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: 0053843

Facility Name: Chalet Living Rehab

Address: 7350 N Sheridan Road (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 274-1000 Fax # (773) 274-2353

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2011

Type of Ownership:

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

PROPRIETARY: X

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) 04/30/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(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 Chalet Living Rehab # 0053843 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	219	Skilled (SNF)	219	80,154	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	219	TOTALS	219	80,154	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	61,888	879	3,059	65,826	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,888	879	3,059	65,826	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.12%

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 10/1/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 219 and days of care provided 2,392

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		10,065	1,240,900	1,250,965		1,250,965	4,134	1,255,099			1
2	Food Purchase		4,141		4,141		4,141	7,864	12,005			2
3	Housekeeping	211	15,969	452,315	468,495		468,495	2,681	471,176			3
4	Laundry	110,603	22,602		133,205		133,205	182	133,387			4
5	Heat and Other Utilities			262,635	262,635		262,635	(14,187)	248,448			5
6	Maintenance	207,826	31,784	184,412	424,022		424,022	15,366	439,388			6
7	Other (specify):*											7
8	**TOTAL General Services**	318,640	84,561	2,140,262	2,543,463		2,543,463	16,040	2,559,503			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	4,600,150	222,172	59,328	4,881,650		4,881,650	123,986	5,005,636			10
10a	Therapy	297,942			297,942		297,942		297,942			10a
11	Activities	179,778	4,596	2,517	186,891		186,891	11	186,902			11
12	Social Services	396,113			396,113		396,113	7,181	403,294			12
13	CNA Training											13
14	Program Transportation			4,392	4,392		4,392		4,392			14
15	Other (specify):*							7,448	7,448			15
16	**TOTAL Health Care and Programs**	5,473,983	226,768	85,737	5,786,488		5,786,488	138,625	5,925,113			16
	C. General Administration											
17	Administrative	180,822			180,822		180,822	79,931	260,753			17
18	Directors Fees											18
19	Professional Services			276,672	276,672	(479)	276,193	(4,110)	272,083			19
20	Dues, Fees, Subscriptions & Promotions			68,301	68,301		68,301	(33,532)	34,769			20
21	Clerical & General Office Expenses	205,340	1,842	402,664	609,846		609,846	75,623	685,469			21
22	Employee Benefits & Payroll Taxes			926,886	926,886		926,886		926,886			22
23	Inservice Training & Education											23
24	Travel and Seminar			193	193		193	178	371			24
25	Other Admin. Staff Transportation			532	532		532	5,975	6,507			25
26	Insurance-Prop.Liab.Malpractice			411,269	411,269		411,269	18,800	430,069			26
27	Other (specify):*							32,037	32,037			27
28	**TOTAL General Administration**	386,162	1,842	2,086,517	2,474,521	(479)	2,474,042	174,902	2,648,944			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,178,785	313,171	4,312,516	10,804,472	(479)	10,803,993	329,567	11,133,560			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 Chalet Living Rehab #0053843 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							900,039	900,039			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,593	34,593		34,593	980,978	1,015,571			32
33	Real Estate Taxes			50	50	479	529	337,811	338,340			33
34	Rent-Facility & Grounds			2,053,950	2,053,950		2,053,950	(2,053,825)	125			34
35	Rent-Equipment & Vehicles			6,282	6,282		6,282	5,805	12,087			35
36	Other (specify):*							158,987	158,987			36
37	TOTAL Ownership			2,094,875	2,094,875	479	2,095,354	329,793	2,425,147			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		252,095	565,425	817,520		817,520	(6,857)	810,663			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			486,524	486,524		486,524		486,524			42
43	Other (specify):*			674,575	674,575		674,575	(674,575)				43
44	TOTAL Special Cost Centers		252,095	1,726,524	1,978,619		1,978,619	(681,432)	1,297,187			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,178,785	565,266	8,133,915	14,877,966		14,877,966	(22,072)	14,855,894			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 Chalet Living Rehab # 0053843 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(15,585)	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	891,416	30		9
10	Interest and Other Investment Income	(22,461)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(773)	21		18
19	Entertainment	(5,322)	21		19
20	Contributions	(12,185)	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	(244,534)	21		24
25	Fund Raising, Advertising and Promotional	(6,950)	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	(774,107)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (190,501)		$	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)	168,430		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 168,430		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (22,071)		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

Chalet Living Rehab

ID# 0053843

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Rebates	$ (2,345)	10	1
2	Patient Personal Items	(8,638)	10	2
3	Bank Charges	(5,000)	21	3
4	Sequestration	(13,320)	21	4
5	Misc Income	(1,778)	21	5
6	Additional R&M	4,129	06	6
7	Capitalized R&M	(2,717)	06	7
8	Non Allowable Expense	(674,107)	43	8
9	Marketing License	(1,299)	20	9
10	PAC Dues	(17,060)	20	10
11	Promotional Expense	(468)	43	11
12	Non Allowable Legal	(25,295)	19	12
13	Bldg Co - Processing Fees	(1,500)	21	13
14	Bldg Co - Filing Fees	(75)	20	14
15	Bldg Co - Accounting Fees	(18,323)	19	15
16	Bldg Co - Amortization	(5,792)	36	16
17	Prior Period Dues	(519)	20	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**	(774,107)		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**

Chalet Living Rehab

ID# 0053843
Report Period Beginning: 01/01/20
Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		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	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chalet Living Rehab # 0053843 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			4,134									4,134	1
2	Food Purchase			7,864									7,864	2
3	Housekeeping			2,681									2,681	3
4	Laundry			182									182	4
5	Heat and Other Utilities	(15,585)				1,398							(14,187)	5
6	Maintenance	1,412		13,438		1,355		(838)					15,366	6
7	Other (specify):*													7
8	**TOTAL General Services**	(14,173)		28,298		2,753		(838)					16,040	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(10,983)		137,456					(2,487)				123,986	10
10a	Therapy													10a
11	Activities			11									11	11
12	Social Services			7,181									7,181	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				7,448								7,448	15
16	**TOTAL Health Care and Programs**	(10,983)		144,647	7,448				(2,487)				138,625	16
	C. General Administration													
17	Administrative			79,931									79,931	17
18	Directors Fees													18
19	Professional Services	(43,618)	18,323	26,241		588	(5,644)						(4,110)	19
20	Fees, Subscriptions & Promotions	(38,088)	75	4,480		1							(33,532)	20
21	Clerical & General Office Expenses	(272,227)	1,500	346,025		325							75,623	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			178									178	24
25	Other Admin. Staff Transportation			5,975									5,975	25
26	Insurance-Prop.Liab.Malpractice		18,291	158		351							18,800	26
27	Other (specify):*			32,037									32,037	27
28	**TOTAL General Administration**	(353,933)	38,189	495,026		1,265	(5,644)						174,902	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(379,089)	38,189	667,971	7,448	4,017	(5,644)	(838)	(2,487)				329,567	29

Facility Name & ID Number Chalet Living Rehab # 0053843 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	891,416				8,623							900,039	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(22,461)	998,593			4,846							980,978	32
33	Real Estate Taxes		333,408			4,403							337,811	33
34	Rent-Facility & Grounds		(2,053,950)	40,577		(40,452)							(2,053,825)	34
35	Rent-Equipment & Vehicles				5,805								5,805	35
36	Other (specify):*	(5,792)	164,779										158,987	36
37	**TOTAL Ownership**	863,163	(557,170)	40,577	5,805	(22,581)							329,793	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(6,857)			(6,857)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(674,575)											(674,575)	43
44	**TOTAL Special Cost Centers**	(674,575)								(6,857)			(681,432)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(190,501)	(518,981)	708,548	13,252	(18,564)	(5,644)	(838)	(2,487)	(6,857)			(22,072)	45

Facility Name & ID Number Chalet Living Rehab # 0053843 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	Rental Income	$ 2,053,950	Chalet Real Property, LLC		$	$ (2,053,950)	1
2	V	32	Interest	641	Chalet Real Property, LLC		999,234	998,593	2
3	V	33	Real Estate Taxes		Chalet Real Property, LLC		333,408	333,408	3
4	V	26	Property Insurance		Chalet Real Property, LLC		18,291	18,291	4
5	V	36	MIP Expense		Chalet Real Property, LLC		158,987	158,987	5
6	V	21	Processing Fees		Chalet Real Property, LLC		1,500	1,500	6
7	V	20	Filing Fees		Chalet Real Property, LLC		75	75	7
8	V	19	Accounting Fees		Chalet Real Property, LLC		18,323	18,323	8
9	V	36	Amortization		Chalet Real Property, LLC		5,792	5,792	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,054,591			$ 1,535,610	$ * (518,981)	14

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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	GPN Family Trust	50.00%	Astoria Place Skilled Nursing Facility LLC	Chicago	Chalet Real Property, LLC		Building Company	1
2	Doros Generation Trust	50.00%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Bethany Terrace	Morton Grove				27
28			Carlton Skilled Nursing Facility LLC	Chicago				28
29			Clark Skilled Nursing Facility	Chicago				29
30			Elmbrook Skilled Nursing Facility LLC	Elmhurst				30

Facility Name & ID Number Chalet Living Rehab # 0053843 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			Evanston Skilled Nursing Facility LLC	Evanston				1
2			Grove at the Lake Skilled Nursing Facility LLC	Zion				2
3			Grove of Berwyn	Berwyn				3
4			Grove of Fox Valley	Aurora				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				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 Chalet Living Rehab # 0053843 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	$	Legacy Healthcare Financial Services		$ 4,112	$ 4,112	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		22	22	16
17	V	02	Food		Legacy Healthcare Financial Services		7,864	7,864	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		2,681	2,681	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		182	182	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		12,685	12,685	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		753	753	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		104,991	104,991	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		9,909	9,909	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		22,556	22,556	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		7,152	7,152	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		11	11	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		28	28	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		79,931	79,931	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		26,241	26,241	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		4,480	4,480	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		322,507	322,507	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		23,518	23,518	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		178	178	33
34	V	25	Travel		Legacy Healthcare Financial Services		5,975	5,975	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		158	158	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		32,037	32,037	36
37	V	34	Rent		Legacy Healthcare Financial Services		40,452	40,452	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		125	125	38
39	Total			$			$ 708,548	$ * 708,548	39

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		540	$ 540	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		5,265	5,265	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		7,448	7,448	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			$			$ 13,252	$ * 13,252	39

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	CF St. Louis LLC		$ 1,398	$ 1,398	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,355	1,355	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		479	479	17
18	V	19	Accounting Fees		CF St. Louis LLC		109	109	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		325	325	20
21	V	26	Insurance		CF St. Louis LLC		351	351	21
22	V	30	Depreciation		CF St. Louis LLC		8,623	8,623	22
23	V	32	Interest Expense		CF St. Louis LLC		4,846	4,846	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		4,403	4,403	24
25	V								25
26	V	34	Rent	40,452	CF St. Louis LLC			(40,452)	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			$ 40,452			$ 21,888	$ * (18,564)	39

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 24,634	ProPay HR LLC		$ 18,990	$ (5,644)	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			$ 24,634			$ 18,990	$ * (5,644)	39

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 34,200	ML Group Design & Development		$ 33,362	$ (838)	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			$ 34,200			$ 33,362	$ * (838)	39

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 8,250	ReMED Services		$ 5,763	$ (2,487)	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			$ 8,250			$ 5,763	$ * (2,487)	39

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 16,847	Lifescan Labs of Illinois		$ 9,990	$ (6,857)	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			$ 16,847			$ 9,990	$ * (6,857)	39

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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 Chalet Living Rehab # 0053843 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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Chalet Living Rehab # 0053843 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]

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

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

	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 Chalet Living Rehab # 0053843 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

Name of Related Organization	Legacy Healthcare Financial Services
Street Address	3450 Oakton Street
City / State / Zip Code	Skokie, IL 60076
Phone Number	(847) 679-9797
Fax Number	(847) 683-2900

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

	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	Dietician Salary	Available Bed Days	2,540,133	53	$ 130,303	$ 130,303	80,154	$ 4,112	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		80,154	22	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		80,154	7,864	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		80,154	2,681	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		80,154	182	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	80,154	12,685	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		80,154	753	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	80,154	104,991	8
9	10	Nurse/Medical Director Consultan	Available Bed Days	2,540,133	53	314,035		80,154	9,909	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		80,154	22,556	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	80,154	7,152	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		80,154	11	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		80,154	28	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	80,154	79,931	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		80,154	26,241	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		80,154	4,480	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	80,154	322,507	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		80,154	23,518	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		80,154	178	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		80,154	5,975	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		80,154	158	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		80,154	32,037	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		80,154	40,452	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		80,154	125	24
25	TOTALS					$ 22,454,338	$ 16,839,706		$ 708,548	25

Facility Name & ID Number Chalet Living Rehab # 0053843 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: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	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	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		80,154	540	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		80,154	5,265	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		80,154	7,448	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					$ 419,973	$		$ 13,252	25

Facility Name & ID Number Chalet Living Rehab # 0053843 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 [ ]

Name of Related Organization: CF St. Louis LLC
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 676-5300
Fax Number: (847) 676-5348

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Bed Days	2,540,133	53	$ 44,301	$	80,154	$ 1,398	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		80,154	1,355	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		80,154	479	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		80,154	109	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		80,154	1	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		80,154	325	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		80,154	351	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		80,154	8,623	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		80,154	4,846	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		80,154	4,403	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					$ 693,655	$		$ 21,888	25

Facility Name & ID Number Chalet Living Rehab # 0053843 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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. Main St.
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905 3268
Fax Number: ( )

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 18,990	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					$	$		$ 18,990	25

Facility Name & ID Number Chalet Living Rehab # 0053843 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

Name of Related Organization: ML Group Design and Development
Street Address: 3424 Oakton St
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 676-5300
Fax Number: ( )

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

	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	6	Maintenance	Direct			$	$		$ 33,362	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					$	$		$ 33,362	25

Facility Name & ID Number Chalet Living Rehab # 0053843 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: ReMED Services LLC
Street Address: 3424 Oakton Street, Suite 102
City / State / Zip Code: Skokie, IL
Phone Number: (847) 440-2600
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	10	Medical Supplies	Direct			$	$		$ 5,763	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					$	$		$ 5,763	25

Facility Name & ID Number Chalet Living Rehab # 0053843 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: Lifescan Labs of Illinois, LLC
Street Address: 5255 Golf Road
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 663 - 8300
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	39	Laboratory	Direct			$	$		$ 9,990	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					$	$		$ 9,990	25

Facility Name & ID Number Chalet Living Rehab # 0053843 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 Chalet Living Rehab # 0053843 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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CIBC Bank		X	Mortgage Payable			$	$ 23,938,685			$ 999,234	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC Bank		X	Interest Only							34,593	6
7												7
8												8
9	TOTAL Facility Related						$	$ 23,938,685			$ 1,033,827	9
	B. Non-Facility Related*											
10	Interest Income		X								(22,461)	10
11	Interest Income - Bldg Co		X								(641)	11
12	Allocated from CF St. Louis	X									4,846	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (18,256)	14
15	TOTALS (line 9+line14)						$	$ 23,938,685			$ 1,015,571	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 158,987 Line # 36

* 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 Chalet Living Rehab # 0053843 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

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

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	342,883	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.)	$	334,351	2
3. Under or (over) accrual (line 2 minus line 1).	$	(8,532)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	346,393	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.)**	$	479	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.	$	338,340	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	220,514	8
	2016	248,596	9
	2017	267,190	10
	2018	324,350	11
	2019	329,948	12

2020 Allocation = $329,948 x 1.05 = $346,393
Allocated from CF St. Louis $4,403

FOR BHF USE ONLY

Line	Description		Line
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 Chalet Living Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053843

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.	11-29-314-026-0000	Long Term Care Facility	$ 8,316.78	$ 8,316.78
2.	11-29-314-027-0000	Long Term Care Facility	$ 7,071.12	$ 7,071.12
3.	11-29-314-028-0000	Long Term Care Facility	$ 157,443.18	$ 157,443.18
4.	11-29-314-029-0000	Long Term Care Facility	$ 157,116.74	$ 157,116.74
5.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 4,402.68
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 789,480.26	$ 334,350.50

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 Chalet Living Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053843

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 76,920 B. General Construction Type: Exterior Masonry Frame ____ Number of Stories 4

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2014	$ 1,752,000	1
2	Allocated from CF St. Louis, LLC			6,228	2
3	TOTALS			$ 1,758,228	3

Facility Name & ID Number Chalet Living Rehab # 0053843 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	219		2014	1979	$ 14,673,000	$	35	$ 419,229	$ 419,229	$ 2,715,461	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2012	858,803		20	42,940	42,940	257,647	9
10	Various			2013	957,090		20	47,855	47,855	287,129	10
11	Various			2014	91,923		20	4,596	4,596	32,177	11
12	Various			2015	83,350		20	4,167	4,167	25,006	12
13	Various			2016	83,642		20	4,182	4,182	24,354	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 Chalet Living Rehab # 0053843 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
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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)		293,094	7,949		13,936	5,987	62,346	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 17,040,902	$ 7,949		$ 536,905	$ 528,956	$ 3,404,119	70

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		$ 17,040,902	$ 7,949		$ 536,905	$ 528,956	$ 3,404,119	1
2	Remove Wall, Drop Ceiling Installment, Install Wallpaper/Vinyl T	2017	11,900		20	595	595	2,280	2
3	Wiring On Wander Guard Secuity System	2017	4,750		20	238	238	831	3
4	Fire Damper Inspection & Service	2017	6,883		20	344	344	1,204	4
5	Install New Fire Proof Insulation/Framing/Drywall & Paint	2017	2,884		20	144	144	480	5
6	Replace Defective Batery/Block Heater/Water-Pump/Breather Ho:	2017	5,795		20	290	290	2,318	6
7	Radiator/Alternator/Pulley	2017	4,486		20	224	224	1,047	7
8	Replacement Of South Exit Door	2017	3,240		20	162	162	432	8
9	Pump Repair	2017	3,933		20	197	197	425	9
10	Serving Shelf, Freezer	2017	3,571		20	179	179	477	10
11	Elevator Repairs	2017	6,641		20	332	332	1,660	11
12	Elevator Repairs	2017	39,537		20	1,977	1,977	9,226	12
13	Electrical Work	2017	7,925		20	396	396	1,585	13
14	Boiler - Replacement Of Flame Safety And Ignition Controls	2017	5,851		20	293	293	1,170	14
15	Repairs Of Mixing Valve And Gate Valve	2017	3,773		20	189	189	755	15
16	Install Three 4" Cast Iron P-Traps And Section Of Pipe - Reconne	2017	2,935		20	147	147	587	16
17	Hot Water Tank Replacement (11,070)	2018	10,246		20	512	512	1,537	17
18	Floor Tile In Basement & North Stairwell; Repair Dmgd Doors (4,	2018	3,934		20	197	197	590	18
19	Install New Wander Systems (23,197)	2018	21,471		20	1,074	1,074	3,221	19
20	Install Backflows For Water Lines (11,205)	2018	10,371		20	519	519	1,556	20
21	Install 3 Ton A/C Heating Unit On 3Rd Floor For Cable Room (6,	2018	5,949		20	297	297	892	21
22	Rm Reno-Electrical,Painting,Curtains,Convert From 2 To 3 Bed R	2019	13,261		20	663	663	1,461	22
23	Bathroom-Office Conversion-Electric, Flooring, Build Doorway ($	2019	14,537		20	727	727	1,852	23
24	Injection Pump - Replace Injectors And Fuel Injection Line ($8,41	2019	8,154		20	408	408	1,109	24
25	Kitchen - Grout Tiles ($2,950)	2019	2,859		20	143	143	389	25
26	Install Lock - Back Door, Install Door Bell Receptionist Area ($3,7	2019	3,621		20	181	181	430	26
27	Repair Cable Signal On 4 Floors - Coaxial Cable ($18,857)	2019	18,275		20	914	914	2,485	27
28	Install 3Kw Heater For Boiler Room ($3,700)	2019	3,586		20	179	179	518	28
29	Carpentry In Common Areas ($8,966)	2019	8,689		20	434	434	1,303	29
30	Boiler Repair - Canisters/Valve/Side Glass ($2,567)	2019	2,488		20	124	124	249	30
31	Installation Of New Mag Lock - Front Door (3,845)	2019	3,726		20	186	186	373	31
32	Generator-Wiring,Rebuild Injection Pump,Load Bank ($4,750)	2019	4,603		20	230	230	460	32
33	Plumbing-Valve,Repair Hot Water Storage Tanks ($6,550)	2019	6,348		20	317	317	635	33
34	TOTAL (lines 1 thru 33)		$ 17,297,123	$ 7,949		$ 549,716	$ 541,767	$ 3,447,656	34

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		$ 17,297,123	$ 7,949		$ 549,716	$ 541,767	$ 3,447,656	1
2	Paint 4 Rooms & Electrical (4,193)	2020	4,091		20	205	205	205	2
3	Installed Concrete For Generators First Floor/Lobby, Wiring 2-4T	2020	234,120		20	11,706	11,706	11,706	3
4	Install 3-Way Mixing Valve For A/C (3,950)	2020	3,853		20	193	193	193	4
5	Repair Elevator 3 - New Car Sill/Fascia/Clutch (4,096)	2020	3,996		20	200	200	200	5
6	Install 4 120V Receptacles On Bldg Exterior (2,717)	2020	2,650		20	133	133	133	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)		$ 17,545,833	$ 7,949		$ 562,152	$ 554,202	$ 3,460,092	34

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		$ 17,545,833	$ 7,949		$ 562,152	$ 554,202	$ 3,460,092	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)		$ 17,545,833	$ 7,949		$ 562,152	$ 554,202	$ 3,460,092	34

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		$ 17,545,833	$ 7,949		$ 562,152	$ 554,202	$ 3,460,092	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
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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)		$ 17,545,833	$ 7,949		$ 562,152	$ 554,202	$ 3,460,092	34

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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 Chalet Living Rehab # 0053843 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
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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 Chalet Living Rehab # 0053843 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 CF St. Louis, LLC	2016	33,533	1,557	35	958	(599)	4,790	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	208,191	5,136	20	10,410	5,274	52,048	9
10	Allocated from CF St. Louis, LLC	2017	4,832	119	20	242	122	966	10
11	Allocated from CF St. Louis, LLC	2019	43,798	1,080	20	2,190	1,109	4,380	11
12	Allocated from CF St. Louis, LLC	2019	2,304	57	20	115	58	115	12
13									13
14	Allocated from Legacy HC	2018	249		20	12	12	37	14
15	Allocated from Legacy HC	2020	188		20	9	9	9	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)		$ 293,094	$ 7,949		$ 13,936	$ 5,987	$ 62,346	34

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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		$ 293,094	$ 7,949		$ 13,936	$ 5,987	$ 62,346	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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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 293,094	$ 7,949		$ 13,936	$ 5,987	$ 62,346	34

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

Facility Name & ID Number Chalet Living Rehab # 0053843 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	$ 3,360,045	$ 671	$ 336,004	$ 335,333	10	$ 2,145,836	71
72	Current Year Purchases	18,823	2	1,882	1,880	10	1,882	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 3,378,867	$ 673	$ 337,887	$ 337,213		$ 2,147,719	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 22,682,928	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,623	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 900,038	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 891,416	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,607,810	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	Architect Fees	$ 2,500	92
93			93
94			94
95		$ 2,500	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: Chalet Living Rehab # 0053843 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	Allocated from Legacy Healthcare				125			5
6								6
7	TOTAL				$ 125 **			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: $ 6,822 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	Allocated from Legacy Healthcare		$	$ 5,265	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,265	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.

STATE OF ILLINOIS

Facility Name & ID Number Chalet Living Rehab # 0053843 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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 201,772	$		$ 201,772	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			92,925			92,925	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			208,577			208,577	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				103,903		103,903	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					62,151	148,192		210,343	13
14	TOTAL			$		$ 565,425	$ 252,095		$ 817,520	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: Chalet Living Rehab # 0053843 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	$ 227,791	$ 1,179,021	1
2	Cash-Patient Deposits	10,762	10,762	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,687,237	7,687,237	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,633	5,633	6
7	Other Prepaid Expenses	609,287	659,747	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	146,609	163,675	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,687,319	$ 9,706,075	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,752,000	13
14	Buildings, at Historical Cost		11,891,700	14
15	Leasehold Improvements, at Historical Cost	249,087	2,156,903	15
16	Equipment, at Historical Cost	477,743	1,561,616	16
17	Accumulated Depreciation (book methods)	(148,028)	(5,045,472)	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	3,575,845	6,663,093	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,154,647	$ 18,979,840	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,841,966	$ 28,685,915	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 858,229	$ 862,273	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,702	147,702	30
31	Accrued Taxes Payable (excluding real estate taxes)	274,767	274,767	31
32	Accrued Real Estate Taxes(Sch.IX-B)		346,393	32
33	Accrued Interest Payable	51,517	131,313	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	8,985,727	8,985,727	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,317,942	$ 10,748,175	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		23,938,685	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,661,581	(116,199)	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,661,581	$ 23,822,486	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,979,523	$ 34,570,661	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 862,443	$ (5,884,746)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,841,966	$ 28,685,915	48

*(See instructions.)

Facility Name & ID Number Chalet Living Rehab # 0053843 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,039,105	1
2	Restatements (describe):		2
3	Bad Debt	491,639	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,530,744	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	166,373	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	(834,674)	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)**	$ (668,301)	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)**	$ 862,443	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	$ 21,457,664	1
2	Discounts and Allowances for all Levels	(9,871,750)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,585,914	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,759,844	6
7	Oxygen	394	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,760,238	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	100,342	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,305	19
20	Radiology and X-Ray		20
21	Other Medical Services	11,015	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 137,662	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22,461	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,461	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	1,538,064	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,538,064	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,044,339	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,543,463	31
32	Health Care	5,786,488	32
33	General Administration	2,474,521	33
	B. Capital Expense		
34	Ownership	2,094,875	34
	C. Ancillary Expense		
35	Special Cost Centers	1,492,095	35
36	Provider Participation Fee	486,524	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,877,966	40
41	**Income before Income Taxes (line 30 minus line 40)****	166,373	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 166,373	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,804,178	44
45	Private Pay - Net Inpatient Revenue	128,971	45
46	Medicare - Net Inpatient Revenue	539,230	46
47	Other-(specify) Insurance	113,535	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,585,914	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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,960	2,120	$ 135,938	$ 64.12	1
2	Assistant Director of Nursing	1,912	2,176	102,095	46.92	2
3	Registered Nurses	13,830	16,394	617,387	37.66	3
4	Licensed Practical Nurses	45,273	58,170	2,053,793	35.31	4
5	CNAs & Orderlies	64,312	83,808	1,516,685	18.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,231	12,857	297,942	23.17	8
9	Activity Director	3,755	4,122	66,353	16.10	9
10	Activity Assistants	7,425	7,959	113,425	14.25	10
11	Social Service Workers	12,994	14,183	290,288	20.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	9,565	10,728	207,826	19.37	17
18	Housekeepers	16	16	211	13.19	18
19	Laundry	6,398	7,335	110,603	15.08	19
20	Administrator	1,592	1,897	114,248	60.24	20
21	Assistant Administrator	2,012	2,144	66,574	31.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,080	11,649	205,340	17.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,864	4,312	127,408	29.55	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	9,710	10,719	152,669	14.24	33
34	TOTAL (lines 1 - 33)	204,929	250,588	$ 6,178,785 *	$ 24.66	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,240,900	01-03	35
36	Medical Director	Monthly	19,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	50,737	10-03	38
39	Pharmacist Consultant	Monthly	7,091	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,517	11-03	44
45	Social Service Consultant				45
46	Other(specify) Psychiatry	30	1,500	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	30	$ 1,322,245		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie Daugherty	Administrator	0	$ 114,248
Anthony Vicere	Asst. Admin.	0	66,574
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 180,822

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 22,000
ProPay HR	Payroll Services	24,634
Onyx Procurement Solutions	Procurement Services	14,970
Achieve Accreditation LLC	Accreditation	8,458
Compliagent	Compliance Services	3,666
Cortex Health	E.H.R. Software	6,675
Elaton Energy Services	Energy Procurement	500
Language Line Services	Interpretation Services	935
MTS Consulting	Tax Consulting	1,452
Personnel Planners	Unemployment Consulting	1,614
See Attached	Legal	183,360
See Supplemental Schedule		8,408
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 276,672

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,287
Unemployment Compensation Insurance	17,471
FICA Taxes	472,677
Employee Health Insurance	226,284
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	29,859
Employee Benefits	30,611
401K Expense	26,296
Voluntary Benefits Contributions	8,346
Employee Physical Exams	8,055
TOTAL (agree to Schedule V, line 22, col.8)	$ 926,886

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	$ 1,990
Advertising: Employee Recruitment	468
Health Care Worker Background Check	
(Indicate # of checks performed 232)	2,320
Patient Background Checks 84	840
Dues & Subscriptions	23,855
Licenses & Fees	815
See Supplemental Schedule	4,481
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,769

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	193
See Supplemental Schedule	178
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 371

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $34,120**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **41,033** 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. $ **486,524**
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? **No** Indicate the amount. $ **N/A**

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