		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: 0046177

Facility Name: Chateau Nrsg Rehab Center

Address: 7050 Madison Street (Number) Willowbrook (City) 60521 (Zip Code)

County: Dupage

Telephone Number: (630) 323-6380 **Fax #** (630) 323-6416

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2003

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed)
* *Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	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	150	TOTALS	150	54,900	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	24,098	3,327	10,163	37,588	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,098	3,327	10,163	37,588	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.47%

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 2/1/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 7,622

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

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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	363,209	70,201	20,650	454,060		454,060	665	454,725			1
2	Food Purchase		214,470		214,470		214,470	(604)	213,866			2
3	Housekeeping	176,073	43,439		219,512		219,512	1,217	220,729			3
4	Laundry	95,755	44,996	59	140,810		140,810		140,810			4
5	Heat and Other Utilities			218,445	218,445		218,445	(15,697)	202,748			5
6	Maintenance	130,663		204,704	335,367		335,367	3,264	338,631			6
7	Other (specify):*							3,316	3,316			7
8	**TOTAL General Services**	765,700	373,106	443,858	1,582,664		1,582,664	(7,839)	1,574,825			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,063,293	387,321	857,579	4,308,193		4,308,193	2,253	4,310,446			10
10a	Therapy	191,771		30,616	222,387		222,387		222,387			10a
11	Activities	196,799	10,650	686	208,135		208,135		208,135			11
12	Social Services	148,700			148,700		148,700	14,208	162,908			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	111,876			111,876		111,876	6,595	118,471			15
16	**TOTAL Health Care and Programs**	3,712,439	397,971	906,881	5,017,291		5,017,291	23,056	5,040,347			16
	C. General Administration											
17	Administrative	142,876			142,876		142,876	105,869	248,745			17
18	Directors Fees											18
19	Professional Services			673,933	673,933	(14)	673,919	(531,783)	142,136			19
20	Dues, Fees, Subscriptions & Promotions			224,075	224,075		224,075	(12,081)	211,994			20
21	Clerical & General Office Expenses	154,692	30,836	308,997	494,525		494,525	(109,530)	384,995			21
22	Employee Benefits & Payroll Taxes			685,435	685,435		685,435	(8,836)	676,599			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,388	9,388		9,388	683	10,071			24
25	Other Admin. Staff Transportation			1,333	1,333		1,333	616	1,949			25
26	Insurance-Prop.Liab.Malpractice			374,906	374,906		374,906	1,686	376,592			26
27	Other (specify):*							42,563	42,563			27
28	**TOTAL General Administration**	297,568	30,836	2,278,067	2,606,471	(14)	2,606,457	(510,813)	2,095,644			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,775,707	801,913	3,628,806	9,206,426	(14)	9,206,412	(495,596)	8,710,816			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 Chateau Nrsg Rehab Center #0046177 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			69,193	69,193		69,193	67,127	136,320			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							226,710	226,710			32
33	Real Estate Taxes			111,807	111,807	14	111,821	4,669	116,490			33
34	Rent-Facility & Grounds			692,654	692,654		692,654	(684,000)	8,654			34
35	Rent-Equipment & Vehicles			16,869	16,869		16,869	225	17,094			35
36	Other (specify):*											36
37	TOTAL Ownership			890,523	890,523	14	890,537	(385,269)	505,268			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		216,617	755,702	972,319		972,319	(14,295)	958,024			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			289,482	289,482		289,482		289,482			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		216,617	1,045,184	1,261,801		1,261,801	(14,295)	1,247,506			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,775,707	1,018,530	5,564,513	11,358,750		11,358,750	(895,160)	10,463,590			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 Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(196)	02		4
5	Telephone, TV & Radio in Resident Rooms	(17,014)	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	(19,911)	30		9
10	Interest and Other Investment Income	(82,004)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(187)	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				18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(248,190)	21		24
25	Fund Raising, Advertising and Promotional	(6,692)	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	(39,196)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (413,890)		$	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)	(481,269)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (481,269)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (895,159)		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

Chateau Nrsg Rehab Center

ID# 0046177

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (5,010)	21	1
2	Vending Income	(311)	02	2
3	Theft Loss	(101)	21	3
4	Collection Expense	(4,546)	21	4
5	Building Co. - Management Fees	(7,500)	19	5
6	Building Co. - Bank Charges	(374)	21	6
7	Building Co. - Filing Fee	(75)	20	7
8	Building Co. - Amortization	(7,612)	36	8
9	Capitalized R&M	(2,616)	06	9
10	PAC Dues	(7,931)	20	10
11	Duplicated Expense	(3,120)	21	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**	(39,196)		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**

Chateau Nrsg Rehab Center

IDF **00461277**

Report Period Beginning: **01/01/20**

Ending: **12/31/20**

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			123	542								665	1
2	Food Purchase	(694)		90									(604)	2
3	Housekeeping			1,074	143								1,217	3
4	Laundry													4
5	Heat and Other Utilities	(17,014)		1,176	141								(15,697)	5
6	Maintenance	(2,616)		5,738	142								3,264	6
7	Other (specify):*			3,236	80								3,316	7
8	**TOTAL General Services**	(20,324)		11,437	1,048								(7,839)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				31,460	(26,756)	(2,450)						2,253	10
10a	Therapy													10a
11	Activities													11
12	Social Services				14,208								14,208	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,595								6,595	15
16	**TOTAL Health Care and Programs**				52,263	(26,756)	(2,450)						23,056	16
	C. General Administration													
17	Administrative			15,381	90,488								105,869	17
18	Directors Fees													18
19	Professional Services	(7,500)	7,500	(396,484)	(135,299)								(531,783)	19
20	Fees, Subscriptions & Promotions	(15,198)	75	2,003	1,039								(12,081)	20
21	Clerical & General Office Expenses	(261,341)	374	104,180	47,257								(109,530)	21
22	Employee Benefits & Payroll Taxes			(8,836)									(8,836)	22
23	Inservice Training & Education													23
24	Travel and Seminar			327	356								683	24
25	Other Admin. Staff Transportation			616									616	25
26	Insurance-Prop.Liab.Malpractice			1,320	366								1,686	26
27	Other (specify):*			22,637	19,926								42,563	27
28	**TOTAL General Administration**	(284,039)	7,949	(258,856)	24,133								(510,813)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(304,363)	7,949	(247,419)	77,444	(26,756)	(2,450)						(495,596)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 **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	(19,911)	84,836	2,071	131								67,127	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(82,004)	301,194	7,401	119								226,710	32
33	Real Estate Taxes			4,119	550								4,669	33
34	Rent-Facility & Grounds		(684,000)										(684,000)	34
35	Rent-Equipment & Vehicles			225									225	35
36	Other (specify):*	(7,612)	7,612											36
37	**TOTAL Ownership**	(109,527)	(290,358)	13,816	800								(385,269)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(14,295)						(14,295)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(14,295)						(14,295)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(413,890)	(282,409)	(233,603)	78,244	(26,756)	(16,745)						(895,160)	45

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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	$ 684,000	Chateau Willowbrook Property LLC		$	$ (684,000)	1
2	V	33	Property Taxes	111,807	Chateau Willowbrook Property LLC		111,807		2
3	V	19	Management Fees		Chateau Willowbrook Property LLC		7,500	7,500	3
4	V	21	Bank Service Charges		Chateau Willowbrook Property LLC		374	374	4
5	V	20	Filing Fee		Chateau Willowbrook Property LLC		75	75	5
6	V	30	Depreciation		Chateau Willowbrook Property LLC		84,836	84,836	6
7	V	36	Amortization		Chateau Willowbrook Property LLC		7,612	7,612	7
8	V	32	Interest		Chateau Willowbrook Property LLC		301,194	301,194	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 795,807			$ 513,398	$ * (282,409)	14

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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	ROTHNER HEALTH VENTURES G II, LLC	100.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	CHATEAU WILLOWBROOK PR	WILLOWBROOK	BUILDING COMPANY	1
2			BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTIN	EVANSTON	MGMT/BOOKKEEPING	2
3			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			GRASMERE PLACE, LLC	CHICAGO	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL DYER	DYER, IN				8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				13
14			MCKINLEY HEALTH CARE CENTER	CANTON, OH				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC		$ 123	$ 123	15
16	V	02	Food		Extended Care Consulting, LLC		90	90	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,074	1,074	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,176	1,176	18
19	V	06	Maintenance		Extended Care Consulting, LLC		2,343	2,343	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	401,272	Extended Care Consulting, LLC		4,788	(396,484)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		2,003	2,003	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		10,545	10,545	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		327	327	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		616	616	25
26	V	26	Insurance		Extended Care Consulting, LLC		1,320	1,320	26
27	V	30	Depreciation		Extended Care Consulting, LLC		2,071	2,071	27
28	V	32	Interest		Extended Care Consulting, LLC		7,401	7,401	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		4,119	4,119	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		225	225	30
31	V	06	Maintenance Salaries	14,348	Extended Care Consulting, LLC		17,743	3,395	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		3,236	3,236	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		15,381	15,381	33
34	V	21	Office and Clerical Salaries	15,106	Extended Care Consulting, LLC		108,741	93,635	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		22,637	22,637	35
36	V	22	Employee Benefits	8,836	Extended Care Consulting, LLC			(8,836)	36
37	V								37
38	V								38
39	Total			$ 439,562			$ 205,959	$ * (233,603)	39

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Salary	$	Extended Care Clinical, LLC		$ 542	$ 542	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		143	143	16
17	V	5	Utilities		Extended Care Clinical, LLC		141	141	17
18	V	6	Maintenance		Extended Care Clinical, LLC		142	142	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		80	80	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		30,666	30,666	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		794	794	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		14,208	14,208	22
23	V	15	Emp. Ben, - Direct Alloc.		Extended Care Clinical, LLC				23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		6,595	6,595	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		90,488	90,488	25
26	V	19	Professional Fees	140,548	Extended Care Clinical, LLC		1,257	(139,291)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC		3,992	3,992	27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		1,039	1,039	28
29	V	21	Office Salary		Extended Care Clinical, LLC		45,096	45,096	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		2,161	2,161	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		356	356	31
32	V	26	Insurance		Extended Care Clinical, LLC		366	366	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		19,926	19,926	33
34	V	30	Depreciation		Extended Care Clinical, LLC		131	131	34
35	V	32	Interest		Extended Care Clinical, LLC		119	119	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		550	550	36
37	V								37
38	V								38
39	Total			$ 140,548			$ 218,792	$ * 78,244	39

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Various Equipment	34,420	Vent Lease LLC		7,664	$ (26,756)	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			$ 34,420			$ 7,664	$ * (26,756)	39

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 26,220	MAC Rx, LLC		$ 23,769	$ (2,450)	15
16	V	39	Ancillary	152,952	MAC Rx, LLC		138,658	(14,295)	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			$ 179,172			$ 162,427	$ * (16,745)	39

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group		$ 291,751	$ 291,751	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	291,751	CCS Employee Benefits Group			(291,751)	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			$ 291,751			$ 291,751	$ *	39

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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 Chateau Nrsg Rehab Center # 0046177 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 Chateau Nrsg Rehab Center # 0046177 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 Chateau Nrsg Rehab Center # 0046177 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 Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	0	See Attached	1.45	3.63	Alloc Salary	$ 2,593	22-7	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	$ 2,593		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 Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,219,947	38	$ 3,992	$	37,588	$ 123	1
2	02	Food	Patient Days	1,219,947	38	2,910		37,588	90	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856		37,588	1,074	3
4	05	Utilities	Patient Days	1,219,947	38	38,173		37,588	1,176	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040		37,588	2,343	5
6	17	Administrative	Patient Days	1,219,947	38			37,588		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408		37,588	4,788	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998		37,588	2,003	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251		37,588	10,545	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602		37,588	327	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988		37,588	616	11
12	26	Insurance	Patient Days	1,219,947	38	42,836		37,588	1,320	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209		37,588	2,071	13
14	32	Interest	Patient Days	1,219,947	38	240,208		37,588	7,401	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701		37,588	4,119	15
16	35	Rent - Equipment	Patient Days	1,219,947	38	7,304		37,588	225	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	575,856	37,588	17,743	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021		37,588	3,236	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	499,202	37,588	15,381	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	3,529,267	37,588	108,741	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685		37,588	22,637	21
22										22
23										23
24										24
25	TOTALS					$ 6,684,506	$ 4,604,325		$ 205,959	25

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Salary	Patient Days	603,308	20	$ 8,692	$ 8,692	37,588	$ 542	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		37,588	143	2
3	5	Utilities	Patient Days	603,308	20	2,264		37,588	141	3
4	6	Maintenance	Patient Days	603,308	20	2,283		37,588	142	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		37,588	80	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	37,588	30,666	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		37,588	794	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	37,588	14,208	8
9	15	Emp. Ben, - Direct Alloc.	Direct Allocation		4	44,957				9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		37,588	6,595	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	37,588	90,488	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		37,588	1,257	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220			3,992	13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		37,588	1,039	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	37,588	45,096	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		37,588	2,161	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		37,588	356	17
18	26	Insurance	Patient Days	603,308	20	5,874		37,588	366	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		37,588	19,926	19
20	30	Depreciation	Patient Days	603,308	20	2,099		37,588	131	20
21	32	Interest	Patient Days	603,308	20	1,914		37,588	119	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		37,588	550	22
23										23
24										24
25	TOTALS					$ 3,507,824	$ 2,905,144		$ 218,792	25

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	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	Various Equipment	Direct Allocation						7,664	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					$	$		$ 7,664	25

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 23,769	1
2	39	Ancillary	Direct Allocation						138,658	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					$	$		$ 162,427	25

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 291,751	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					$	$		$ 291,751	25

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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 Chateau Nrsg Rehab Center # 0046177 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 Chateau Nrsg Rehab Center # 0046177 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 Chateau Nrsg Rehab Center # 0046177 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 Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Mortgage Payable			$	$ 4,860,368			$ 301,194	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Advance HFG II		X	Line of Credit				244,215				6
7	IL Dept of HFS		X					137,850				7
8												8
9	TOTAL Facility Related						$	$ 5,242,433			$ 301,194	9
	B. Non-Facility Related*											
10	Interest Income		X								(82,004)	10
11	Alloc from Extended Care Consulting										7,401	11
12	Alloc from Extended Care Clinical										119	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (74,484)	14
15	TOTALS (line 9+line14)						$	$ 5,242,433			$ 226,710	15

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

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

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 91,561	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.)		$ 103,873	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,312	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 104,164	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.)		$ 14	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.		$ 116,490	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	96,848	8
	2016	97,991	9
	2017	93,504	10
	2018	87,201	11
	2019	99,204	12

2020 Accrual = $99,204 x 1.05 = $104,164

Allocated from Extended Care Consulting $4,119

Allocated from Extended Care Clinical $550

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chateau Nrsg Rehab Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0046177

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.	09-23-407-043	Long Term Care Property	$ 99,203.80	$ 99,203.80
2.	See Attached	Alloc from Exended Care Consulting	$ 197,162.69	$ 4,119.49
3.	See Attached	Alloc from Exended Care Clinical	$ 197,162.69	$ 550.42
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 493,529.18	$ 103,873.71

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 Chateau Nrsg Rehab Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0046177

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,447 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

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	273,121	2003	$ 295,367	1
2	Allocated from Care Center Building			19,422	2
3	TOTALS	273,121		$ 314,789	3

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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	150		2003	1987	$ 2,658,301	$ 84,836	39	$ 68,162	$ (16,674)	$ 1,809,720	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	51,953		20	1,516	1,516	43,766	9
10	Various			2004	98,685		20	4,649	4,649	82,944	10
11	Various			2005	69,862		20	3,493	3,493	52,897	11
12	Various			2006	50,399		20	1,814	1,814	40,796	12
13	Various			2007	126,729		20	6,024	6,024	90,276	13
14	Various			2008	30,544		20	1,527	1,527	22,718	14
15	Various			2009	25,582		20	944	944	17,169	15
16	Various			2010	12,771		20	639	639	7,527	16
17	Various			2011	110,418		20	5,522	5,522	54,495	17
18	Various			2012	56,744		20	1,042	1,042	45,613	18
19	Various			2013	176,755		20	7,989	7,989	76,971	19
20	Various			2014	129,172		20	6,101	6,101	48,023	20
21	Various			2015	104,360		20	5,218	5,218	77,364	21
22	Various			2016	13,144		20	657	657	2,769	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 Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		238,642			11,932	11,932	178,610	67
68	Related Party Allocations (Pages 12H & 12I)		96,603	1,500		1,500		68,166	68
69	Financial Statement Depreciation			69,193			(69,193)		69
70	TOTAL (lines 4 thru 69)		$ 4,050,664	$ 155,529		$ 128,729	$ (26,800)	$ 2,719,824	70

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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		$ 4,050,664	$ 155,529		$ 128,729	$ (26,800)	$ 2,719,824	1
2	Installation Of New Heat Exchanger	2017	4,100		20	205	205	786	2
3	Sprinkler System Modifications	2017	14,995		20	750	750	2,562	3
4	Laundry & Kitchen Boiler Repairs-Damper Motors & Relays	2017	5,943		20	297	297	916	4
5	Elevators - Replaced Relays, Wiring	2017	5,229		20	261	261	871	5
6	Replaced Sprinkler Heads In Laundry, Office, Electric Room	2017	2,757		20	138	138	529	6
7	Revent Boiler & 2 Hot Water Tanks	2018	36,500		20	1,825	1,825	4,867	7
8	Replace Walk-In Cooler Evaporator Coil	2019	3,290		20	165	165	330	8
9	Elevator Repair	2019	2,779		20	139	139	278	9
10	Furnish And Install Elevator Starter Contactor And Auxiliary Co	2019	4,504		20	225	225	450	10
11	Water Heater	2020	10,056		20	503	503	503	11
12	Replace Laundry Room Pumps	2020	2,616		20	131	131	131	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)		$ 4,143,433	$ 155,529		$ 133,368	$ (22,161)	$ 2,732,046	34

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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		$ 4,143,433	$ 155,529		$ 133,368	$ (22,161)	$ 2,732,046	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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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)		$ 4,143,433	$ 155,529		$ 133,368	$ (22,161)	$ 2,732,046	34

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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		$ 4,143,433	$ 155,529		$ 133,368	$ (22,161)	$ 2,732,046	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)		$ 4,143,433	$ 155,529		$ 133,368	$ (22,161)	$ 2,732,046	34

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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		$ 4,143,433	$ 155,529		$ 133,368	$ (22,161)	$ 2,732,046	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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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)		$ 4,143,433	$ 155,529		$ 133,368	$ (22,161)	$ 2,732,046	34

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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	Life Safety Code Improvements (Net of Settlement)	2005	231,242		20	11,562	11,562	173,430	9
10	Professional Fees - Architect	2007	7,400		20	370	370	5,180	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)		$ 238,642	$		$ 11,932	$ 11,932	$ 178,610	34

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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		$ 238,642	$		$ 11,932	$ 11,932	$ 178,610	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 238,642	$		$ 11,932	$ 11,932	$ 178,610	34

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	23,610	605	35	605		11,073	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	7,395	164	35	164		2,211	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,155	81	35	81		1,480	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	19,504		20			19,504	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	22,985		20			22,985	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,142		20			1,142	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	206	10	20	10		124	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,978	99	20	99		692	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	325	16	20	16		210	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,284	64	20	64		321	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,226	111	20	111		445	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,020	51	20	51		153	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	384	19	20	19		38	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	103	5	20	5		5	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,606		20			2,606	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2003	3,071		20			3,071	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2005	153		20			153	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2009	28	1	20	1		17	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2014	256	13	20	13		90	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2015	43	2	20	2		28	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2016	172	9	20	9		43	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2017	297	15	20	15		59	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2018	136	7	20	7		20	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2019	51	3	20	3		5	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2020	14	1	20	1		1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 92,143	$ 1,277		$ 1,277	$	$ 66,477	34

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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		$ 92,143	$ 1,277		$ 1,277	$	$ 66,477	1
2									2
3									3
4									4
5	Leasehold Improvements:								5
6	Allocated from Extended Care Consulting	2007	142	7	20	7		99	6
7	Allocated from Extended Care Consulting	2009	85	4	20	4		51	7
8	Allocated from Extended Care Consulting	2010	831	42	20	42		457	8
9	Allocated from Extended Care Consulting	2011	299	15	20	15		150	9
10	Allocated from Extended Care Consulting	2012	99	5	20	5		44	10
11	Allocated from Extended Care Consulting	2014	1,367	68	20	68		478	11
12	Allocated from Extended Care Consulting	2016	1,638	82	20	82		410	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)		$ 96,603	$ 1,500		$ 1,500	$	$ 68,166	34

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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	$ 29,510	$ 702	$ 2,952	$ 2,250	10	$ 18,406	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	767,708				10	766,834	73
74								74
75	TOTALS	$ 797,218	$ 702	$ 2,952	$ 2,250		$ 785,240	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		2003 FORD ECONO VAN	2003	$ 33,833	$	$	$	5	$ 33,833	76
77		TRUCK REPAIR	2004	1,083				5	1,083	77
78		Truck Repairs	2013	5,548				5	5,548	78
79		See Attached		3,985					3,985	79
80	TOTALS			$ 44,449	$	$	$		$ 44,449	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)	$ 5,299,890	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 156,232	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 136,320	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,911)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,561,736	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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	Offsite Storage				8,654			5
6								6
7	TOTAL				$ 8,654 **			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: $ 7,180 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	Facility	Ford	$ 826	$ 9,914	17
18					18
19					19
20					20
21	TOTAL		$ 826	$ 9,914	21

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

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 325,678	$		$ 325,678	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			78,408			78,408	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			342,372			342,372	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				168,563		168,563	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					9,244	48,054		57,298	13
14	TOTAL			$		$ 755,702	$ 216,617		$ 972,319	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 Chateau Nrsg Rehab Center # 0046177 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	$ 163,460	$ 327,365	1
2	Cash-Patient Deposits	57,197	57,197	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,690,440	2,690,440	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	142,823	142,823	6
7	Other Prepaid Expenses	9,501	9,501	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	11,301,869	11,301,869	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 14,365,290	$ 14,529,195	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		295,367	13
14	Buildings, at Historical Cost		3,805,411	14
15	Leasehold Improvements, at Historical Cost	957,906	957,906	15
16	Equipment, at Historical Cost	471,421	471,421	16
17	Accumulated Depreciation (book methods)	(1,243,189)	(4,190,579)	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	55,075	4,484,418	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 241,213	$ 5,823,944	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,606,503	$ 20,353,139	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,513,055	$ 3,513,056	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,027	50,027	28
29	Short-Term Notes Payable	244,215	244,215	29
30	Accrued Salaries Payable	252,946	252,946	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,996	10,996	31
32	Accrued Real Estate Taxes(Sch.IX-B)	104,164	104,164	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,117,200	1,117,200	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,292,603	$ 5,292,604	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	137,850	137,850	39
40	Mortgage Payable		4,860,368	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	785,010	785,010	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 922,860	$ 5,783,228	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,215,463	$ 11,075,832	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,391,040	$ 9,277,307	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,606,503	$ 20,353,139	48

***(See instructions.)**

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 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**	$ 7,974,766	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,974,766	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	416,274	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)**	$ 416,274	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)**	$ 8,391,040	24 *

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

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 10,537,254	1
2	Discounts and Allowances for all Levels	(2,613,935)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,923,319	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,535,605	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,535,605	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	790	13
14	Non-Patient Meals	196	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	161,242	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	73,415	19
20	Radiology and X-Ray	17,600	20
21	Other Medical Services	(23,484)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 229,759	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	82,004	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 82,004	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,004,337	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,004,337	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,775,024	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,582,664	31
32	Health Care	5,017,291	32
33	General Administration	2,606,471	33
	B. Capital Expense		
34	Ownership	890,523	34
	C. Ancillary Expense		
35	Special Cost Centers	972,319	35
36	Provider Participation Fee	289,482	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,358,750	40
41	**Income before Income Taxes (line 30 minus line 40)****	416,274	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 416,274	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,673,486	44
45	Private Pay - Net Inpatient Revenue	1,005,385	45
46	Medicare - Net Inpatient Revenue	1,749,178	46
47	Other-(specify) Hospice	421,817	47
48	Other-(specify) Insurance	73,453	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,923,319	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.**

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,959	2,628	$ 142,877	$ 54.37	1
2	Assistant Director of Nursing	686	890	34,735	39.05	2
3	Registered Nurses	23,091	25,085	1,052,253	41.95	3
4	Licensed Practical Nurses	26,840	29,226	1,053,912	36.06	4
5	CNAs & Orderlies	34,795	38,208	724,385	18.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,815	6,333	191,771	30.28	8
9	Activity Director	1,920	2,096	37,572	17.93	9
10	Activity Assistants	10,029	11,381	159,227	13.99	10
11	Social Service Workers	5,629	6,288	148,700	23.65	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,342	61,935	26.45	13
14	Head Cook	5,347	5,763	92,577	16.06	14
15	Cook Helpers/Assistants	14,509	15,938	208,697	13.09	15
16	Dishwashers					16
17	Maintenance Workers	5,476	6,342	130,663	20.60	17
18	Housekeepers	12,023	12,023	176,073	14.64	18
19	Laundry	6,255	6,255	95,755	15.31	19
20	Administrator	1,864	1,864	89,807	48.18	20
21	Assistant Administrator	1,089	1,089	53,069	48.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,500	7,299	154,692	21.19	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	2,150	2,292	55,131	24.05	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	8,036	8,956	111,876	12.49	33
34	TOTAL (lines 1 - 33)	176,069	192,296	$ 4,775,707 *	$ 24.84	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	423	$ 20,650	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,981	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	259	30,616	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	686	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	696	$ 77,933		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	522	$ 59,963	10-03	50
51	Licensed Practical Nurses	587	36,766	10-03	51
52	Certified Nurse Assistants/Aides	24,529	752,869	10-03	52
53	TOTAL (lines 50 - 52)	25,638	$ 849,598		53

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lauren O. Carrieri	Administrator	0	$ 63,750
Laura A. Aranda	Administrator	0	26,057
Theresa L. Williams	Asst. Admin	0	49,356
Jennifer L. Sarto	Asst. Admin	0	3,713
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 142,876

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
ECC Consulting	Home Office Expense	$ 401,272
ECC Clinical	Home Office Expense	140,548
Marcum LLP	Accounting	41,499
Personnel Planners	Unemployment Consultant	1,185
ECC Consulting	Data Processing	24,420
FSS Technologies LLC	Data Processing	450
National Datacare Corporation	Resident Fund Processing	1,421
Paycor	Payroll Processing	21,443
Collaborative Healthcare	Compliance	425
Benefit Services Group	Benefit Administration	544
See Attached	Legal	10,628
See Supplemental Schedule		30,099
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 673,934

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,016
Unemployment Compensation Insurance	19,094
FICA Taxes	365,342
Employee Health Insurance	164,091
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	368
Other Employee Welfare	6,493
Holiday Expense	2,195
TOTAL (agree to Schedule V, line 22, col.8)	$ 676,599

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	$ 1,658
Advertising: Employee Recruitment	175,696
Health Care Worker Background Check	
(Indicate # of checks performed 202)	2,015
Patient Background Checks	
Dues & Subscriptions	21,961
Licenses & Fees	7,622
See Supplemental Schedule	3,042
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 211,994

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,388
See Supplemental Schedule	683
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,071

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chateau Nrsg Rehab Center # 0046177 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 $15,863**

(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. $ **55,033** 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. $ **289,482**
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? **Yes** Indicate the amount. $ **196**

(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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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