FOR BHF USE

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0052217

Facility Name: Champaign Urbana Nrsg Rehab

Address: 302 Burwash Avenue (Number) Savoy (City) 61874 (Zip Code)

County: Champaign

Telephone Number: (217) 402-9700 **Fax #** (217) 402-9750

HFS ID Number:

Date of Initial License for Current Owners: 41275

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	213	Skilled (SNF)	213	77,958	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	213	TOTALS	213	77,958	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			8,286	8,286	8
9	SNF/PED					9
10	ICF	23,563	5,154		28,717	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,563	5,154	8,286	37,003	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.47%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 1/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 213 and days of care provided 5,732

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	370,460	71,584	11,779	453,823		453,823		453,823			1
2	Food Purchase		230,007		230,007		230,007	(199)	229,808			2
3	Housekeeping	131,139	64,889	50,890	246,918		246,918		246,918			3
4	Laundry	53,011	6,927		59,938		59,938		59,938			4
5	Heat and Other Utilities			251,546	251,546		251,546	1,115	252,661			5
6	Maintenance	120,569		126,470	247,039		247,039	6,902	253,941			6
7	Other (specify):* Waste Removal			38,965	38,965		38,965		38,965			7
8	TOTAL General Services	675,179	373,407	479,650	1,528,236		1,528,236	7,818	1,536,054			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	3,056,214	335,178	313,104	3,704,496		3,704,496	69,832	3,774,328			10
10a	Therapy	46,935		49,500	96,435		96,435	(37,922)	58,513			10a
11	Activities	108,220		11,589	119,809		119,809		119,809			11
12	Social Services	129,059		5,308	134,367		134,367		134,367			12
13	CNA Training											13
14	Program Transportation			21,946	21,946		21,946		21,946			14
15	Other (specify):* Mgmt Co Benefits Alloc							14,548	14,548			15
16	TOTAL Health Care and Programs	3,340,428	335,178	431,447	4,107,053		4,107,053	46,458	4,153,511			16
	C. General Administration											
17	Administrative	128,675			128,675		128,675	75,807	204,482			17
18	Directors Fees											18
19	Professional Services			422,229	422,229		422,229	13,885	436,114			19
20	Dues, Fees, Subscriptions & Promotions			36,960	36,960		36,960	13,393	50,353			20
21	Clerical & General Office Expenses	386,087	43,253	65,602	494,942		494,942	162,671	657,613			21
22	Employee Benefits & Payroll Taxes			642,654	642,654		642,654		642,654			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,426	6,426		6,426	240	6,666			24
25	Other Admin. Staff Transportation			28,227	28,227		28,227	2,087	30,314			25
26	Insurance-Prop.Liab.Malpractice			(15,896)	(15,896)		(15,896)	3,539	(12,357)			26
27	Other (specify):* Mgmt Co Benefits Alloc							45,744	45,744			27
28	TOTAL General Administration	514,762	43,253	1,186,202	1,744,217		1,744,217	317,366	2,061,583			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,530,369	751,838	2,097,299	7,379,506		7,379,506	371,642	7,751,148			29

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

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 Champaign Urbana Nrsg Rehab #0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			126,096	126,096		126,096	361,541	487,637			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,146	75,146		75,146	835,201	910,347			32
33	Real Estate Taxes			90,000	90,000		90,000		90,000			33
34	Rent-Facility & Grounds			1,400,000	1,400,000		1,400,000	(1,379,277)	20,723			34
35	Rent-Equipment & Vehicles			104,988	104,988		104,988	2,129	107,117			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,796,230	1,796,230		1,796,230	(180,406)	1,615,824			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		301,089	1,128,124	1,429,213		1,429,213	(229,580)	1,199,633			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			350,884	350,884		350,884		350,884			42
43	Other (specify):* **Disallowed Costs**	255,678	10,005	265,050	530,733		530,733	(530,733)				43
44	**TOTAL Special Cost Centers**	255,678	311,094	1,744,058	2,310,830		2,310,830	(760,313)	1,550,517			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,786,047	1,062,932	5,637,587	11,486,566		11,486,566	(569,077)	10,917,489			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(39,436)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(298,565)	30		9
10	Interest and Other Investment Income	(1,613)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(18,897)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,381)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(198,875)	43		24
25	Fund Raising, Advertising and Promotional	(25,839)	43		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 See Page 5A	(242,077)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (836,683)		$	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)	267,606		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 267,606		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (569,077)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Champaign Urbana Nrsg Rehab

ID# 0052217

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Comissions	$ (199)	2	1
2	Marketing Salary	(255,678)	43	2
3	Disallow Collections Expenses	(1,712)	19	3
4	Expense Repairs under $2,500	6,899	6	4
5	Expense Clerical Supplies that were Capitalized	8,952	21	5
6	Disallow Marketing Travel Exp	(339)	25	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(242,077)		49

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1 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	19	Professional Fees		Champaign Urbana Realty	100.00%	$ 6,239	$ 6,239	1
2	V	30	Depreciation		Champaign Urbana Realty	100.00%	659,846	659,846	2
3	V	32	Interest		Champaign Urbana Realty	100.00%	823,390	823,390	3
4	V	34	Rent-Facility & Grounds	1,400,000	Champaign Urbana Realty	100.00%		(1,400,000)	4
5	V	43	Late Fees		Champaign Urbana Realty	100.00%	7,992	7,992	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,400,000			$ 1,497,467	$ * 97,467	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 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	5	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 1,115	$ 1,115	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	3	3	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	69,832	69,832	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	14,548	14,548	18
19	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	75,807	75,807	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	10,741	10,741	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	292	292	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	152,464	152,464	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	240	240	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	1,758	1,758	24
25	V	26	Insurance-Prop.Liab.Malpractice		Premier Healthcare Management, LLC	100.00%	111	111	25
26	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	45,744	45,744	26
27	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	20,723	20,723	27
28	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	2,129	2,129	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			$			$ 395,507	$ * 395,507	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 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	10A	Therapy	$ 37,922	REX Therapeutics	100.00%	$	$ (37,922)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	9,998	9,998	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	13,101	13,101	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	1,255	1,255	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	668	668	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	3,428	3,428	20
21	V	30	Depreciation		REX Therapeutics	100.00%	260	260	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	13,424	13,424	22
23	V	39	Therapy Management Wages		REX Therapeutics	100.00%	26,106	26,106	23
24	V								24
25	V								25
26	V								26
27	V	39	Therapy Wages		REX Therapeutics	100.00%	402,244	402,244	27
28	V	39	Contract Therapy	700,562	REX Therapeutics	100.00%		(700,562)	28
29	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	42,632	42,632	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			$ 738,484			$ 513,116	$ * (225,368)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joseph Knopf	2.80	Gardenview Manor	Danville	Premier Healthcare	Skokie	Management Co.	1
2	Ayelet Knopf	2.80	Gilman Healthcare Center	Gilman	Management, LLC			2
3	Naomi Lapin	2.80	Winfield Woods Healthcare Center	Winfield	Premier Healthcare	Skokie	Medical Supply	3
4	Yisroel Lapin	2.80	Pershing Gardens Healthcare Center	Stickney	Supplies, LLC			4
5	Michael & Carol Knopf	.90	Norridge Gardens	Norridge	Champaign Urbana	Savoy	Lessor	5
6	Isaac & Rachel Knopf	.50	Premier Healthcare of New Harmony, LLC	New Harmony, IN	Realty			6
7	Orsheve Enterprises	3.30			REX Therapeutics	Skokie	Therapy	7
8	Orsheve Enterprises	3.30						8
9	Waxcap, Inc.	12.20						9
10	Barak Baver	70.90						10
11	Champaign Urbana Nursing General Partı	1.00						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sara Baver	Relative	Clerical	0.00	See Att Sch 7A	6.55	16.38	Alloc Salary	$ 7,241	21-7	1
2	Yocheved Baver	Relative	Consulting	0.00	See Att Sch 7A	N/A	N/A	Consulting	10,800	19-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 18,041		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Premier Healthcare Management, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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	Heat and Other Utilities	Operating Revenues	64,636,666	8	$ 6,803	$	10,589,285	$ 1,115	1
2	6	Maintenance	Operating Revenues	64,636,666	8	20		10,589,285	3	2
3	10	Nursing and Medical Records	Operating Revenues	64,636,666	8	426,253	426,253	10,589,285	69,832	3
4	15	Emp Benefit Alloc-Healthcare	Operating Revenues	64,636,666	8	88,802		10,589,285	14,548	4
5	17	Administrative	Operating Revenues	64,636,666	8	462,726	462,726	10,589,285	75,807	5
6	19	Professional Services	Operating Revenues	64,636,666	8	65,562		10,589,285	10,741	6
7	20	Dues, Fees, Subs & Promo	Operating Revenues	64,636,666	8	1,782		10,589,285	292	7
8	21	Clerical & Gen Office Expenses	Operating Revenues	64,636,666	8	930,635	877,535	10,589,285	152,464	8
9	24	Travel and Seminar	Operating Revenues	64,636,666	8	1,464		10,589,285	240	9
10	25	Other Admin. Staff Trans	Operating Revenues	64,636,666	8	10,729		10,589,285	1,758	10
11	26	Insurance-Prop.Liab.Malpractice	Operating Revenues	64,636,666	8	675		10,589,285	111	11
12	27	Emp Benefit Alloc-Gen Admin	Operating Revenues	64,636,666	8	279,218		10,589,285	45,744	12
13	34	Rent-Facility & Grounds	Operating Revenues	64,636,666	8	126,494		10,589,285	20,723	13
14	35	Equipment Rental	Operating Revenues	64,636,666	8	12,997		10,589,285	2,129	14
15								10,589,285		15
16	17	Professional Services	Direct Allocation	60,000	1	60,000			0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,474,160	$ 1,766,514		$ 395,507	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: REX Therapeutics
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Therapy Revenue	8,309,425	12	$ 112,512	$	738,354	$ 9,998	1
2	20	Fees and Subscriptions	Therapy Revenue	8,309,425	12	147,440		738,354	13,101	2
3	21	Clerical & General Office Exp	Therapy Revenue	8,309,425	12	14,128		738,354	1,255	3
4	25	Other Admin Staff Transp	Therapy Revenue	8,309,425	12	7,522		738,354	668	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	8,309,425	12	38,581		738,354	3,428	5
6	30	Depreciation	Therapy Revenue	8,309,425	12	2,921		738,354	260	6
7	32	Interest Expense	Therapy Revenue	8,309,425	12	151,084		738,354	13,424	7
8	39	Therapy Management Wages	Therapy Revenue	8,309,425	12	293,802	293,802	738,354	26,106	8
9										9
10										10
11										11
12	39	Therapy Wages	Direct Allocation	5,717,814	12	5,424,012	5,424,012	402,244	402,244	12
13	39	Contract Therapy	Direct Allocation	206,555	3	206,555				13
14	39	Allocated Employee Benefits	Total Wages	5,717,814	12	569,187		428,350	42,632	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,967,744	$ 5,717,814		$ 513,116	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Midwest Bank		X	Mortgage		7/25/2014	$ 16,100,000	$ 12,919,736	8/5/2017		$ 823,390	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit		12/31/14		1,336,182	3/31/17		75,146	6
7												7
8												8
9	TOTAL Facility Related						$ 16,100,000	$ 14,255,918			$ 898,536	9
	B. Non-Facility Related*											
10												10
11								Allocated from REX Therapeutics			13,424	11
12								Offset Interest Income			(1,613)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 11,811	14
15	TOTALS (line 9+line14)						$ 16,100,000	$ 14,255,918			$ 910,347	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 94,227	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.)	2019	$ 91,287	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,940)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 92,940	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 90,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	84,687	8
	2016	82,598	9
	2017	91,276	10
	2018	91,121	11
	2019	91,287	12

Accrual based on prior year tax bill.

Adjusted beginning accrual to actual-prior year post closing adjustment

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

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign Urbana Nrsg Rehab COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0052217

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 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.	03-20-25-300-004	Long Term Care Property	$ 91,287.03	$ 91,287.03
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 91,287.03	$ 91,287.03

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,118 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2015	$ 945,720	1
2					2
3	TOTALS			$ 945,720	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	213		2015	1975	$ 9,141,960	$	35	$ 261,199	$ 261,199	$ 1,567,194	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New Skilled Unit: Reroute Power In Therapy, Dialysis Room Outlets			2014	14,697		20	735	735	5,084	9
10	New Floor, Wall Tiles, Paint In 2 Shower Rooms			2014	12,750		20	638	638	4,359	10
11	Paint 15 Units, Including Bathrooms			2014	4,500		20	225	225	1,538	11
12	Gym Flooring & Cove Base			2014	23,343		20	1,167	1,167	7,974	12
13	Dialysis Room Carpet			2014	9,271		20	464	464	3,093	13
14	Plumbing			2014	3,282		20	164	164	1,080	14
15	Install Generator Controller			2014	23,115		20	1,156	1,156	7,514	15
16	Water Supply Line & Piping			2014	3,690		20	185	185	1,279	16
17	Replace Compressor			2014	4,630		20	232	232	1,469	17
18	Install Dome Lights & Pull Cords In Rehab Area Bathrooms			2014	3,815		20	191	191	1,193	18
19	Change Two 85 Gallon/500,000 Btu Water Heaters			2015	30,687		20	1,534	1,534	9,204	19
20	Install 2' Gas Main To 4 Water Heaters/Fix Gas Leak In Basement			2015	5,300		20	265	265	1,360	20
21	Addition Of 4 Circuilts For New Dialysis Machinesl/Gfci Breaker			2015	5,015		20	251	251	1,506	21
22	Remove/Install High & Low Slow Mixing Valve			2015	3,248		20	162	162	972	22
23	Install Epdm Rubber Roof At East/Center Of Building			2015	5,635		20	282	282	1,692	23
24	Security System			2015	10,195		20	510	510	3,060	24
25	Dialysis Room - Electrical, Wall boxes, paint, cabinets and faucets			2016	2,680		20	134	134	603	25
26	Flooring in Rehab Nurses station, Rms 105-113, Lobby, Hallway,			2016	51,174		20	2,559	2,559	11,515	26
27	South Corridor and Dialysis Den Room										27
28	Install Two 85 Gallon BTU Water Heating Units			2016	29,497		20	1,475	1,475	6,637	28
29	Boiler Repair			2016	3,239		20	162	162	729	29
30	Reapirs on 3 Boilers - Replace Pumps, Motors, Blades & Contactors			2017	5,084		20	254	254	889	30
31	Install 2 new ASI Controls with Sensors,AAON RTUs, Pumps and Exhuas			2017	15,800		20	790	790	2,765	31
32	Replaced Blower Motors and Circuit Boards on 3 PTAC units			2017	2,862		20	143	143	501	32
33	Repair Water Damaged Fire Alarm System			2017	2,769		20	138	138	483	33
34	Electrical Wiring and Circuts for new Dialysis Room			2017	7,097		20	355	355	1,242	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sprinkler Repair-Replace Compressor	2018	$ 3,775	$	20	$ 189	$ 189	$ 472	37
38	Replace Compressor in Sprinkler System	2018	2,654		20	133	133	332	38
39	Six PTAC Units	2018	4,925		20	246	246	690	39
40	Four PTAC Units	2018	3,863		20	193	193	483	40
41	Repair Two Boilers	2018	5,737		20	287	287	717	41
42	Remove and Install Kitchen Flooring	2019	12,550		20	628	628	942	42
43	Remove and Install Careting (4 Corridors)	2019	30,000		20	1,500	1,500	2,250	43
44	Painting 2nd Floor Dining Room, Nurses Station, Lounge	2019	6,378		20	319	319	478	44
45	PTAC's (8)	2019	8,152		20	408	408	612	45
46	Install New Fire Hydrant - Southeast Corner	2019	10,565		20	528	528	792	46
47	Water Heater Repair	2019	7,070		20	354	354	531	47
48	Rooftop AC Unit	2020	8,442		20	211	211	211	48
49	Heat Pump and Install Gas Piping from Main Line to New Unit	2020	8,443		20	211	211	211	49
50									50
51									51
52									52
53									53
54	Allocated from Premier Healthcare Management, LLC	2013	4,077		20	204	204	1,262	54
55									55
56	Allocated from REX Therapeutics					260	260		56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66	Financial Statement Depreciation Expense			34,274			(34,274)		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,541,966	$ 34,274		$ 281,041	$ 246,767	$ 1,654,918	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,021,647	$ 84,076	$ 202,165	$ 118,089	10 yrs	$ 1,276,267	71
72	Current Year Purchases	44,312	7,746	4,431	(3,315)	10 yrs	4,431	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,065,959	$ 91,822	$ 206,596	$ 114,774		$ 1,280,698	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	N/A									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)	$ 12,553,645	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 126,096	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 487,637	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 361,541	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,935,616	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				20,723			5
6								6
7	TOTAL				$ 20,723 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: $ 104,988 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	Allocated from Management Co			2,129	18
19					19
20					20
21	TOTAL		$	$ 2,129	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Champaign Urbana Nrsg Rehab**
IDPH License ID Number: **0052217**
Fiscal Year End: **12/31/2020**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	73,686
Office Equipment	31,302
Total - Line 16	**104,988**

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)(7)	4809 hrs	$ 179,842		$ 190,060	$	4,809	$ 369,902	1
2	Licensed Speech and Language Development Therapist	39(3)(7)	2023 hrs	75,662		79,961		2,023	155,623	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)(7)	3924 hrs	146,740		155,078		3,924	301,818	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				300,421		300,421	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Therapy Manager-Allo	39(7)	186	26,106				186	26,106	12
13	Other (specify): See Attached Sch 16A					10,024	668		10,692	13
14	TOTAL			$ 428,350		$ 435,123	$ 301,089	10,942	$ 1,164,562	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Champaign Urbana Nrsg Rehab**
IDPH License ID Number: **0052217**
Fiscal Year End: **12/31/2020**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	10,024
Medical Supplies - MCA	39(2)	668
Total - Line 13		**10,692**

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 40,649	$ 43,671	1
2	Cash-Patient Deposits	80,409	80,409	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 11,135)	2,462,479	2,462,479	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,207	47,207	6
7	Other Prepaid Expenses	2,667	2,667	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Others	48,760	48,760	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,682,171	$ 2,685,193	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		945,720	13
14	Buildings, at Historical Cost		9,141,960	14
15	Leasehold Improvements, at Historical Cost	391,977	400,006	15
16	Equipment, at Historical Cost	768,299	2,065,959	16
17	Accumulated Depreciation (book methods)	(799,423)	(2,935,616)	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 Att Sch 17A	1,000	76,597	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 361,853	$ 9,694,626	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,044,024	$ 12,379,819	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,013,807	$ 2,013,807	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,336,182	1,336,182	29
30	Accrued Salaries Payable	367,376	367,376	30
31	Accrued Taxes Payable (excluding real estate taxes)	164,264	164,264	31
32	Accrued Real Estate Taxes(Sch.IX-B)		92,940	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	872,084	895,499	36
37	Due to Related Parties	3,067,859	3,663,779	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,821,572	$ 8,533,847	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,919,736	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,919,736	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,821,572	$ 21,453,583	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,777,548)	$ (9,073,764)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,044,024	$ 12,379,819	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Champaign Urbana Nrsg Rehab**
IDPH License ID Number: **0052217**
Fiscal Year End: **12/31/2020**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Loan Costs	1,000	1,000
Loan Origination Fees - CUR		480,173
Amortization - CUR		(445,539)
Capital Impr Reserve - CUR		43,933
RE Tax Escrow - CUR		(2,976)
Debt Service Reserve Fund - CUR		6
Total - Line 23	**1,000**	**76,597**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due to Medicare	599,878	599,878
Accrued MDS Tax	45,267	45,267
Accrued Expenses	105,735	129,150
Due to HFS	119,858	119,858
Payroll Withholdings	1,346	1,346
Total - Line 36	**872,084**	**895,499**

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,625,164)	1
2	Restatements (describe):		2
3	**Post closing adjustments -Depr/Amort**	(12,893)	3
4	**Post closing adjustments - Penalties**	(223,048)	4
5	**Post closing adjustments - FICA Tax**	(43,471)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (6,904,576)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,127,028	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,127,028	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)**	$ (4,777,548)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,321,761	1
2	Discounts and Allowances for all Levels	344,962	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,666,723	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	673,750	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 673,750	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,071,836	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	199	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	248,498	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	115	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,320,648	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,613	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,613	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	**Prior Year Vendor Balance Forgiveness**	950,860	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 950,860	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,613,594	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,528,236	31
32	Health Care	4,107,053	32
33	General Administration	1,744,217	33
	B. Capital Expense		
34	Ownership	1,796,230	34
	C. Ancillary Expense		
35	Special Cost Centers	1,959,946	35
36	Provider Participation Fee	350,884	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,486,566	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,127,028	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,127,028	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,856,513	44
45	Private Pay - Net Inpatient Revenue	1,526,519	45
46	Medicare - Net Inpatient Revenue	2,745,692	46
47	Other-(specify) Insurance	1,328,025	47
48	Other-(specify) Hospice	209,974	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,666,723	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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,566	2,686	$ 142,208	$ 52.94	1
2	Assistant Director of Nursing	2,613	2,733	100,079	36.62	2
3	Registered Nurses	18,761	19,778	678,355	34.30	3
4	Licensed Practical Nurses	21,813	22,582	690,961	30.60	4
5	CNAs & Orderlies	76,470	79,951	1,305,704	16.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,228	2,579	46,935	18.20	8
9	Activity Director					9
10	Activity Assistants	3,335	3,717	108,220	29.11	10
11	Social Service Workers	3,810	4,275	87,189	20.40	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,080	71,260	34.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,556	23,110	299,200	12.95	15
16	Dishwashers					16
17	Maintenance Workers	5,374	5,558	120,569	21.69	17
18	Housekeepers	12,449	12,897	131,139	10.17	18
19	Laundry	4,227	4,529	53,011	11.70	19
20	Administrator	1,968	2,104	128,675	61.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,317	20,748	386,087	18.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,109	1,265	22,841	18.06	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	8,993	9,490	413,614	43.58	33
34	TOTAL (lines 1 - 33)	210,613	220,082	$ 4,786,047 *	$ 21.75	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 11,779	L1, C3	35
36	Medical Director	Monthly	30,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly		L10, C3	38
39	Pharmacist Consultant	Monthly	8,602	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	78	5,308	L12,C3	45
46	Other(specify)				46
47	Rehab Consultant	25	4,018	L10A, C3	47
48					48
49	TOTAL (lines 35 - 48)	103	$ 59,707		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,299	$ 77,449	L10, C3	50
51	Licensed Practical Nurses	2,692	174,865	L10, C3	51
52	Certified Nurse Assistants/Aides	3,252	52,188	L10, C3	52
53	TOTAL (lines 50 - 52)	7,243	$ 304,502		53

SEE ACCOUNTANTS' PREPARATION REPORT

Champaign Urbana Nrsg Rehab

Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	3,244	3,413	116,066	34.01
Transportation	2,245	2,413	41,870	17.35
Marketing	3,504	3,664	255,678	69.78
TOTAL	8,993	9,490	413,614	

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Katheryn Eyre	Administrator	0	$ 105,053
Donna Horn	Administrator	0	23,622
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 128,675

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 119,501
Richard Peelo & Associates, Inc	Accounting	2,800
CohnReznick LLP	Accounting	47,450
Sikich, LLP	Accounting	9,950
Plante & Moran, PLLC	Accounting	112
Wipfli LLP	Accounting	22,500
Ability Network Inc.	Data Processing	5,962
HDSI	Data Processing	3,700
MatrixCare	Data Processing	51,680
See Attached Schedule 21A		158,574
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 422,229

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 142,544
Unemployment Compensation Insurance	53,787
FICA Taxes	327,941
Employee Health Insurance	84,531
Employee Meals	7,645
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	26,206
TOTAL (agree to Schedule V, line 22, col.8)	$ 642,654

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,824
Advertising: Employee Recruitment	19,448
Health Care Worker Background Check	
(Indicate # of checks performed 256)	2,561
Patient Background Checks 34	340
Allscripts	6,103
Licenses & Permits	1,085
Dues & Subscriptions	5,599
Allocated from Management Co.	292
Allocated from REX Therapeutics	13,101
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,353

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,426
Allocated from Management Co.	240
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,666

* Attach copy of IMRF notifications
**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Champaign Urbana Nrsg Rehab**
IDPH License ID Number: **0052217**
Fiscal Year End: **12/31/2020**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Transworld Systems Inc	AR Collections	1,712
Resolute Healthcare Solutions	Healthcare Billing	11,150
Personnel Planners	Unemployment Consultants	1,725
Terrill Consulting Services, Inc.	Billing Consultant	26,975
GCHMO, Inc	Managed Care Contracting Services	16,050
Yocheved Baver	Website Services	10,800
Change Healthcare	Data Processing	1,399
eSolutions, Inc	Data Processing	6,174
Paycor	Payroll Processing	25,045
TaxSaver Plan	Benefits Administration	479
Healthcare Solutions Group	Benefits Consultant	13,032
Blymas, Inc.	Tax Credit Consultant	5,208
Collaborative Healthcare Urgency Group	Healthcare Emergency Preparedness	1,000
Dyatech, LLC	Benefits Consultant	1,150
Experian Health Inc.	Revenue Cycle Management	432
IPR Tech Group LLC	Data Processing	32,539
Sedgwick CMS	Claims Management	700
Bill.com	Bill Payment Processing	2,990
Miscellaneous		14
Total		**158,574**

Facility Name & ID Number Champaign Urbana Nrsg Rehab # 0052217 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,447** 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. $ **350,884**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **7,645** Has any meal income been offset against related costs? **N/A** 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% Line 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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.