		FOR BHF USE				

LL1

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.

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

I. IDPH License ID Number: 0039693

Facility Name: Abbington Rehab Nursing Ctr

Address: 31 West Central (Number) Roselle (City) 60172 (Zip Code)

County: Dupage

Telephone Number: (630)894-5058 **Fax #** (630)894-5070

HFS ID Number:

Date of Initial License for Current Owners: 07/01/1994

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[ ] VOLUNTARY,NON-PROFIT	[X] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code ____	[ ] Corporation	[ ] Other ____
	[X] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other ____	

In the event there are further questions about this report, please contact:
Name: Mendel Schneider   Telephone Number: (847)933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	See Accountants Report Attached
	(Firm Name & Address)	Mendel S Schneider C.P.A & Associates 4051 Old Orchard Rd, Skokie, Il 60076
	(Telephone)	(847)933-1274 Fax # (847)933-1283

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

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	22	Skilled (SNF)	22	8,052	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,960	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	30,012	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	2,055	1,028	784	3,867	8
9	SNF/PED					9
10	ICF	18,497			18,497	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,552	1,028	784	22,364	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.52%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 784

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number: Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	286,456	28,605	5,990	321,051		321,051	5,883	326,934			1
2	Food Purchase		155,231		155,231		155,231	(330)	154,901			2
3	Housekeeping	194,467	30,209	10,376	235,052		235,052		235,052			3
4	Laundry	30,141	3,309	35,525	68,975		68,975		68,975			4
5	Heat and Other Utilities			75,387	75,387		75,387	1,212	76,599			5
6	Maintenance	61,770		51,326	113,096		113,096	1,438	114,534			6
7	Other (specify):*											7
8	**TOTAL General Services**	572,834	217,354	178,604	968,792		968,792	8,203	976,995			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,753,683	189,606	8,131	1,951,420		1,951,420		1,951,420			10
10a	Therapy											10a
11	Activities	78,910	86	786	79,782		79,782		79,782			11
12	Social Services	73,828			73,828		73,828		73,828			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,906,421	189,692	14,917	2,111,030		2,111,030		2,111,030			16
	C. General Administration											
17	Administrative	106,179		253,194	359,373		359,373	(199,167)	160,206			17
18	Directors Fees											18
19	Professional Services			81,360	81,360		81,360	(52,345)	29,015			19
20	Dues, Fees, Subscriptions & Promotions			33,993	33,993		33,993	(6,960)	27,033			20
21	Clerical & General Office Expenses	115,000	33,669	102,012	250,681		250,681	111,792	362,473			21
22	Employee Benefits & Payroll Taxes			366,110	366,110		366,110		366,110			22
23	Inservice Training & Education											23
24	Travel and Seminar			190	190		190	97	287			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			129,471	129,471		129,471	2,725	132,196			26
27	Other (specify):* Allocated Benifets							53,156	53,156			27
28	**TOTAL General Administration**	221,179	33,669	966,330	1,221,178		1,221,178	(90,702)	1,130,476			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,700,434	440,715	1,159,851	4,301,000		4,301,000	(82,499)	4,218,501			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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			59,340	59,340		59,340	84,638	143,978			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,406	3,406		3,406	120,319	123,725			32
33	Real Estate Taxes			46,389	46,389		46,389	3,748	50,137			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(240,000)				34
35	Rent-Equipment & Vehicles							6,962	6,962			35
36	Other (specify):*							2,828	2,828			36
37	**TOTAL Ownership**			349,135	349,135		349,135	(21,505)	327,630			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,456	69,287	88,743		88,743		88,743			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,009	176,009		176,009		176,009			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		19,456	245,296	264,752		264,752		264,752			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,700,434	460,171	1,754,282	4,914,887		4,914,887	(104,004)	4,810,883			45

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

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	24,814	30		9
10	Interest and Other Investment Income	(7,901)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(330)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				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	(11,208)	21		24
25	Fund Raising, Advertising and Promotional	(6,960)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,618)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,203)		$	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)	(94,801)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (94,801)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (104,004)		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

Abbington Rehab Nursing Ctr

ID# 0039693

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	5,883	0	0	0	0	0	0	0	0	5,883	1
2	Food Purchase	(330)	0	0	0	0	0	0	0	0	0	0	(330)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,212	0	0	0	0	0	0	0	0	1,212	5
6	Maintenance	0	0	1,438	0	0	0	0	0	0	0	0	1,438	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(330)	0	8,533	0	0	0	0	0	0	0	0	8,203	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(199,167)	0	0	0	0	0	0	0	0	(199,167)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(53,097)	752	0	0	0	0	0	0	0	(52,345)	19
20	Fees, Subscriptions & Promotions	(6,960)	0	0	0	0	0	0	0	0	0	0	(6,960)	20
21	Clerical & General Office Expenses	(18,826)	4,120	126,369	129	0	0	0	0	0	0	0	111,792	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	97	0	0	0	0	0	0	0	0	97	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	1,972	753	0	0	0	0	0	0	0	2,725	26
27	Other (specify):*	0	0	53,156	0	0	0	0	0	0	0	0	53,156	27
28	**TOTAL General Administration**	(25,786)	4,120	(70,670)	1,634	0	0	0	0	0	0	0	(90,702)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,116)	4,120	(62,137)	1,634	0	0	0	0	0	0	0	(82,499)	29

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	24,814	59,824	0	0	0	0	0	0	0	0	0	84,638	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,901)	128,152	0	68	0	0	0	0	0	0	0	120,319	32
33	Real Estate Taxes	0	0	0	3,748	0	0	0	0	0	0	0	3,748	33
34	Rent-Facility & Grounds	0	(240,000)	14,962	(14,962)	0	0	0	0	0	0	0	(240,000)	34
35	Rent-Equipment & Vehicles	0	0	6,962	0	0	0	0	0	0	0	0	6,962	35
36	Other (specify):*	0	2,828	0	0	0	0	0	0	0	0	0	2,828	36
37	**TOTAL Ownership**	16,913	(49,196)	21,924	(11,146)	0	0	0	0	0	0	0	(21,505)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(9,203)	(45,076)	(40,213)	(9,512)	0	0	0	0	0	0	0	(104,004)	45

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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. [X] YES [ ] NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 240,000	Abbington Health Care Associates, LLC	100.00%	$	$ (240,000)	1
2	V	32	Interest	100	Abbington Health Care Associates, LLC		128,252	128,152	2
3	V	30	Depreciation		Abbington Health Care Associates, LLC		59,824	59,824	3
4	V	36	Amortization		Abbington Health Care Associates, LLC		2,828	2,828	4
5	V	21	Replacement Tax		Abbington Health Care Associates, LLC		4,043	4,043	5
6	V	21	Office		Abbington Health Care Associates, LLC		77	77	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 240,100			$ 195,024	$ * (45,076)	14

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

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	STAYCARE MANAGEMENT	100.00%	$ 1,212	$ 1,212	15
16	V	6	Repairs & Maintenance		STAYCARE MANAGEMENT	100.00%	1,438	1,438	16
17	V	17	Admin Salary-H Wengrow		STAYCARE MANAGEMENT	100.00%	25,897	25,897	17
18	V	17	Admin Salary-J Webster		STAYCARE MANAGEMENT	100.00%	28,130	28,130	18
19	V	19	Professional Fees		STAYCARE MANAGEMENT	100.00%	368	368	19
20	V	21	Clerical Salaries		STAYCARE MANAGEMENT	100.00%	149,731	149,731	20
21	V	21	Office Supplies		STAYCARE MANAGEMENT	100.00%	9,439	9,439	21
22	V	26	Insurance		STAYCARE MANAGEMENT	100.00%	1,972	1,972	22
23	V	27	Health Insurance		STAYCARE MANAGEMENT	100.00%	32,286	32,286	23
24	V	1	Dietary Salary-S Webster		STAYCARE MANAGEMENT	100.00%	1,482	1,482	24
25	V	1	Dietary Salary-D Wengrow		STAYCARE MANAGEMENT	100.00%	4,401	4,401	25
26	V	24	Seminars		STAYCARE MANAGEMENT	100.00%	97	97	26
27	V	34	Rent		STAYCARE MANAGEMENT	100.00%	14,962	14,962	27
28	V	27	Payroll taxes		STAYCARE MANAGEMENT	100.00%	13,306	13,306	28
29	V	27	Employee Benifets		STAYCARE MANAGEMENT	100.00%	7,564	7,564	29
30	V	35	Equipment Rental -Auto		STAYCARE MANAGEMENT	100.00%	6,962	6,962	30
31	V								31
32	V	17	Management Fees	253,194	STAYCARE MANAGEMENT	100.00%		(253,194)	32
33	V	19	Administrative Consultant	53,465	STAYCARE MANAGEMENT	100.00%		(53,465)	33
34	V	21	Admissions Director	14,100	STAYCARE MANAGEMENT	100.00%		(14,100)	34
35	V	21	Reimbursement Consultant	18,701	STAYCARE MANAGEMENT	100.00%		(18,701)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 339,460			$ 299,247	$ * (40,213)	39

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

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	DOUBLE YOU REALTY	100.00%	$ 752	$ 752	15
16	V	26	Insurance		DOUBLE YOU REALTY	100.00%	753	753	16
17	V	30	Depreciation		DOUBLE YOU REALTY	100.00%	0		17
18	V	32	Interest Expense		DOUBLE YOU REALTY	100.00%	68	68	18
19	V	33	Real Estate Taxes		DOUBLE YOU REALTY	100.00%	3,748	3,748	19
20	V	21	Office Supplies		DOUBLE YOU REALTY	100.00%	129	129	20
21	V								21
22	V	34	Rent	14,962	DOUBLE YOU REALTY	100.00%		(14,962)	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			$ 14,962			$ 5,450	$ * (9,512)	39

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

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 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	Howard L. Wengrow	50	Arbour Health Care Center, LTD	Chicago	Abbington HC Associat	Lincolnwood	Building company	1
2	Jeffrey J. Webster	50	Atrium Health Care Center, LTD	Chicago	Double You realty	Lincolnwood	Building company	2
3			Hickory Nursing Pavilion, INC.	Hickory Hills	StayCare management	Lincolnwood	Management	3
4			Zikanim, INC D/B/A All American Nursing Home	Chicago				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

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 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	2	3	4	5	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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Jeffrey Webster	Owner	Administartive	50.00	150,648	8	20.00	Alloc Salary	$ 28,130	17-07	1
2	Howard Wengrow	Owner	Administartive	50.00	150,648	8	20.00	Alloc Salary	25,897	17-07	2
3	Sara Webster	Relative	Dietary		8,518	8	20.00	Alloc Salary	1,482	01-07	3
4	Deborah Wengrow	Relative	Dietary		25,599	8	20.00	Alloc Salary	4,401	01-07	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 59,910		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 Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 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 X NO

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

Name of Related Organization: STAYCARE MANAGEMENT
Street Address: 3737 W ARTHUR AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)679-2121
Fax Number: (847)679-2122

	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	5	Utilities	Number of Beds	559	5	$ 8,261	$	82	$ 1,212	1
2	6	Repairs & Maintenance	Number of Beds	559	5	9,800		82	1,438	2
3	17	Admin Salary-H Wengrow	Number of Beds	559	5	176,545	176,545	82	25,897	3
4	17	Admin Salary-J Webster	Number of Beds	559	5	191,761	191,761	82	28,130	4
5	19	Professional Fees	Number of Beds	559	5	2,509		82	368	5
6	21	Clerical Salaries	Number of Beds	559	5	1,020,725	1,020,725	82	149,731	6
7	21	Office Supplies	Number of Beds	559	5	64,344		82	9,439	7
8	26	Insurance	Number of Beds	559	5	13,444		82	1,972	8
9	27	Health Insurance	Number of Beds	559	5	220,093		82	32,286	9
10	1	Dietary Salary-S Webster	Number of Beds	559	5	10,104	10,104	82	1,482	10
11	1	Dietary Salary-D Wengrow	Number of Beds	559	5	30,000	30,000	82	4,401	11
12	24	Seminars	Number of Beds	559	5	660		82	97	12
13	34	Rent	Number of Beds	559	5	102,000		82	14,962	13
14	27	Payroll taxes	Number of Beds	559	5	90,708		82	13,306	14
15	27	Employee Benifets	Number of Beds	559	5	51,563		82	7,564	15
16	35	Equipment Rental -Auto	Number of Beds	559	5	47,460		82	6,962	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,039,977	$ 1,429,135		$ 299,247	25

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 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 [X] NO [ ]

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

Name of Related Organization: Double You Realty
Street Address: 3737 W Arthur
City / State / Zip Code: Lincolnwood, Il 60712
Phone Number: ((847)679-2121
Fax Number: ((847)679-2122

	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	19	Professional Fees	Number of Beds	559	5	$ 5,127	$	82	$ 752	1
2	26	Insurance	Number of Beds	559	5	5,130		82	753	2
3	30	Depreciation	Number of Beds	559	5			82		3
4	32	Interest Expense	Number of Beds	559	5	465		82	68	4
5	33	Real Estate Taxes	Number of Beds	559	5	25,547		82	3,748	5
6	21	Office Supplies	Number of Beds	559	5	881		82	129	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					$ 37,150	$		$ 5,450	25

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	FIFTH THIRD BANK		X	Mortgage			$	$ 3,097,470			$ 128,152	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIFTH THIRD BANK		X	Working Capital							3,406	6
7	Allocated from Double You Realty										68	7
8												8
9	TOTAL Facility Related						$	$ 3,097,470			$ 131,626	9
	B. Non-Facility Related*											
10	INTEREST INCOME										(7,901)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,901)	14
15	TOTALS (line 9+line14)						$	$ 3,097,470			$ 123,725	15

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

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	39,231	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	42,177	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,946	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	43,443	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	50,137	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2015	32,338	8
2016	35,634	9
2017	36,757	10
2018	38,089	11
2019	42,177	12

2020 ACCRUAL:42177 X 1.03

Allocated from Double You Realty 3748

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Abbington Rehab Nursing Ctr COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039693

CONTACT PERSON REGARDING THIS REPORT Mendel Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-03-303-029	LONG TERM CARE PROPERTY	$ 42,177.68	$ 42,177.68
2.	10-35-329-014-0000	Home Office Allocation	$ 25,547.37	$ 3,748.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 67,725.05	$ 45,925.68

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: 20,478 B. General Construction Type: Exterior Brick Frame ___ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 28,278
2. Number of Years Over Which it is Being Amortized: 10
3. Current Period Amortization: 2,828
4. Dates Incurred: 07/01/2016

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	41,400	1994	$ 100,000	1
2	Allocated from Double You Realty			5,950	2
3	TOTALS	41,400		$ 105,950	3

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	82		1994	1976	$ 2,393,000	$ 59,824	35	$ 59,824	$	$ 1,704,510	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	7,258		20			7,258	9
10	Various			1995	41,235		20			34,660	10
11	Various			1996	14,284		20			13,722	11
12	Various			1997	19,228		20			19,227	12
13	Various			1998	8,781		20			8,781	13
14	Various			1999	74,013		20	3,701	3,701	46,156	14
15	Various			2000	16,733		20	581	581	16,733	15
16	Various			2001	3,412		20	171	171	3,373	16
17	Various			2002	100,056		20			100,056	17
18	Various			2003	172,044		20	1,554	1,554	168,545	18
19	Various			2004	17,406		20	870	870	14,215	19
20	Various			2005	31,352		20			31,352	20
21	Various			2006	1,000		20			1,000	21
22	Various			2007	23,100		20			23,100	22
23	Various			2008	15,797		20			15,797	23
24	Various			2009	6,310		20	(359)	(359)	6,310	24
25	Various			2010	27,030		20	2,184	2,184	22,563	25
26	Various			2011	74,494		20	4,988	4,988	50,918	26
27	Various			2012	18,109		20	892	892	7,706	27
28	Various			2013	158,448		20	15,485	15,485	113,790	28
29	Various			2014	42,333		20	2,117	2,117	13,515	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 Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Related Party		$	$		$	$	$	37
38	Buildings:								38
39	Allocated from Double You Realty LLC	2003	56,870		35	1,458	1,458	26,188	39
40									40
41									41
42									42
43	Leasehold Improvements:								43
44	Allocated from Staycare management	2016	3,094		20	155	155	723	44
45	Allocated from Staycare management	2003	2,634		20	132	132	2,313	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									67
68									68
69	Finanical statement Depreciation			59,340			(59,340)		69
70	TOTAL (lines 4 thru 69)		$ 3,328,021	$ 119,164		$ 93,753	$ (25,411)	$ 2,452,511	70

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

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		$ 3,328,021	$ 119,164		$ 93,753	$ (25,411)	$ 2,452,511	1
2	Elevator Shunt Trip	2015	5,000		20	250	250	1,438	2
3	Load Center Circuit Breaker For Backup generator	2015	10,000		20	500	500	3,000	3
4	14 Square of Sidewalk with new concrete	2015	5,600		20	280	280	1,423	4
5	Replacement of front Concrete Ramp	2016	2,750		20	138	138	562	5
6	Electrical Feeder for 1st Floor Boiler Room	2017	15,000		20	750	750	2,875	6
7	New Trane HVAC Unit-Pump room	2017	14,000		20	700	700	2,392	7
8	Construction,Electrical,Flooring,Millwork,Plumbing, Wall Surfaces	2017	459,383		20	22,969	22,969	82,303	8
9	Installed ceiling Lighting in lobby	2017	36,075		20	1,804	1,804	6,464	9
10	Howard Bernath Heating-Water Heater	2018	10,693		20	535	535	1,382	10
11	Walk-In Freezer compressor	2018	4,688		20	234	234	605	11
12	Rising development-Roof work	2018	4,390		20	220	220	623	12
13	Rising development-Water Damage roof	2018	3,955		20	198	198	528	13
14	Re-Cover Awning	2018	5,990		20	300	300	625	14
15	Johnstone/Bernath-Pump Parts	2018	3,905		20	195	195	406	15
16	Water Heater in Kitchen	2019	9,339		20	467	467	700	16
17	4 Room A/c east Corridor	2019	5,494		20	275	275	412	17
18	Install new Laundry Water Heater	2020	6,493		20	325	325	325	18
19	install a 5 ton rooftop heating and a/c unit	2020	12,500		20	625	625	625	19
20	Install backup generator	2020	11,809		20	590	590	590	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)		$ 3,955,085	$ 119,164		$ 125,108	$ 5,944	$ 2,559,789	34

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

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 187,301	$	$ 18,730	$ 18,730	10	$ 120,474	71
72	Current Year Purchases	1,400		140	140	10	140	72
73	Fully Depreciated Assets	104,552					104,552	73
74								74
75	TOTALS	$ 293,253	$	$ 18,870	$ 18,870		$ 225,166	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		Allocated from staycare	2018	$ 4,027	$	$	$	5	$ 4,027	76
77										77
78										78
79										79
80	TOTALS			$ 4,027	$	$	$		$ 4,027	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)	$ 4,358,315	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 119,164	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,978	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 24,814	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,788,982	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.

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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	$

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	ALLOCATED FROM STAYCARE		$	$ 6,962	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,962	21

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

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

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   [X] 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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-03	hrs	$		$ 31,491	$		$ 31,491	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			218			218	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			37,578			37,578	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				19,456		19,456	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 69,287	$ 19,456		$ 88,743	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.

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,079,875	$ 1,284,193	1
2	Cash-Patient Deposits	54,997	54,997	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	152,157	152,157	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,538	38,538	6
7	Other Prepaid Expenses	3,957	3,957	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Insurance Escrow	78,422	78,422	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,407,946	$ 1,612,264	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		101,756	13
14	Buildings, at Historical Cost		2,333,258	14
15	Leasehold Improvements, at Historical Cost	1,225,116	1,225,116	15
16	Equipment, at Historical Cost	254,990	361,990	16
17	Accumulated Depreciation (book methods)	(864,048)	(2,539,043)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		28,278	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(12,726)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	120,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 736,058	$ 1,498,629	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,144,004	$ 3,110,893	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 175,328	$ 175,328	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,027	55,027	28
29	Short-Term Notes Payable	462,227	462,227	29
30	Accrued Salaries Payable	331,834	331,834	30
31	Accrued Taxes Payable (excluding real estate taxes)	822	822	31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,443	43,443	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Partnership	571,448		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,640,129	$ 1,068,681	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,097,470	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,097,470	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,640,129	$ 4,166,151	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 503,875	$ (1,055,258)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,144,004	$ 3,110,893	48

*(See instructions.)

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 474,756	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 474,756	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,119	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)**	$ 29,119	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)**	$ 503,875	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,316,894	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,316,894	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,901	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,901	26
	E. Other Revenue (specify):** **		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Government Stimulus Income	619,211	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 619,211	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,944,006	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	968,792	31
32	Health Care	2,111,030	32
33	General Administration	1,221,178	33
	B. Capital Expense		
34	Ownership	349,135	34
	C. Ancillary Expense		
35	Special Cost Centers	88,743	35
36	Provider Participation Fee	176,009	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,914,887	40
41	**Income before Income Taxes (line 30 minus line 40)****	29,119	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 29,119	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,491,022	44
45	Private Pay - Net Inpatient Revenue	299,840	45
46	Medicare - Net Inpatient Revenue	491,543	46
47	Other-(specify) Med B income	34,489	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,316,894	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No,Cash Basis 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.

Facility Name & ID Number Abbington Rehab Nursing Ctr # 0039693 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	2,038	2,246	$ 99,092	$ 44.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,712	15,805	561,251	35.51	3
4	Licensed Practical Nurses	9,230	10,603	329,628	31.09	4
5	CNAs & Orderlies	31,733	39,199	703,503	17.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,289	2,983	60,210	20.18	8
9	Activity Director	1,658	1,846	34,387	18.63	9
10	Activity Assistants	2,463	2,767	44,523	16.09	10
11	Social Service Workers	2,888	3,264	73,828	22.62	11
12	Dietician					12
13	Food Service Supervisor	1,781	1,917	45,436	23.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,377	11,742	241,019	20.53	15
16	Dishwashers					16
17	Maintenance Workers	2,001	2,468	61,770	25.03	17
18	Housekeepers	9,543	12,814	194,467	15.18	18
19	Laundry	1,633	2,181	30,141	13.82	19
20	Administrator	2,048	2,168	106,179	48.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,234	7,289	115,000	15.78	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	100,628	119,292	$ 2,700,434 *	$ 22.64	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	Monthly	$ 5,990	1-3	35
36	Medical Director	Monthly	6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,872	10-3	39
40	Physical Therapy Consultant	Monthly	1,184	10-3	40
41	Occupational Therapy Consultant	Monthly	1,043	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	32	10-3	43
44	Activity Consultant	15	786	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	16	$ 20,907		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janet Cantelo	Administrative		$ 106,179
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 106,179

B. Administrative - Other

Description	Amount
Staycare Management Fees	$ 253,194
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 253,194

C. Professional Services

Vendor/Payee	Type	Amount
Staycare Management	Other Professional Fees	$ 53,465
Mendel S Schneider	Accounting	12,000
Cukierski & Cochrane	Accounting	1,035
Ohagon Meyer	Legal	13,460
Prinz	Legal	1,000
Skidelsky& Associates	Legal	400
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 81,360

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,812
Unemployment Compensation Insurance	9,424
FICA Taxes	191,750
Employee Health Insurance	83,194
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	921
union pension	22,009
TOTAL (agree to Schedule V, line 22, col.8)	$ 366,110

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,126
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	3,831
Advertising	6,960
Health Care Council	14,596
Misc License	1,490
Less: Public Relations Expense	( )
Non-allowable advertising	(6,960)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,033

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Illinois Council	190
Allocated from staycare	97
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 287

**See instructions.

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? **Yes**
If YES, give association name and amount. **Health Care Council $14,596**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? ______

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,485** 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. ______

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **176,009**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: ______

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.