

		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>0056259</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>University Rehab Northmoor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>2/1/2020</u> to <u>12/31/2020</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>1500 W Northmoor Rd</u> <u>Peoria</u> <u>61614</u>																									
Number City Zip Code																									
County: <u>Peoria</u>																									
Telephone Number: <u>(309) 691-2200</u> Fax # <u>(309) 691-1548</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) <u>David Trimble</u></td></tr><tr><td>(Title) <u>Vice President, Reimbursement</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>David Trimble</u>	(Title) <u>Vice President, Reimbursement</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
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Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>2/1/2020</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>David Trimble</u> Telephone Number: <u>(813) 675-2318</u>																									
Email Address: _____																									

Facility Name & ID Number University Rehab Northmoor

0056259 Report Period Beginning: 2/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

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>120</u>	Skilled (SNF)	<u>120</u>	<u>40,200</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>120</u>	TOTALS	<u>120</u>	<u>40,200</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>17,173</u>	<u>1,675</u>	<u>3,387</u>	<u>22,235</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,173</u>	<u>1,675</u>	<u>3,387</u>	<u>22,235</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.31%

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

N/A (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)

N/A

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 2/1/2020

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

YES ☒ Date 2/1/2020 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 120 and days of care provided 1,595

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number University Rehab Northmoor # 0056259 Report Period Beginning: 2/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	92,269	9,485	182,473	284,227		284,227	3,232	287,459			1
2	Food Purchase		163,860		163,860		163,860		163,860			2
3	Housekeeping		112	188,823	188,935		188,935		188,935			3
4	Laundry		5,967	85,346	91,313		91,313		91,313			4
5	Heat and Other Utilities			127,140	127,140		127,140	(7,422)	119,718			5
6	Maintenance	39,153	18,841	151,688	209,682		209,682	5,211	214,893			6
7	Other (specify):*											7
8	TOTAL General Services	131,422	198,265	735,470	1,065,157		1,065,157	1,021	1,066,178			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	1,936,532	648,927	361,613	2,947,072		2,947,072	89,582	3,036,654			10
10a	Therapy			308,094	308,094		308,094	(237,670)	70,424			10a
11	Activities	95,796	1,760	2,470	100,026		100,026		100,026			11
12	Social Services	44,311		2,420	46,731		46,731		46,731			12
13	CNA Training											13
14	Program Transportation			5,705	5,705		5,705		5,705			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,076,639	650,687	696,802	3,424,128		3,424,128	(148,088)	3,276,040			16
	C. General Administration											
17	Administrative	95,064		282,878	377,942		377,942	105,993	483,935			17
18	Directors Fees											18
19	Professional Services			14,712	14,712		14,712		14,712			19
20	Dues, Fees, Subscriptions & Promotions			11,161	11,161		11,161	(953)	10,208			20
21	Clerical & General Office Expenses	169,047	27,152	218,730	414,929		414,929	(78,666)	336,263			21
22	Employee Benefits & Payroll Taxes			316,464	316,464		316,464		316,464			22
23	Inservice Training & Education			1,032	1,032		1,032		1,032			23
24	Travel and Seminar			20,316	20,316		20,316		20,316			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			137,297	137,297		137,297		137,297			26
27	Other (specify):*											27
28	TOTAL General Administration	264,111	27,152	1,002,590	1,293,853		1,293,853	26,374	1,320,227			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,472,172	876,104	2,434,862	5,783,138		5,783,138	(120,693)	5,662,445			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			3,803	3,803		3,803	76,346	80,149			30
31	Amortization of Pre-Op. & Org.			226	226		226	(226)				31
32	Interest			118,483	118,483		118,483	188,436	306,919			32
33	Real Estate Taxes			102,549	102,549		102,549	(1,479)	101,070			33
34	Rent-Facility & Grounds			205,212	205,212		205,212	(192,460)	12,752			34
35	Rent-Equipment & Vehicles			148,047	148,047		148,047		148,047			35
36	Other (specify):*											36
37	TOTAL Ownership			578,320	578,320		578,320	70,617	648,937			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,023	8,226	91,249		91,249	239,959	331,208			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,998	181,998		181,998		181,998			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		83,023	190,224	273,247		273,247	239,959	513,206			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,472,172	959,127	3,203,406	6,634,705		6,634,705	189,883	6,824,588			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	(7,422)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,148)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(488)	21		18
19	Entertainment				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	(102,968)	21		24
25	Fund Raising, Advertising and Promotional	(953)	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	(2,827)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (115,806)		\$	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)	305,689		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 305,689		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 189,883		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Rev Vending	\$ (1,122)	1	1
2	Amortization of Operating Rights	(226)	31	2
3	Real Estate Tax to Actual	(1,479)	33	3
4	Medicare Therapy Costs	239,959	39	4
5	Medicare Therapy Costs	(239,959)	10a	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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32				32
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,827)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number University Rehab Northmoor# 0056259

Report Period Beginning:

2/1/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,122)	4,354	0	0	0	0	0	0	0	0	0	3,232	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(7,422)	0	0	0	0	0	0	0	0	0	0	(7,422)	5
6	Maintenance	0	5,211	0	0	0	0	0	0	0	0	0	5,211	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,544)	9,565	0	0	0	0	0	0	0	0	0	1,021	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	89,582	0	0	0	0	0	0	0	0	0	89,582	10
10a	Therapy	(239,959)	2,289	0	0	0	0	0	0	0	0	0	(237,670)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(239,959)	91,871	0	0	0	0	0	0	0	0	0	(148,088)	16
	C. General Administration													
17	Administrative	0	105,993	0	0	0	0	0	0	0	0	0	105,993	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(953)	0	0	0	0	0	0	0	0	0	0	(953)	20
21	Clerical & General Office Expenses	(103,456)	24,790	0	0	0	0	0	0	0	0	0	(78,666)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(104,409)	130,783	0	0	0	0	0	0	0	0	0	26,374	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(352,912)	232,219	0	0	0	0	0	0	0	0	0	(120,693)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number University Rehab Northmoor # 0056259 Report Period Beginning: 2/1/2020 Ending: 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	76,346	0	0	0	0	0	0	0	0	0	76,346	30
31	Amortization of Pre-Op. & Org.	(226)	0	0	0	0	0	0	0	0	0	0	(226)	31
32	Interest	(1,148)	189,584	0	0	0	0	0	0	0	0	0	188,436	32
33	Real Estate Taxes	(1,479)	0	0	0	0	0	0	0	0	0	0	(1,479)	33
34	Rent-Facility & Grounds	0	(192,460)	0	0	0	0	0	0	0	0	0	(192,460)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,853)	73,470	0	0	0	0	0	0	0	0	0	70,617	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	239,959	0	0	0	0	0	0	0	0	0	0	239,959	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	239,959	0	0	0	0	0	0	0	0	0	0	239,959	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(115,806)	305,689	0	0	0	0	0	0	0	0	0	189,883	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
NH Operator Holdings VII LLC	100	Edwardsville NH LLC	Edwardsville,IL	Wood River NH LLC	Wood River, IL	Supportive Living Facility
1500 West Northmoor Road LLC	0	Rockford NH LLC	Rockford,IL	Springs of Lady Lake	Lady Lake,FL	Assisted Living Facility
Greystone Healthcare Management Corp	0	Moline NH LLC	Moline,IL	Greystone Home Health	Orlando, FL	Home Health
		St. Charles NH LLC	St. Charles,IL	Greystone Home Health	Sun City Center, FL	Home Health
		Elgin NH LLC	Elgin,IL	Greystone Home Health	Clearwater, FL	Home Health
		Inverness NH LLC	Inverness,IL	Greystone Home Health	The Villages, FL	Home Health
		See PG6-Supp	See PG6-Supp	See PG6-Supp	See PG6-Supp	See PG6-Supp

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	17	Home Office Cost - Admin	\$ 248,008	Greystone Healthcare Management Corp.	0.00%	\$ 315,255	\$ 67,247	1
2	V	10	Home Office Cost - Nursing		Greystone Healthcare Management Corp.	0.00%	86,160	86,160	2
3	V	1	Home Office Cost - Dietary		Greystone Healthcare Management Corp.	0.00%	3,793	3,793	3
4	V	10a	Home Office Cost - Ancillary		Greystone Healthcare Management Corp.	0.00%	2,289	2,289	4
5	V	34	Home Office Cost - Property		Greystone Healthcare Management Corp.	0.00%	12,752	12,752	5
6	V	34	Rent	205,212	1500 West Northmoor Road LLC	0.00%		(205,212)	6
7	V	32	Interest		1500 West Northmoor Road LLC	0.00%	189,584	189,584	7
8	V	30	Depreciation/Amortization		1500 West Northmoor Road LLC	0.00%	76,346	76,346	8
9	V	17	Other Administrative		1500 West Northmoor Road LLC	0.00%	38,746	38,746	9
10	V	1	Expense Equip - Dietary		1500 West Northmoor Road LLC	0.00%	561	561	10
11	V	6	Expense Equip - Maintenance		1500 West Northmoor Road LLC	0.00%	5,211	5,211	11
12	V	10	Expense Equip - Nursing		1500 West Northmoor Road LLC	0.00%	3,422	3,422	12
13	V	21	Expense Equip - Admin		1500 West Northmoor Road LLC	0.00%	24,790	24,790	13
14	Total			\$ 453,220			\$ 758,909	\$ * 305,689	14

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

Facility Name & ID Number

University Rehab Northmoor

0056259

Report Period Beginning:

2/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Northbrook NH LLC	Northbrook,IL	Greystone Home Health	Daytona Beach, FL	Home Health	1
2			Joliet NH LLC	Joliet,IL	Solana Home Health A	Sarasota, FL	Home Health	2
3			East Peoria NH LLC	East Peoria,IL				3
4			Alton NH LLC	Alton,IL				4
5			St. Louis NH LLC	St. Louis,MO				5
6			Alhambra NH, L.L.C.	Saint Petersburg,FL				6
7			Greenbrook NH, L.L.C.	Saint Petersburg,FL				7
8			LP Orlando LLC	Apopka,FL				8
9			Carlton Shores NH LLC	Daytona Beach,FL				9
10			Greenbriar NH, L.L.C.	Bradeenton,FL				10
11			Isle Health NH LLC	Orange Park,FL				11
12			La Mer LLC	Miami,FL				12
13			Lady Lake NH, L.L.C.	Lady Lake,FL				13
14			Lehigh Acres NH LLC	Lehigh Acres,FL				14
15			Colonial Care NH, L.L.C.	Saint Petersburg,FL				15
16			Heritage NH, L.L.C.	North Miami Beach,FL				16
17			North Rehab NH, L.L.C.	Saint Petersburg,FL				17
18			The Oaks NH, L.L.C.	Gainesville,FL				18
19			Ridgecrest NH, L.L.C.	Deland,FL				19
20			Riverwood Health NH LLC	Starke,FL				20
21			Rockledge NH, L.L.C.	Rockledge,FL				21
22			Venice NH, L.L.C.	Venice,FL				22
23			Terrace Health NH LLC	Gainesville,FL				23
24			Mulberry Grove NH LLC	The Villages,FL				24
25			Gardens Health NH LLC	Daytona Beach,FL				25
26			Citrus Hills NH LLC	Hernando,FL				26
27			Innovative Medical Management Solutions LLC	Clermont,FL				27
28			New Horizon NH, L.L.C.	Ocala,FL				28
29			Ponce NH LLC	St. Augustine,FL				29
30			See PG6-Supp (2)	See PG6-Supp (2)				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			Jackson Heights NH, L.L.C.	Miami,FL				1
2			Viera NH LLC	Viera,FL				2
3			Villa Health NH LLC	Deland,FL				3
4			Village Place NH LLC	Port Charlotte,FL				4
5			Palm Court NH, L.L.C.	Wilton Manors,FL				5
6			Woodland Grove NH LLC	Jacksonville,FL				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

Facility Name & ID Number University Rehab Northmoor # 0056259 Report Period Beginning: 2/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number University Rehab Northmoor # 0056259 Report Period Beginning: 2/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Greystone Healthcare Management Corp
Street Address 4042 Park Oaks Blvd., Suite 300
City / State / Zip Code Tampa, FL 33610
Phone Number (813)675-2318
Fax Number (813) 635-0008

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Clinical Nursing	Accumulated Costs	462,711,567	43	\$ 6,254,384	\$	6,374,289	\$ 86,160	1
2	1	Dietary	Accumulated Costs	465,656,695	44	277,112		6,374,289	3,793	2
3	10a	Ancillary	Accumulated Costs	460,282,346	42	165,316		6,374,289	2,289	3
4	34	Property	Accumulated Costs	481,058,730	50	962,398		6,374,289	12,752	4
5	17	Admin	Accumulated Costs	481,058,730	50	23,791,846		6,374,289	315,255	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					\$ 31,451,056	\$		\$ 420,249	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	Mizuho Capital Markets LLC		X	Mortgage		2/1/2020	\$ 2,948,628	\$ 2,948,628	2/1/2045	0.0700	\$ 189,584	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Mizuho Capital Markets LLC		X	Line of Credit		2/1/2020	1,827,008	1,827,008	2/1/2025	0.0700	118,483	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,775,637	\$ 4,775,637			\$ 308,067	9	
	B. Non-Facility Related*												
10	Interest Income/Misc Rev Interest		X								(1,148)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,148)	14	
15	TOTALS (line 9+line14)						\$ 4,775,637	\$ 4,775,637			\$ 306,919	15	

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

[illegible]

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME University Rehab Northmoor COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0056259

CONTACT PERSON REGARDING THIS REPORT David Trimble

TELEPHONE (813) 675 - 2318 FAX #: (813) 635 - 0008

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 14-17-326-009	Long Term Care Property	\$ 107,403.48	\$ 107,403.48
2. 14-17-326-010	Long Term Care Property	\$ 1,939.64	\$ 1,939.64
3. 14-17-376-001	Long Term Care Property	\$ 915.54	\$ 915.54
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 110,258.66	\$ 110,258.66

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

38,500

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).

N/A

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:

N/A

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

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

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	Nursing Facility Land	320,166	2020	\$ 382,327	1
2	Nursing Facility	38,500	2020		2
3	TOTALS	358,666		\$ 382,327	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	120		2020	1989	\$ 2,538,758	\$ 59,672	39	\$ 59,672	\$	\$ 59,672
5										
6										
7										
8										
	Improvement Type**									
9	15 BTUs		2020		30,578	364	7	364		364
10	1 Control Board Kit, 1 Compressor		2020		3,787	541	7	541		541
11	CAT 6 Installation		2020		7,494	375	15	375		375
12	Cable Drops for Main Server		2020		6,856	342	15	342		342
13	3 Heat Pumps		2020		12,465	208	15	208		208
14	Parking Lot Lamps		2020		3,744	62	5	62		62
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	104,582	14,782	14,782		5-7	14,782	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 104,582	\$ 14,782	\$ 14,782	\$		\$ 14,782	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		2019 T150 XL Wagon	2020	\$ 57,044	\$ 3,803	\$ 3,803	\$	5	\$ 3,803	76
77										77
78										78
79										79
80	TOTALS			\$ 57,044	\$ 3,803	\$ 3,803	\$		\$ 3,803	80

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	3,147,635
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	80,149
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	80,149
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	80,149

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

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$ 51,434
93		
94		
95		\$ 51,434

* 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: _____
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: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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)	\$			

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 109,285	\$		\$ 109,285	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			17,335			17,335	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			113,339			113,339	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				83,023		83,023	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Lab/X-Ray</u>	39-3				8,226			8,226	12
13	Other (specify): _____									13
14	TOTAL			\$		\$ 248,185	\$ 83,023		\$ 331,208	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	\$ 30,681	\$ 38,541	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 99,199)	1,094,947	1,094,947	3
4	Supply Inventory (priced at cost)	9,863	9,863	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,495	21,495	6
7	Other Prepaid Expenses	7,384	7,384	7
8	Accounts Receivable (owners or related parties)	149,098	180,924	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,313,468	\$ 1,353,154	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		382,327	13
14	Buildings, at Historical Cost		2,538,758	14
15	Leasehold Improvements, at Historical Cost		57,392	15
16	Equipment, at Historical Cost	57,044	203,141	16
17	Accumulated Depreciation (book methods)	(3,803)	(84,032)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	15,680	36,237	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(226)	(3,990)	20
21	Restricted Funds		455,464	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP		51,434	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 68,695	\$ 3,636,731	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,382,163	\$ 4,989,885	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 427,342	\$ 464,877	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,108	10,108	29
30	Accrued Salaries Payable	93,200	93,200	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,182	4,393	31
32	Accrued Real Estate Taxes(Sch.IX-B)	102,277	102,277	32
33	Accrued Interest Payable		17,323	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	49,452	61,002	36
37	Accounts Payable - Related Parties	869,453	1,019,488	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,556,014	\$ 1,772,668	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	44,208	44,208	39
40	Mortgage Payable			40
41	Bonds Payable		2,948,628	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 44,208	\$ 2,992,836	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,600,222	\$ 4,765,504	46
47	TOTAL EQUITY(page 18, line 24)	\$ (218,059)	\$ 224,381	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,382,163	\$ 4,989,885	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(864,747)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,161,517	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,514,829)	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)	\$ (218,059)	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)	\$ (218,059)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number University Rehab Northmoor

0056259

Report Period Beginning: 2/1/2020

Ending: 12/31/2020

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,385,770	1
2	Discounts and Allowances for all Levels	(520,685)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,865,085	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	922,810	6
7	Oxygen	17,463	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 940,273	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	809,346	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,122	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	136,462	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,834	19
20	Radiology and X-Ray	1,688	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 963,452	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,148	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,148	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,769,958	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,065,157	31
32	Health Care	3,424,128	32
33	General Administration	1,293,853	33
	B. Capital Expense		
34	Ownership	578,320	34
	C. Ancillary Expense		
35	Special Cost Centers	91,249	35
36	Provider Participation Fee	181,998	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,634,705	40
41	Income before Income Taxes (line 30 minus line 40)**	(864,747)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (864,747)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,834,037	44
45	Private Pay - Net Inpatient Revenue	242,830	45
46	Medicare - Net Inpatient Revenue	252,930	46
47	Other-(specify) <u>HMO/Ins</u>	129,888	47
48	Other-(specify) <u>Hospice</u>	405,400	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,865,085	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,522	1,587	\$ 84,956	\$ 53.53	1
2	Assistant Director of Nursing	1,314	1,359	51,879	38.17	2
3	Registered Nurses	8,931	9,355	319,254	34.13	3
4	Licensed Practical Nurses	20,613	21,839	683,531	31.30	4
5	CNAs & Orderlies	43,225	45,605	741,979	16.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,956	2,023	44,187	21.84	9
10	Activity Assistants	3,882	4,048	51,609	12.75	10
11	Social Service Workers	2,081	2,175	44,311	20.37	11
12	Dietician					12
13	Food Service Supervisor	1,302	1,367	26,744	19.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,185	5,438	65,525	12.05	15
16	Dishwashers					16
17	Maintenance Workers	1,793	1,853	39,153	21.13	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,493	1,757	95,064	54.11	20
21	Assistant Administrator					21
22	Other Administrative	4,174	4,364	93,078	21.33	22
23	Office Manager	1,826	1,867	40,230	21.55	23
24	Clerical	4,708	4,952	63,628	12.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,537	1,693	26,078	15.40	31
32	Other Health C: Central Supply	43	47	965	20.53	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,585	111,329	\$ 2,472,171 *	\$ 22.21	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		\$		35
36	Medical Director	88	16,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	98	17,732	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,420	11-3	44
45	Social Service Consultant	44	2,420	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	274	\$ 39,072		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	859	\$ 65,287	10-3	50
51	Licensed Practical Nurses	1,466	8,028	10-3	51
52	Certified Nurse Assistants/Aides	5,331	151,781	10-3	52
53	TOTAL (lines 50 - 52)	7,656	\$ 225,096		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? 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? 5.60
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,084 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. 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. \$ 181,998
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? No Indicate the amount. \$ 0
- (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% Line
d. Have vehicle usage logs been maintained? Yes
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? N/A
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? In Process
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (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.