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: 0055434

Facility Name: Burbank Rehablitation Center

Address: 5400 West 87th St (Number) Burbank (City) 60459 (Zip Code)

County: Cook

Telephone Number: (708) 423-1200 **Fax #** (708) 423-8405

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2019

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/20 to 12/31/20 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)
* *Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	163	Skilled (SNF)	163	59,658	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	163	TOTALS	163	59,658	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,033	1,636	5,733	24,402	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,033	1,636	5,733	24,402	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.90%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 1/1/2019

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2019 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 163 and days of care provided 2,457

Medicare Intermediary Novitas Solutions Inc

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] 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 Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	277,997	28,894	16,544	323,435		323,435	432	323,867			1
2	Food Purchase		135,180		135,180		135,180	(33)	135,147			2
3	Housekeeping	145,656	29,884		175,540		175,540	790	176,330			3
4	Laundry	66,059	15,870	903	82,832		82,832		82,832			4
5	Heat and Other Utilities			172,068	172,068		172,068	(18,370)	153,698			5
6	Maintenance	119,606		251,644	371,250		371,250	(63,246)	308,004			6
7	Other (specify):*							2,153	2,153			7
8	TOTAL General Services	609,318	209,828	441,159	1,260,305		1,260,305	(78,274)	1,182,031			8
	B. Health Care and Programs											
9	Medical Director			42,700	42,700		42,700		42,700			9
10	Nursing and Medical Records	2,405,487	501,281	730,053	3,636,821		3,636,821	17,823	3,654,644			10
10a	Therapy	10,177		32,486	42,663		42,663	(30)	42,633			10a
11	Activities	75,304	7,807	297	83,408		83,408		83,408			11
12	Social Services	167,618			167,618		167,618	9,224	176,842			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,282	4,282			15
16	TOTAL Health Care and Programs	2,658,586	509,088	805,536	3,973,210		3,973,210	31,299	4,004,509			16
	C. General Administration											
17	Administrative	143,149			143,149		143,149	68,729	211,878			17
18	Directors Fees											18
19	Professional Services			614,910	614,910	(659)	614,251	(433,998)	180,254			19
20	Dues, Fees, Subscriptions & Promotions			47,047	47,047		47,047	(1,551)	45,496			20
21	Clerical & General Office Expenses	165,503	12,097	222,416	400,016		400,016	(82,870)	317,146			21
22	Employee Benefits & Payroll Taxes			638,197	638,197		638,197	(13,621)	624,576			22
23	Inservice Training & Education											23
24	Travel and Seminar			349	349		349	443	792			24
25	Other Admin. Staff Transportation			56	56		56	400	456			25
26	Insurance-Prop.Liab.Malpractice			565,042	565,042		565,042	1,095	566,137			26
27	Other (specify):*							27,632	27,632			27
28	TOTAL General Administration	308,652	12,097	2,088,017	2,408,766	(659)	2,408,107	(433,740)	1,974,367			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,576,556	731,013	3,334,712	7,642,281	(659)	7,641,622	(480,715)	7,160,907			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.

Facility Name & ID Number Burbank Rehablitation Center #0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			38,403	38,403		38,403	264,730	303,133			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,564	49,564		49,564	303,663	353,227			32
33	Real Estate Taxes			526,491	526,491	659	527,150	3,031	530,181			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			4,298	4,298		4,298	146	4,444			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,098,756	1,098,756	659	1,099,415	91,570	1,190,985			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	296,383	199,387	459,865	955,635		955,635	(12,908)	942,727			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			210,954	210,954		210,954		210,954			42
43	Other (specify):*			747	747		747	(747)				43
44	**TOTAL Special Cost Centers**	296,383	199,387	671,566	1,167,336		1,167,336	(13,655)	1,153,681			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,872,939	930,400	5,105,034	9,908,373		9,908,373	(402,800)	9,505,573			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 Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Reference	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	(19,226)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(88,650)	30		9
10	Interest and Other Investment Income	(438)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(91)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(325)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(181,250)	21		24
25	Fund Raising, Advertising and Promotional	(3,025)	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	(93,345)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (386,850)		$	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)	(15,949)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (15,949)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (402,799)		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

Burbank Rehablitation Center

ID# 0055434

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Expense	$ (747)	43	1
2	Theft Loss	(2,303)	21	2
3	Collection Expense	(550)	21	3
4	Building Company - Accounting Fees	(9,500)	19	4
5	Building Company - Misc Admin Expense	(75)	21	5
6	Building Company - Amortization	(7,072)	36	6
7	Credit Card Processing	(1,105)	21	7
8	Capitalized R&M	(34,049)	06	8
9	Non-Allowable Legal	(10,200)	19	9
10	Out of Period Professional Fees	(25,215)	19	10
11	Rehab Income	(30)	10a	11
12	Duplicated Expense	(2,500)	21	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**	(93,345)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Burbank Rehabilitation Center

IDF 0055434

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 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			80	352								432	1
2	Food Purchase	(91)		58									(33)	2
3	Housekeeping			697	93								790	3
4	Laundry													4
5	Heat and Other Utilities	(19,226)		764	92								(18,370)	5
6	Maintenance	(34,049)		(29,289)	92								(63,246)	6
7	Other (specify):*			2,101	52								2,153	7
8	**TOTAL General Services**	(53,366)		(25,589)	681								(78,274)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				20,424	(2,601)							17,823	10
10a	Therapy	(30)											(30)	10a
11	Activities													11
12	Social Services				9,224								9,224	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				4,282								4,282	15
16	**TOTAL Health Care and Programs**	(30)			33,930	(2,601)							31,299	16
	C. General Administration													
17	Administrative			9,985	58,744								68,729	17
18	Directors Fees													18
19	Professional Services	(44,915)	9,500	(211,989)	(186,594)								(433,998)	19
20	Fees, Subscriptions & Promotions	(3,525)		1,300	674								(1,551)	20
21	Clerical & General Office Expenses	(188,108)	195	74,364	30,679								(82,870)	21
22	Employee Benefits & Payroll Taxes			(13,621)									(13,621)	22
23	Inservice Training & Education													23
24	Travel and Seminar			212	231								443	24
25	Other Admin. Staff Transportation			400									400	25
26	Insurance-Prop.Liab.Malpractice			857	238								1,095	26
27	Other (specify):*			14,696	12,936								27,632	27
28	**TOTAL General Administration**	(236,547)	9,695	(123,796)	(83,092)								(433,740)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(289,943)	9,695	(149,385)	(48,481)	(2,601)							(480,715)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burbank Rehablitation Center # 0055434 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(88,650)	351,951	1,344	85								264,730	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(438)	299,219	4,805	77								303,663	32
33	Real Estate Taxes			2,674	357								3,031	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			146									146	35
36	Other (specify):*	(7,072)	7,072											36
37	**TOTAL Ownership**	(96,160)	178,242	8,969	519								91,570	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(12,908)							(12,908)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(747)											(747)	43
44	**TOTAL Special Cost Centers**	(747)				(12,908)							(13,655)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(386,850)	187,937	(140,416)	(47,962)	(15,508)							(402,800)	45

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 480,000	Burbank Property LLC		$	$ (480,000)	1
2	V	33	Real Estate Tax	526,491	Burbank Property LLC		526,491		2
3	V	19	Accounting Fee		Burbank Property LLC		9,500	9,500	3
4	V	21	Misc Admin Expenses		Burbank Property LLC		75	75	4
5	V	21	Bank Charges		Burbank Property LLC		120	120	5
6	V	30	Depreciation		Burbank Property LLC		351,951	351,951	6
7	V	36	Amortization		Burbank Property LLC		7,072	7,072	7
8	V	32	Interest		Burbank Property LLC		299,219	299,219	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,006,491			$ 1,194,428	$ * 187,937	14

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Atied Associates, LLC	50.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	BURBANK PROPERTY LLC	BURBANK	BUILDING COMPANY	1
2	William Rothner	50.00%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CONSULTIN	EVANSTON	MGMT/BOOKKEEPING	2
3			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			GRASMERE PLACE, LLC	CHICAGO	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL DYER	DYER, IN				8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				13
14			MCKINLEY HEALTH CARE CENTER	CANTON, OH				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC		$ 80	$ 80	15
16	V	02	Food		Extended Care Consulting, LLC		58	58	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		697	697	17
18	V	05	Utilities		Extended Care Consulting, LLC		764	764	18
19	V	06	Maintenance		Extended Care Consulting, LLC		1,521	1,521	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	215,098	Extended Care Consulting, LLC		3,109	(211,989)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		1,300	1,300	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		6,846	6,846	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		212	212	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		400	400	25
26	V	26	Insurance		Extended Care Consulting, LLC		857	857	26
27	V	30	Depreciation		Extended Care Consulting, LLC		1,344	1,344	27
28	V	32	Interest		Extended Care Consulting, LLC		4,805	4,805	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		2,674	2,674	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		146	146	30
31	V	06	Maintenance Salaries	42,329	Extended Care Consulting, LLC		11,519	(30,810)	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		2,101	2,101	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		9,985	9,985	33
34	V	21	Office and Clerical Salaries	3,076	Extended Care Consulting, LLC		70,594	67,518	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		14,696	14,696	35
36	V	22	Employee Benefits	13,621	Extended Care Consulting, LLC			(13,621)	36
37	V								37
38	V								38
39	Total			$ 274,124			$ 133,708	$ * (140,416)	39

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Salary	$	Extended Care Clinical, LLC		$ 352	$ 352	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		93	93	16
17	V	5	Utilities		Extended Care Clinical, LLC		92	92	17
18	V	6	Maintenance		Extended Care Clinical, LLC		92	92	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		52	52	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		19,909	19,909	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		515	515	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		9,224	9,224	22
23	V	15	Emp. Ben, - Direct Alloc.		Extended Care Clinical, LLC				23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		4,282	4,282	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		58,744	58,744	25
26	V	19	Professional Fees	187,410	Extended Care Clinical, LLC		816	(186,594)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC				27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		674	674	28
29	V	21	Office Salary		Extended Care Clinical, LLC		29,276	29,276	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		1,403	1,403	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		231	231	31
32	V	26	Insurance		Extended Care Clinical, LLC		238	238	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		12,936	12,936	33
34	V	30	Depreciation		Extended Care Clinical, LLC		85	85	34
35	V	32	Interest		Extended Care Clinical, LLC		77	77	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		357	357	36
37	V								37
38	V								38
39	Total			$ 187,410			$ 139,448	$ * (47,962)	39

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 27,826	MAC Rx, LLC		$ 25,225	$ (2,601)	15
16	V	39	Ancillary	138,114	MAC Rx, LLC		125,206	(12,908)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 165,940			$ 150,431	$ * (15,508)	39

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		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 Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary	Patient Days	1,219,947	38	$ 3,992	$	24,402	$ 80	1
2	02	Food	Patient Days	1,219,947	38	2,910		24,402	58	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856		24,402	697	3
4	05	Utilities	Patient Days	1,219,947	38	38,173		24,402	764	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040		24,402	1,521	5
6	17	Administrative	Patient Days	1,219,947	38			24,402		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408		24,402	3,109	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998		24,402	1,300	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251		24,402	6,846	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602		24,402	212	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988		24,402	400	11
12	26	Insurance	Patient Days	1,219,947	38	42,836		24,402	857	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209		24,402	1,344	13
14	32	Interest	Patient Days	1,219,947	38	240,208		24,402	4,805	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701		24,402	2,674	15
16	35	Rent - Equipment	Patient Days	1,219,947	38	7,304		24,402	146	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	575,856	24,402	11,519	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021		24,402	2,101	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	499,202	24,402	9,985	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	3,529,267	24,402	70,594	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685		24,402	14,696	21
22										22
23										23
24										24
25	TOTALS					$ 6,684,506	$ 4,604,325		$ 133,708	25

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Salary	Patient Days	603,308	20	$ 8,692	$ 8,692	24,402	$ 352	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		24,402	93	2
3	5	Utilities	Patient Days	603,308	20	2,264		24,402	92	3
4	6	Maintenance	Patient Days	603,308	20	2,283		24,402	92	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		24,402	52	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	24,402	19,909	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		24,402	515	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	24,402	9,224	8
9	15	Emp. Ben, - Direct Alloc.	Direct Allocation		4	44,957				9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		24,402	4,282	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	24,402	58,744	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		24,402	816	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220				13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		24,402	674	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	24,402	29,276	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		24,402	1,403	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		24,402	231	17
18	26	Insurance	Patient Days	603,308	20	5,874		24,402	238	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		24,402	12,936	19
20	30	Depreciation	Patient Days	603,308	20	2,099		24,402	85	20
21	32	Interest	Patient Days	603,308	20	1,914		24,402	77	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		24,402	357	22
23										23
24										24
25	TOTALS					$ 3,507,824	$ 2,905,144		$ 139,448	25

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	Nursing And Medical Records	Direct Allocation			$	$		$ 25,225	1
2	39	Ancillary	Direct Allocation						125,206	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 150,431	25

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank & Trust		X	Mortgage			$	$ 4,810,973			$ 250,269	1
2	Forest Park Loan Company		X	Note Payable				821,282			35,823	2
3	First Bank		X	Note Payable				372,540			13,127	3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				800,000			49,564	6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,804,795			$ 348,783	9
	B. Non-Facility Related*											
10	Interest Income		X								(438)	10
11	Alloc from Extended Care Consulting										4,805	11
12	Alloc from Extended Care Clinical										77	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,444	14
15	TOTALS (line 9+line14)						$	$ 6,804,795			$ 353,227	15

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 502,914	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.)		$ 505,180	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,266	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 527,256	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.)		$ 659	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.		$ 530,181	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	1,021,466	8
	2016	978,080	9
	2017	527,129	10
	2018	478,966	11
	2019	502,149	12

2020 Accrual = $502,149 x 1.05 = $527,256 (rounded)

Allocated from Extended Care Consulting $2674

Allocated from Extended Care Clinical $357

	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 Burbank Rehablitation Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055434

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

A. **Summary of Real Estate Tax Cost**

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-33-313-008-0000	Long Term Property Care	$ 62,864.72	$ 62,864.72
2.	19-33-313-010-0000	Long Term Property Care	$ 349,846.15	$ 349,846.15
3.	19-33-313-014-0000	Long Term Property Care	$ 5,113.85	$ 5,113.85
4.	19-33-313-017-0000	Long Term Property Care	$ 60,967.85	$ 60,967.85
5.	19-33-323-014-0000	Long Term Property Care	$ 6,620.48	$ 6,620.48
6.	19-33-323-015-0000	Long Term Property Care	$ 16,735.63	$ 16,735.63
7.	See Attached	Alloc from Extended Care Consulting	$ 197,162.69	$ 2,674.36
8.	See Attached	Alloc from Extended Care Clinical	$ 197,162.69	$ 357.33
9.			$	$
10.			$	$
		TOTALS	$ 896,474.06	$ 505,180.37

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burbank Rehablitation Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055434

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,476 B. General Construction Type: Exterior Brick Frame Wood 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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2019	$ 566,240	1
2	Allocated from Care Center Building			12,609	2
3	TOTALS			$ 578,849	3

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 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	163		2019	1977	$ 5,575,258	$ 351,951	35	$ 159,293	$ (192,658)	$ 318,586	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1920	5,833		20	292	292	292	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		62,714	973		973		44,253	68
69	Financial Statement Depreciation			38,403			(38,403)		69
70	TOTAL (lines 4 thru 69)		$ 5,643,805	$ 391,327		$ 160,557	$ (230,769)	$ 363,131	70

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,643,805	$ 391,327		$ 160,557	$ (230,769)	$ 363,131	1
2	Remote Boiler Shutdown	2019	3,000		20	150	150	288	2
3	Boiler Pump	2019	8,498		20	425	425	814	3
4	Dialysis Center-Demolition/Frame/Drywall/Panel/Paint/Plumbing/	2019	49,100		20	2,455	2,455	4,501	4
5	Interlock Boiler To Combustion Air Intake Fan	2019	4,219		20	211	211	387	5
6	Water Supply Piping	2019	7,450		20	373	373	559	6
7	Piping For Hvac	2019	19,750		20	988	988	1,482	7
8	Signage	2019	3,077		20	154	154	218	8
9	Plans For Diaylsis Room	2019	3,500		20	175	175	248	9
10	Roof Repairs	2019	25,300		20	1,265	1,265	1,581	10
11	Roof Repairs	2019	29,745		20	1,487	1,487	1,859	11
12	Plans For Diaylsis Room	2019	4,000		20	200	200	233	12
13	Exhaust Fan	2019	6,880		20	344	344	401	13
14	Hot Water Taco Pumps	2019	7,432		20	372	372	434	14
15	Trane Rooftop Unit	2019	15,770		20	789	789	920	15
16	Piping To Lochinvar Boiler	2019	3,049		20	152	152	177	16
17	Heating/Cooling Units Evaluation For Repairs	2019	4,328		20	216	216	432	17
18	Ventilator Control Valves	2020	16,909		20	845	845	845	18
19	Condenser, Evaporator & Lineset For Walk-In Cooler	2020	6,515		20	326	326	326	19
20	Repairs To Rooms 205-210 - Heating Repairs	2020	10,981		20	549	549	549	20
21	Repairs To Rooms 201-203 & 301-304 - Heating Repairs	2020	12,411		20	621	621	621	21
22	Repairs To Rooms 109, 204, 403 ,411 - Heating Repairs	2020	14,925		20	746	746	746	22
23	Canvas Canopry - Frame Repair	2020	8,693		20	435	435	435	23
24	Repairs To Resident Rooms - Heating Repairs	2020	18,638		20	932	932	932	24
25	2 Series V Circulating Pumps For Boiler	2020	15,595		20	780	780	780	25
26	Plumbing Repairs - Kitchen & Conference,Training,Janitor Rms	2020	40,500		20	2,025	2,025	2,025	26
27	Flashing Repairs To Cooler Wall In Kitchen	2020	7,838		20	392	392	392	27
28	Silicone Installation On Existing Roof	2020	25,500		20	1,275	1,275	1,275	28
29	Medical Air And Vacuum System Repairs	2020	4,955		20	248	248	248	29
30	Plumbing Repairs In Dialysis Room	2020	62,750		20	3,138	3,138	3,138	30
31	Deck - Shingle Tear-Off, Install New Shingles	2020	11,500		20	575	575	575	31
32	Automatic Door Installation	2020	6,462		20	323	323	323	32
33	New Blower Motor For Rehab Fan Coil Unit	2020	4,016		20	201	201	201	33
34	TOTAL (lines 1 thru 33)		$ 6,107,091	$ 391,327		$ 183,723	$ (207,604)	$ 391,074	34

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,107,091	$ 391,327		$ 183,723	$ (207,604)	$ 391,074	1
2	Backflow Preventer Assembly	2020	3,048		20	152	152	152	2
3	Install Sentronic Door Closer - Rms 502,506,508,511	2020	3,568		20	178	178	178	3
4	Hydronic System Repair - Rooftop Cooling Coils	2020	5,096		20	255	255	255	4
5	Boiler And Chiller Repairs - Wiring	2020	6,846		20	342	342	342	5
6	Installed Magnetic Door Lock In 400 Hallway At Back Door	2020	2,889		20	144	144	144	6
7	Sprinkler Repairs In South Basement	2020	2,754		20	138	138	138	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,131,291	$ 391,327		$ 184,933	$ (206,394)	$ 392,284	34

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,131,291	$ 391,327		$ 184,933	$ (206,394)	$ 392,284	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
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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)		$ 6,131,291	$ 391,327		$ 184,933	$ (206,394)	$ 392,284	34

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,131,291	$ 391,327		$ 184,933	$ (206,394)	$ 392,284	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,131,291	$ 391,327		$ 184,933	$ (206,394)	$ 392,284	34

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	15,328	393	35	393		7,189	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	4,801	106	35	106		1,436	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,048	53	35	53		961	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	12,662		20			12,662	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	14,921		20			14,921	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	741		20			741	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	134	7	20	7		80	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,284	64	20	64		449	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	211	11	20	11		136	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	833	42	20	42		208	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	1,445	72	20	72		289	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	662	33	20	33		99	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	250	12	20	12		25	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	67	3	20	3		3	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2002	1,692		20			1,692	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2003	1,994		20			1,994	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2005	99		20			99	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2009	18	1	20	1		11	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2014	166	8	20	8		58	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2015	28	1	20	1		18	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2016	111	6	20	6		28	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2017	193	10	20	10		39	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2018	88	4	20	4		13	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2019	33	2	20	2		3	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2020	9		20				29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 59,818	$ 828		$ 828	$	$ 43,156	34

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 59,818	$ 828		$ 828	$	$ 43,156	1
2									2
3									3
4									4
5	Leasehold Improvements:								5
6	Allocated from Extended Care Consulting	2007	92	5	20	5		64	6
7	Allocated from Extended Care Consulting	2009	55	3	20	3		33	7
8	Allocated from Extended Care Consulting	2010	540	27	20	27		297	8
9	Allocated from Extended Care Consulting	2011	194	10	20	10		97	9
10	Allocated from Extended Care Consulting	2012	64	3	20	3		29	10
11	Allocated from Extended Care Consulting	2014	887	44	20	44		311	11
12	Allocated from Extended Care Consulting	2016	1,064	53	20	53		266	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 62,714	$ 973		$ 973	$	$ 44,253	34

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,181,998	$ 456	$ 118,199	$ 117,744	10	$ 239,428	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	61,507				10	61,507	73
74								74
75	TOTALS	$ 1,243,506	$ 456	$ 118,199	$ 117,744		$ 300,935	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		Alloc. Extended Care Clinical	2012	$ 2,078	$	$	$	5	$ 2,078	76
77		Alloc. Extended Care Consulting	2014	509				5	509	77
78										78
79										79
80	TOTALS			$ 2,587	$	$	$		$ 2,587	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)	$ 7,956,233	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 391,783	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 303,132	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (88,650)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 695,807	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 Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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	$

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: $ 4,444 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.

Facility Name & ID Number Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	hrs	$ 919		$ 145,107	$		$ 146,026	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	404		100,407			100,811	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	1,019		202,988			204,007	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				161,610		161,610	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			294,041		11,363	37,777		343,181	13
14	TOTAL			$ 296,383		$ 459,865	$ 199,387		$ 955,635	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 Burbank Rehablitation Center # 0055434 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (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	$ 1,320,599	$ 1,336,289	1
2	Cash-Patient Deposits	21,208	21,208	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,912,487	2,912,487	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	117,299	117,299	6
7	Other Prepaid Expenses	13,683	13,683	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	773,714	706,759	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,158,990	$ 5,107,725	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		566,240	13
14	Buildings, at Historical Cost		5,359,432	14
15	Leasehold Improvements, at Historical Cost	454,943	670,769	15
16	Equipment, at Historical Cost	5,444	1,174,689	16
17	Accumulated Depreciation (book methods)	(48,164)	(1,810,942)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		15,324	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 412,223	$ 5,975,512	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,571,213	$ 11,083,237	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,705,534	$ 1,705,535	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,118	25,118	28
29	Short-Term Notes Payable	800,000	800,000	29
30	Accrued Salaries Payable	237,021	237,021	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,587	12,587	31
32	Accrued Real Estate Taxes(Sch.IX-B)	527,256	527,256	32
33	Accrued Interest Payable	3,272	116,908	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	882,795	882,795	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,193,583	$ 4,307,220	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,193,822	39
40	Mortgage Payable		4,810,973	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	2,628,095	5,695,402	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,628,095	$ 11,700,197	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,821,678	$ 16,007,417	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,250,465)	$ (4,924,180)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,571,213	$ 11,083,237	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (148,432)	1
2	Restatements (describe):		2
3	**Bad Debt**	(451,473)	3
4	**Rounding**	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (599,903)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(650,562)	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)**	$ (650,562)	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)**	$ (1,250,465)	24 *

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

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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	$ 7,758,366	1
2	Discounts and Allowances for all Levels	(137,392)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,620,974	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	107,775	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 107,775	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	13,632	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,508	19
20	Radiology and X-Ray	802	20
21	Other Medical Services	2,920	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 22,862	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	438	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 438	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,505,762	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,505,762	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,257,811	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,260,305	31
32	Health Care	3,973,210	32
33	General Administration	2,408,766	33
	B. Capital Expense		
34	Ownership	1,098,756	34
	C. Ancillary Expense		
35	Special Cost Centers	956,382	35
36	Provider Participation Fee	210,954	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,908,373	40
41	**Income before Income Taxes (line 30 minus line 40)****	(650,562)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (650,562)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,757,133	44
45	Private Pay - Net Inpatient Revenue	615,829	45
46	Medicare - Net Inpatient Revenue	1,668,501	46
47	Other-(specify) Hospice	256,370	47
48	Other-(specify) Insurance	1,323,141	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,620,974	49

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

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

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

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,095	$ 96,899	$ 46.25	1
2	Assistant Director of Nursing	825	850	32,715	38.49	2
3	Registered Nurses	10,441	11,760	407,981	34.69	3
4	Licensed Practical Nurses	27,520	31,434	1,000,505	31.83	4
5	CNAs & Orderlies	41,173	47,181	861,995	18.27	5
6	CNA Trainees					6
7	Licensed Therapist	9,188	10,122	296,383	29.28	7
8	Rehab/Therapy Aides	508	581	10,177	17.51	8
9	Activity Director	2,002	2,145	36,467	17.00	9
10	Activity Assistants	2,542	2,816	38,356	13.62	10
11	Social Service Workers	5,426	5,875	167,618	28.53	11
12	Dietician					12
13	Food Service Supervisor	709	800	16,791	20.98	13
14	Head Cook	4,709	5,290	88,998	16.82	14
15	Cook Helpers/Assistants	10,228	10,903	172,208	15.79	15
16	Dishwashers					16
17	Maintenance Workers	5,369	5,787	119,606	20.67	17
18	Housekeepers	9,381	10,037	145,656	14.51	18
19	Laundry	3,768	4,130	66,059	15.99	19
20	Administrator	2,429	2,565	143,149	55.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,389	1,475	31,171	21.13	23
24	Clerical	8,175	8,809	134,332	15.25	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) See Attached	220	291	5,873	20.18	33
34	TOTAL (lines 1 - 33)	147,905	164,947	$ 3,872,939 *	$ 23.48	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	352	$ 16,544	01-03	35
36	Medical Director	Monthly	42,700	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	202,537	10-03	38
39	Pharmacist Consultant	Monthly	6,195	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	325	32,486	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	297	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	ER Consultant	Monthly	5,100	10-03	47
48					48
49	TOTAL (lines 35 - 48)	683	$ 305,859		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	482	$ 66,411	10-03	50
51	Licensed Practical Nurses	2,246	184,687	10-03	51
52	Certified Nurse Assistants/Aides	5,201	265,123	10-03	52
53	TOTAL (lines 50 - 52)	7,929	$ 516,221		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yehuda Rosenblatt	Administrator	0	$ 6,145
Richard Rellora	Administrator	0	68,556
Mayer Cohen	Administrator	0	68,448
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 143,149

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Extended Care Clinical	Home Office Expense	$ 187,410
Extended Care Consulting	Home Office Expense	215,098
Extended Care Consulting	Accounting	270
Marcum LLP	Accounting	24,000
Plant Moran	Accounting	6,150
Personnel Planners, Inc.	Unemployment Consultant	2,400
Ability	Medicare Billing Services	1,030
ProPay	Payroll Processing	21,118
Extended Care Consulting	Computer Services	8,050
Altitude Health Services, Inc	Computer Services	273
See Attached	Legal	10,200
See Supplemental Schedule		138,911
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 614,910

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,808
Unemployment Compensation Insurance	68,359
FICA Taxes	296,280
Employee Health Insurance	153,852
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Welfare	6,178
Holiday Expense	2,099
TOTAL (agree to Schedule V, line 22, col.8)	$ 624,576

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,500
Advertising: Employee Recruitment	27,973
Health Care Worker Background Check	
(Indicate # of checks performed 270)	2,809
Patient Background Checks	
Dues & Subscriptions	6,288
Licenses & Fees	4,952
See Supplemental Schedule	1,974
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,496

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	349
See Supplemental Schedule	443
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 792

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

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

(3) Did the nursing home make political contributions or payments to a political 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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,714** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **210,954**
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. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

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

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

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

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