</u>		642	642	27
28	V	21	<u>Clerical / Office - Salaries</u>		<u>Altitude Health Service, Inc.</u>		186,737	186,737	28
29	V	21	<u>Clerical / Office - Other Expense</u>		<u>Altitude Health Service, Inc.</u>		8,473	8,473	29
30	V	25	<u>Auto & Travel</u>		<u>Altitude Health Service, Inc.</u>		779	779	30
31	V	26	<u>Insurance</u>		<u>Altitude Health Service, Inc.</u>		908	908	31
32	V	27	<u>Employee Benefits-Administrative</u>		<u>Altitude Health Service, Inc.</u>		30,000	30,000	32
33	V	30	<u>Depreciation</u>		<u>Altitude Health Service, Inc.</u>		7,133	7,133	33
34	V	32	<u>Interest</u>		<u>Altitude Health Service, Inc.</u>		594	594	34
35	V	33	<u>Real Estate Tax</u>		<u>Altitude Health Service, Inc.</u>		2,741	2,741	35
36	V	35	<u>Rent - Auto</u>		<u>Altitude Health Service, Inc.</u>		873	873	36
37	V	35	<u>Rent - Equipment</u>		<u>Altitude Health Service, Inc.</u>		1,298	1,298	37
38	V	19	<u>Home Office Expense</u>	512,300				(512,300)	38
39	Total			\$ 512,300			\$ 323,371	\$ * (188,929)	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.

VII. RELATED PARTIES (continued)

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

YESNO

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

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

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

Facility Name & ID Number University Rehab # 0055525 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	William Rothner	Owner	Administrative	50.00%	See Attached	8.09	16.19%	Sal/Mgmt Fee	\$ 40,465	17-07	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	\$ 40,465		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 Rehab # 0055525 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 Rehab# 0055525

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

Altitude Health Services, Inc.

Street Address

2201 Main Street

City / State / Zip Code

Evanston, IL 60202

Phone Number

(847) 261-2400

Fax Number

(847) 261-2410

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	2	Food	PATIENT DAYS	8	\$ 1,196	\$	51,319	\$ 194	1
2	3	Housekeeping	PATIENT DAYS	8	4,468		51,319	723	2
3	5	Utilities	PATIENT DAYS	8	4,339		51,319	702	3
4	6	Maintenance	PATIENT DAYS	8	6,207		51,319	1,005	4
5	10	Nursing - Salaries	PATIENT DAYS	8	54,259	54,259	51,319	8,782	5
6	10	Nursing - Other Expense	PATIENT DAYS	8	434		51,319	70	6
7	15	Employee Benefits-Nursing	PATIENT DAYS	8	7,300		51,319	1,182	7
8	17	Administrative Salaries	PATIENT DAYS	8	216,187	216,187	51,319	34,992	8
9	17	Management Fees	PATIENT DAYS	8	174,587		51,319	28,259	9
10	19	Professional Fees	PATIENT DAYS	8	44,958		51,319	7,277	10
11	19	Professional Fees - Direct Allocation	DIRECT		135,000				11
12	19	Professional Fees - Tax Appeal	PATIENT DAYS	8	50		51,319	8	12
13	20	Due, Fees, Subscriptions	PATIENT DAYS	8	3,967		51,319	642	13
14	21	Clerical / Office - Salaries	PATIENT DAYS	8	1,153,683	1,153,683	51,319	186,737	14
15	21	Clerical / Office - Other Expense	PATIENT DAYS	8	52,347		51,319	8,473	15
16	25	Auto & Travel	PATIENT DAYS	8	4,811		51,319	779	16
17	26	Insurance	PATIENT DAYS	8	5,607		51,319	908	17
18	27	Employee Benefits-Administrative	PATIENT DAYS	8	185,344		51,319	30,000	18
19	30	Depreciation	PATIENT DAYS	8	44,067		51,319	7,133	19
20	32	Interest	PATIENT DAYS	8	3,668		51,319	594	20
21	33	Real Estate Tax	PATIENT DAYS	8	16,933		51,319	2,741	21
22	35	Rent - Auto	PATIENT DAYS	8	5,395		51,319	873	22
23	35	Rent - Equipment	PATIENT DAYS	8	8,018		51,319	1,298	23
24									24
25	TOTALS				\$ 2,132,825	\$ 1,424,129		\$ 323,371	25

Facility Name & ID Number University Rehab # 0055525 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 Rehab # 0055525 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 Rehab # 0055525 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
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number University Rehab # 0055525 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 Rehab # 0055525 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 Rehab # 0055525 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
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number University Rehab # 0055525 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
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number University Rehab # 0055525 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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12										12
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	M&T Bank		X	Mortgage			\$		\$	9,661,472			\$	542,579		1			
2																2			
3																3			
4																4			
5																5			
	Working Capital																		
6	M&T Bank		X	Line of Credit						1,105,445					45,087		6		
7																7			
8																8			
9	TOTAL Facility Related						\$		\$	10,766,917			\$	587,666		9			
	B. Non-Facility Related*																		
10	Interest Income		X												(104)		10		
11	Alloc from Altitude Health Service														594		11		
12																	12		
13																	13		
14	TOTAL Non-Facility Related						\$		\$				\$	490		14			
15	TOTALS (line 9+line14)						\$		\$	10,766,917			\$	588,156		15			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 Rehab COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0055525

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. 92-21-16-200-023	Long Term Care Property	\$ 287,346.80	\$ 287,346.80
2. See Attached	Alloc from Care Centers Bldg	\$ 197,162.69	\$ 2,740.83
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 484,509.49	\$ 290,087.63

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to 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 NAME University Rehab COUNTY Champaign
FACILITY IDPH LICENSE NUMBER 0055525
CONTACT PERSON REGARDING THIS REPORT Steven 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: 135,500

B. General Construction Type: Exterior Brick Frame Wood

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2019	\$ 824,209	1
2	Allocated from Altitude Health Service-Care Centers Building			11,399	2
3	TOTALS			\$ 835,608	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	243		2019	2007	\$ 7,526,947	\$ 473,395	35	\$ 215,056	\$ (258,339)	\$ 430,112	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number University Rehab

0055525

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	
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)		108,639	3,599		3,599		58,331	68
69	Financial Statement Depreciation			18,182			(18,182)		69
70	TOTAL (lines 4 thru 69)		\$ 7,635,586	\$ 495,176		\$ 218,655	\$ (276,521)	\$ 488,443	70

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

Facility Name & ID Number University Rehab

0055525

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		\$ 7,635,586	\$ 495,176		\$ 218,655	\$ (276,521)	\$ 488,443	1
2	Part For Generator	2019	8,722		20	436	436	472	2
3	Landscaping Signs	2019	6,496		20	325	325	460	3
4	Replace Lettering On Brick Monument Sign	2019	5,695		20	285	285	309	4
5	Repair Sensors And Wiring On Both Chillers	2019	4,637		20	232	232	464	5
6	Security System Installation	2019	10,150		20	508	508	508	6
7	Replace Coil For A/C On Roof Above Kitchen	2020	8,300		20	415	415	415	7
8	Kitchen Fixture Relocated	2020	5,524		20	276	276	276	8
9	Ran Wire For New Piv Switch To Sprinkler System In Basement	2020	3,571		20	179	179	179	9
10	Replaced Split Condensing Unit On A/C	2020	8,950		20	448	448	448	10
11	Tile Floor Replaced-Kitchen	2020	4,895		20	245	245	245	11
12	Demo Damaged Drywall Ceiling, Patch, Tape, Paint - Kitchen	2020	5,700		20	285	285	285	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)		\$ 7,708,225	\$ 495,176		\$ 222,287	\$ (272,889)	\$ 492,502	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		\$ 7,708,225	\$ 495,176		\$ 222,287	\$ (272,889)	\$ 492,502	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,708,225	\$ 495,176		\$ 222,287	\$ (272,889)	\$ 492,502	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,708,225	\$ 495,176		\$ 222,287	\$ (272,889)	\$ 492,502	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)		\$ 7,708,225	\$ 495,176		\$ 222,287	\$ (272,889)	\$ 492,502	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		\$ 7,708,225	\$ 495,176		\$ 222,287	\$ (272,889)	\$ 492,502	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)		\$ 7,708,225	\$ 495,176		\$ 222,287	\$ (272,889)	\$ 492,502	34

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

Facility Name & ID Number University Rehab

0055525

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.

Facility Name & ID Number University Rehab

0055525

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Altitude Health Service-Care Centers Building	2002	15,708	403	39	403		7,367	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Altitude Health Service-Care Centers Building	2002	12,976		20			12,976	9
10	Allocated from Altitude Health Service-Care Centers Building	2003	15,292		20			15,292	10
11	Allocated from Altitude Health Service-Care Centers Building	2005	760		20			760	11
12	Allocated from Altitude Health Service-Care Centers Building	2009	137	7	20	7		82	12
13	Allocated from Altitude Health Service-Care Centers Building	2013	60,212	3,011	20	3,011		21,074	13
14	Allocated from Altitude Health Service-Care Centers Building	2015	216	11	20	11		140	14
15	Allocated from Altitude Health Service-Care Centers Building	2016	854	43	20	43		213	15
16	Allocated from Altitude Health Service-Care Centers Building	2017	1,481	74	20	74		296	16
17	Allocated from Altitude Health Service-Care Centers Building	2018	679	34	20	34		102	17
18	Allocated from Altitude Health Service-Care Centers Building	2019	256	13	20	13		26	18
19	Allocated from Altitude Health Service-Care Centers Building	2020	68	3	20	3		3	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)		\$ 108,639	\$ 3,599		\$ 3,599	\$	\$ 58,331	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		\$ 108,639	\$ 3,599		\$ 3,599	\$	\$ 58,331	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
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 108,639	\$ 3,599		\$ 3,599	\$	\$ 58,331	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,460,802	\$ 3,535	\$ 146,081	\$ 142,546	10	\$ 308,085	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	4,350				10	4,350	73
74								74
75	TOTALS	\$ 1,465,152	\$ 3,535	\$ 146,081	\$ 142,546		\$ 312,435	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		2016 FORD STARCRAFT	2019	\$ 48,832	\$	\$ 9,766	\$ 9,766	5	\$ 17,091	76
77										77
78										78
79										79
80	TOTALS			\$ 48,832	\$	\$ 9,766	\$ 9,766		\$ 17,091	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,057,817	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 498,711	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 378,134	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (120,577)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 822,028	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								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?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$14,442
- 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	Alloc from Altitude Health Service		\$	\$873	17
18					18
19					19
20					20
21	TOTAL		\$	\$873	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	\$		\$ 172,499	\$		\$ 172,499	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			66,124			66,124	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			177,344			177,344	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				207,194		207,194	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					1,154	69,229		70,383	13
14	TOTAL			\$		\$ 417,121	\$ 276,423		\$ 693,544	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	\$ 107,740	\$ 113,051	1
2	Cash-Patient Deposits	1,425	1,425	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,518,179	1,518,179	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	252,198	252,198	6
7	Other Prepaid Expenses	69,567	69,567	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	98,416	196,370	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,047,525	\$ 2,150,790	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		824,209	13
14	Buildings, at Historical Cost		7,526,947	14
15	Leasehold Improvements, at Historical Cost	43,431	43,431	15
16	Equipment, at Historical Cost	98,375	1,500,354	16
17	Accumulated Depreciation (book methods)	(26,320)	(846,719)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		1,598,332	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 115,486	\$ 10,646,554	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,163,011	\$ 12,797,344	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,610,159	\$ 2,314,192	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,105,445	1,105,445	29
30	Accrued Salaries Payable	381,091	381,091	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,250	9,250	31
32	Accrued Real Estate Taxes(Sch.IX-B)		295,967	32
33	Accrued Interest Payable		151,503	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,938,384	2,938,384	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,044,329	\$ 7,195,832	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,661,472	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	2,889,193	3,489,193	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,889,193	\$ 13,150,665	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,933,522	\$ 20,346,497	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,770,511)	\$ (7,549,153)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,163,011	\$ 12,797,344	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,285,763)	1
2	Restatements (describe):		2
3	Depreciation	(8)	3
4	Rounding	(5)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,285,776)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(4,484,735)	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)	\$ (4,484,735)	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)	\$ (7,770,511)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number University Rehab

0055525

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	\$ 9,904,369	1
2	Discounts and Allowances for all Levels	(1,740,903)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,163,466	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,615,798	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,615,798	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	223,557	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,424	19
20	Radiology and X-Ray	7,718	20
21	Other Medical Services	54,113	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 290,812	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	104	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 104	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	421,919	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 421,919	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,492,099	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,736,915	31
32	Health Care	6,322,477	32
33	General Administration	3,503,649	33
	B. Capital Expense		
34	Ownership	1,160,726	34
	C. Ancillary Expense		
35	Special Cost Centers	829,694	35
36	Provider Participation Fee	423,373	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,976,834	40
41	Income before Income Taxes (line 30 minus line 40)**	(4,484,735)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (4,484,735)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,738,245	44
45	Private Pay - Net Inpatient Revenue	1,677,822	45
46	Medicare - Net Inpatient Revenue	283,014	46
47	Other-(specify) Hospice	429,325	47
48	Other-(specify) Insurance	35,060	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,163,466	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,145	2,343	\$ 107,802	\$ 46.01	1
2	Assistant Director of Nursing	1,026	1,113	43,147	38.77	2
3	Registered Nurses	24,075	26,836	950,990	35.44	3
4	Licensed Practical Nurses	42,341	47,035	1,355,268	28.81	4
5	CNAs & Orderlies	98,881	109,687	1,801,592	16.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	666	713	26,628	37.35	8
9	Activity Director	4,022	4,861	100,983	20.77	9
10	Activity Assistants	5,732	6,184	63,088	10.20	10
11	Social Service Workers	10,432	11,891	297,461	25.02	11
12	Dietician					12
13	Food Service Supervisor	6,207	7,008	161,670	23.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,758	11,842	162,565	13.73	15
16	Dishwashers	30,876	33,818	347,266	10.27	16
17	Maintenance Workers	12,629	13,878	284,230	20.48	17
18	Housekeepers	31,421	36,518	435,787	11.93	18
19	Laundry	4,673	5,502	63,773	11.59	19
20	Administrator	2,384	2,522	123,482	48.96	20
21	Assistant Administrator	104	204	6,671	32.70	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,448	18,756	308,323	16.44	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	3,787	4,264	68,573	16.08	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	4,703	5,526	87,319	15.80	33
34	TOTAL (lines 1 - 33)	313,310	350,501	\$ 6,796,618 *	\$ 19.39	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	6	\$ 460	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	1,296	10-03	38
39	Pharmacist Consultant	176	17,513	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	87	8,461	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,239	11-03	44
45	Social Service Consultant	19	1,239	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	307	\$ 30,208		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,167	\$ 110,549	10-03	50
51	Licensed Practical Nurses	2,459	110,854	10-03	51
52	Certified Nurse Assistants/Aides	21,815	656,477	10-03	52
53	TOTAL (lines 50 - 52)	26,441	\$ 877,880		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Dawn Job	Administrator	0	\$ 67,225
Araceli Henson	Administrator	0	44,483
Robin Lemasters	Administrator	0	11,774
Robin Lemasters	Asst. Administrator	0	6,671
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 130,153
B. Administrative - Other			
Description			Amount
		\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Marcum LLP	Accounting	\$	26,877
Ability Network, Inc.	Eligibility Software		450
Beyond Trust Company	Cyber Security		1,083
Comodo Security Solutions	Cyber Security		1,567
CTS Complete Technology	Technology Solutions		303
Matrixcare	Data Processing		51,938
National Datacare Corp.	Resident Trust Fund Services		919
Propay HR	Payroll Processing		38,041
Team TSI Corporation	Data Analytics		5,940
See Attached	Legal		11,139
See Supplemental Schedule			585,300
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 723,557
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance	\$		196,642
Unemployment Compensation Insurance			73,674
FICA Taxes			519,941
Employee Health Insurance			818,946
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Physicals			1,944
Other Employee Welfare			252
Employee Enrichment			5,927
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,617,326
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee	\$		
Advertising: Employee Recruitment			539
Health Care Worker Background Check (Indicate # of checks performed 174)			1,736
Patient Background Checks			
Dues & Subscriptions			1,784
Licenses & Fees			4,261
Allocated from Altitude Health Service			642
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 8,962
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel	\$		
In-State Travel			
Seminar Expense			2,074
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 2,074

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number University Rehab	STATE OF ILLINOIS # 0055525	Report Period Beginning: 01/01/20	Ending: 12/31/20	Page 22
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

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

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

(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? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 93,148 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 423,373
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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