FOR BHF USE

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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: 0018424

Facility Name: Childrens Habilitation Ctr

Address: 121 West 154th St (Number) Harvey (City) 60426 (Zip Code)

County: Cook

Telephone Number: (708) 596-2220 **Fax #** (708) 596-2258

HFS ID Number:

Date of Initial License for Current Owners: 2/5/1973

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler **Telephone Number:** (847) 940-3269
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) Andrew B. Cutler, Managing Director, Healthcare
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr. 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 940-3269 Fax # (847) 964-5469

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 Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds None

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	67	Intermediate/DD	67	24,522	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	67	TOTALS	67	24,522	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	22,511			22,511	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,511			22,511	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.80%

D. How many bed reserve days during this year were paid by the Department?
203 (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 2/5/1973

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	88,268		23,865	112,133		112,133		112,133			1
2	Food Purchase		215,196		215,196		215,196		215,196			2
3	Housekeeping	183,397	43,629		227,026		227,026		227,026			3
4	Laundry	214,265			214,265		214,265		214,265			4
5	Heat and Other Utilities			121,392	121,392		121,392		121,392			5
6	Maintenance	137,111	128,968	350,389	616,468		616,468		616,468			6
7	Other (specify):*											7
8	TOTAL General Services	623,041	387,793	495,646	1,506,480		1,506,480		1,506,480			8
	B. Health Care and Programs											
9	Medical Director			36,431	36,431		36,431		36,431			9
10	Nursing and Medical Records	5,104,048	1,111,211	497,356	6,712,615		6,712,615		6,712,615			10
10a	Therapy			29,558	29,558		29,558		29,558			10a
11	Activities	55,820		72	55,892		55,892		55,892			11
12	Social Services	106,643			106,643		106,643		106,643			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Education	440,001	329	10,276	450,606		450,606		450,606			15
16	TOTAL Health Care and Programs	5,706,512	1,111,540	573,693	7,391,745		7,391,745		7,391,745			16
	C. General Administration											
17	Administrative	284,343			284,343		284,343		284,343			17
18	Directors Fees											18
19	Professional Services			949,355	949,355		949,355	(539,093)	410,262			19
20	Dues, Fees, Subscriptions & Promotions			106,000	106,000		106,000	(34,509)	71,491			20
21	Clerical & General Office Expenses	561,642		178,360	740,002		740,002	(50,731)	689,271			21
22	Employee Benefits & Payroll Taxes			1,297,309	1,297,309		1,297,309		1,297,309			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,567	4,567		4,567	(3,339)	1,228			24
25	Other Admin. Staff Transportation			17,140	17,140		17,140		17,140			25
26	Insurance-Prop.Liab.Malpractice			429,278	429,278		429,278		429,278			26
27	Other (specify):*											27
28	TOTAL General Administration	845,985		2,982,009	3,827,994		3,827,994	(627,672)	3,200,322			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,175,538	1,499,333	4,051,348	12,726,219		12,726,219	(627,672)	12,098,547			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 Childrens Habilitation Ctr #0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			141,843	141,843		141,843	(47,022)	94,821			30
31	Amortization of Pre-Op. & Org.			8,571	8,571		8,571		8,571			31
32	Interest											32
33	Real Estate Taxes			294,400	294,400		294,400		294,400			33
34	Rent-Facility & Grounds			12,174	12,174		12,174		12,174			34
35	Rent-Equipment & Vehicles			17,186	17,186		17,186		17,186			35
36	Other (specify):*											36
37	**TOTAL Ownership**			474,174	474,174		474,174	(47,022)	427,152			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,493,541	191,092	153,520	1,838,153		1,838,153		1,838,153			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,878	176,878		176,878		176,878			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	1,493,541	191,092	330,398	2,015,031		2,015,031		2,015,031			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,669,079	1,690,425	4,855,920	15,215,424		15,215,424	(674,694)	14,540,730			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 Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,842)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(34,509)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(42,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(565,343)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (674,694)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (674,694)		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

Childrens Habilitation Ctr

ID# 0018424

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income Offset	$ (50)	21	1
2	Garnishment Income Offset	(665)	21	2
3	Non-Allowable Legal Fees	(539,093)	19	3
4	IHCA PAC Dues	(830)	21	4
5	Annual Report Fees	(320)	21	5
6	Bank Fees	(1,338)	21	6
7	Late Charges	(528)	21	7
8	Non-Allowable Out of State Seminar	(3,339)	24	8
9		(19,180)	30	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(565,343)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(539,093)	0	0	0	0	0	0	0	0	0	0	(539,093)	19
20	Fees, Subscriptions & Promotions	(34,509)	0	0	0	0	0	0	0	0	0	0	(34,509)	20
21	Clerical & General Office Expenses	(50,731)	0	0	0	0	0	0	0	0	0	0	(50,731)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,339)	0	0	0	0	0	0	0	0	0	0	(3,339)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(627,672)	0	0	0	0	0	0	0	0	0	0	(627,672)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(627,672)	0	0	0	0	0	0	0	0	0	0	(627,672)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(47,022)	0	0	0	0	0	0	0	0	0	0	(47,022)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(47,022)	0	0	0	0	0	0	0	0	0	0	(47,022)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(674,694)	0	0	0	0	0	0	0	0	0	0	(674,694)	45

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

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 [X] 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Donald Blivas	22.24%						1
2	Pauline Lightfoot	5.04%						2
3	Stuart Love	2.64%						3
4	William G. Love	5.27%						4
5	Doris L. Zollar Revocable Trust	21.08%						5
6	Estate of David Markle	33.19%						6
7	Erin Miller	2.34%						7
8	Alison Miller	2.34%						8
9	Clarence R. English	0.25%						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 Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Pamela Markle	Relative	CEO	0.00	None	50	100.00	Salary	$ 284,343	17-1	1
2	Theodore Schaetzle, IV	Relative	Dir. Of Special Pro	0.00	None	33	100.00	Salary	65,065	21-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 349,408		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 Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] 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 Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,005)	10
11	Interest - Employee Loan		X								(18)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,023)	14
15	TOTALS (line 9+line14)						$	$			$ (7,023)	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 Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 372,001	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.)		$ 333,197	2
3. Under or (over) accrual (line 2 minus line 1).		$ (38,804)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 333,204	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 294,400	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	225,609	8
	2016	234,540	9
	2017	317,266	10
	2018	322,615	11
	2019	333,197	12

2020 Accrual based on tax bill -$333,197 accrual estimated at $333,204

	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 Childrens Habilitation Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0018424

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 940-3269 FAX #: (847) 964-5469

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.	219-18-217-044-000	Long Term Care Property	$ 188.82	$ 188.82
2.	219-18-217-045-000	Long Term Care Property	$ 329,187.37	$ 329,187.37
3.	219-18-217-046-000	Long Term Care Property	$ 3,820.96	$ 3,820.96
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 333,197.15	$ 333,197.15

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,000 B. General Construction Type: Exterior Brick Frame Cinder Block Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (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 [ ] (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? [X] YES [ ] 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: 8,571
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	46,186	1971	$ 58,845	1
2					2
3	TOTALS	46,186		$ 58,845	3

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	67		1973	1973	$ 818,025	$	35	$	$	$ 818,025	4
5			1974	1974	3,368		35			3,368	5
6			1978	1978	1,701		35			1,701	6
7			1979	1979	1,425		35			1,425	7
8			1980	1980	4,255		35			4,255	8
	Improvement Type**										
9	Various			1988	4,961		20			4,961	9
10	Various			1989	39,620		20			39,620	10
11	Various			1990	87,762		20			87,762	11
12	Various			1991	3,429		20			3,429	12
13	Various			1993	26,119		20			26,119	13
14	Various			1994	20,166		20			20,166	14
15	Various			1995	159,072		20			159,072	15
16	Various			1996	8,175		20			8,175	16
17	Various			1997	20,753		20			20,753	17
18	Various			1998	65,828		20			65,828	18
19	Various			1999	5,438		20			5,438	19
20	Various			2000	1,399		20			1,399	20
21	Various			2001	9,450		20			9,450	21
22	Various			2002	2,000		20			2,000	22
23	Various			2003	71,216		20			71,216	23
24	Various			2005	4,842		20	115	115	4,289	24
25	Various			2007	4,459		20			4,459	25
26	Various			2008	96,118		20	2,465	2,465	31,218	26
27	Various			2009	14,685		20			14,685	27
28	Various			2012	85,028		20	2,064	2,064	21,901	28
29	Various			2014	31,668		20	1,583	1,583	10,556	29
30	Various			2015	3,489		20	174	174	916	30
31	Various			2016	3,155		20			3,154	31
32											32
33											33
34											34
35											35
36	Current Book Depreciation					141,843					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 Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Repaired Concrete Work by South Side of Building/Permit Fees	2017	$ 4,130	$	20	$ 207	$ 207	$ 723	37
38	Repaired Parking Lot Asphualt Pavement	2017	5,800		20	290	290	967	38
39	Installed Carpet in Common Areas	2017	3,929		20	196	196	785	39
40	AMS Mechanical Systems (Building Electric)	2018	38,265		20	1,913	1,913	3,986	40
41	Budget Bob Concrete & Custom Design	2018	7,700		20	35	35	1,091	41
42	Eagle Security Cameras (Interior and Exterior Building)	2018	54,998		20	2,750	2,750	5,729	42
43	Brand Lighting (Entire Building)	2018	76,864		20	3,843	3,843	8,007	43
44	Integrated Health Systems (Wiring Building)	2018	23,106		20	1,155	1,155	3,466	44
45	New Image Sign - Front Entrance	2018	21,941		20	1,097	1,097	2,377	45
46	Semcor Lighting (signage)	2018	9,944		20	497	497	994	46
47	Triple R Electric Wiring (Exterior)	2018	2,535		20	127	127	359	47
48	Signage (Exterior)	2018	19,150		20	958	958	2,075	48
49	Roof Repair	2018	2,890		20	145	145	422	49
50	Cut and Replace Drain in RM 105	2018	2,505		20	125	125	312	50
51	Semcor Lighting (signage)	2019	9,944		20	497	497	944	51
52	Eagle Security Cameras (Interior and Exterior Building)	2019	16,430		20	822	822	1,164	52
53	New Image Technologies Facility Wallcoverings Windos and Door	2019	14,595		20	730	730	973	53
54	IE Brand Facility Wall Coverings Common Area/Nurses Stations	2019	13,345		20	667	667	1,001	54
55	AMC Electric Co. Electric Panel Updgrade	2020	32,000		20	1,600	1,600	1,600	55
56	D. Anderson Contracting - Parking Lot Repairs	2020	16,000		20	133	133	133	56
57	Winchester House Acquisition	2020	1,000		20				57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,974,677	$ 141,843		$ 24,187	$ 24,187	$ 1,482,448	70

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

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,094,624	$	$ 82,328	$ 82,328	5	$ 1,904,574	71
72	Current Year Purchases	68,926		7,486	7,486	5	7,486	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,163,550	$	$ 89,814	$ 89,814		$ 1,912,060	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		Chevy 4500 Bus	2009	$ 106,252	$	$	$	5	$ 106,252	76
77										77
78										78
79										79
80	TOTALS			$ 106,252	$	$	$		$ 106,252	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,303,324	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 141,843	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 114,001	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,842)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,500,760	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	LEGAT Architect Fees	$ 157,159	92
93			93
94			94
95		$ 157,159	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 Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage/Parking Lot				12,174			5
6								6
7	TOTAL				$ 12,174 **			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: $ 17,186 Description: Copy Machines
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-1	hrs	$ 36,351		$	$		$ 36,351	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	26,405					26,405	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	243,869					243,869	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				34,505		34,505	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education	15-1	hrs	440,001					440,001	11
12	Other (specify): Med Supply/Lab/O2	39-2/39-3				153,520	156,587		310,107	12
13	Other (specify): Respiratory Therapy	39-1		1,186,916					1,186,916	13
14	TOTAL			$ 1,933,542		$ 153,520	$ 191,092		$ 2,278,154	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.

STATE OF ILLINOIS

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,190,789	$	1
2	Cash-Patient Deposits	103,949		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (35,000))	1,761,284		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,915		6
7	Other Prepaid Expenses	57,324		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposit on Fixed Assets	82,551		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,218,812	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	58,845		13
14	Buildings, at Historical Cost	1,949,749		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,197,484		16
17	Accumulated Depreciation (book methods)	(3,321,920)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(29,536)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	157,159		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,011,781	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,230,593	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 252,478	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	103,949		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	797,452		30
31	Accrued Taxes Payable (excluding real estate taxes)	66,461		31
32	Accrued Real Estate Taxes(Sch.IX-B)	333,204		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Exp./Audit Fee/Due HFS	1,122,625		36
37	Due HFS	90,778		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,766,947	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,766,947	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,463,646	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,230,593	$	48

*(See instructions.)

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,051,820	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,051,820	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,755,828	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	(1,344,002)	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)**	$ 1,411,826	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)**	$ 5,463,646	24 *

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

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,075,972	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,075,972	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	76,631	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 76,631	8
	C. Other Operating Revenue		
9	Payments for Education	2,399,680	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,425	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,401,105	23
	D. Non-Operating Revenue		
24	Contributions	9,400	24
25	Interest and Other Investment Income***	7,023	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,423	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	HFS CARES FUNDING/EARLY INTERVENTION	398,931	28
28a	Misc./Garnishment Income ADJ P.5- Early Intervention	2,190	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 401,121	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,971,252	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,506,480	31
32	Health Care	7,391,745	32
33	General Administration	3,827,994	33
	B. Capital Expense		
34	Ownership	474,174	34
	C. Ancillary Expense		
35	Special Cost Centers	1,838,153	35
36	Provider Participation Fee	176,878	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,215,424	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,755,828	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,755,828	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 15,075,972	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,075,972	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,437	2,744	$ 158,409	$ 57.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,110	15,890	606,017	38.14	3
4	Licensed Practical Nurses	46,243	52,080	1,673,182	32.13	4
5	CNAs & Orderlies	127,011	143,044	2,621,479	18.33	5
6	CNA Trainees					6
7	Licensed Therapist	40,908	45,448	1,493,541	32.86	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	958	1,056	55,820	52.86	10
11	Social Service Workers	8,134	9,037	106,643	11.80	11
12	Dietician	1,751	2,080	75,540	36.32	12
13	Food Service Supervisor					13
14	Head Cook	679	806	12,728	15.79	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,982	4,617	137,111	29.70	17
18	Housekeepers	8,449	9,131	183,397	20.09	18
19	Laundry	10,682	12,479	214,265	17.17	19
20	Administrator	1,938	2,080	284,343	136.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,951	17,123	561,642	32.80	24
25	Vocational Instruction					25
26	Academic Instruction	9,899	10,776	440,001	40.83	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,953	2,097	44,961	21.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	299,085	330,488	$ 8,669,079 *	$ 26.23	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	608	$ 23,865	1-3	35
36	Medical Director	Monthly	36,431	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	10	500	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	422	29,558	10A-3	41
42	Respiratory Therapy Consultant	1,535	79,393	39-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Education Consultant	Monthly	10,276	15-3	47
48					48
49	TOTAL (lines 35 - 48)	2,575	$ 180,023		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,883	$ 103,174	10-3	50
51	Licensed Practical Nurses	378	19,814	10-3	51
52	Certified Nurse Assistants/Aides	12,776	373,867	10-3	52
53	TOTAL (lines 50 - 52)	15,037	$ 496,855		53

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pamela Markle	CEO/Administrator	0.00	$ 284,343
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 284,343

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
Management Performance Associates	Compliance	$ 78,000
Legat	Architect/Compliance	92,822
I-Solved	Payroll	20,929
Duane Morris	Legal	334,742
Greenberg Traurig	Legal	229,115
FGMK	Audit/Consulting	132,422
PSM, LLC	IT Services	53,387
Websense Technologies	Technology Services	7,938
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 949,355

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 152,870
Unemployment Compensation Insurance	61,442
FICA Taxes	614,968
Employee Health Insurance	346,911
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	8,589
Dental Insurance	9,095
401K Match	8,738
COVID-19 FMLA	6,547
Life Insurance AD&D	2,920
Pension	85,229
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,297,309

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	$
Advertising: Employee Recruitment	46,555
Health Care Worker Background Check	
(Indicate # of checks performed 426)	4,259
Patient Background Checks	
Licenses & Support	6,925
Subscriptions	1,755
Dues, Licenses & Fees	11,997
Advertising & Marketing	34,509
Less: Public Relations Expense	( )
Non-allowable advertising	(34,509)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 71,491

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,228
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,228

* Attach copy of IMRF notifications

**See instructions.

Children's Habilitation Center
0018424
Legal Schedule
1/1/2020-12/31/2020

DATE	G/L ACCT. #	PAYEE/VENDOR	Type of Services Provided	AMOUNT	ADJ	Allowable
03/06/2020	680.21	DUANE MORRIS LLP	LEGAL	17,962.65	-17,962.65	0.00
03/06/2020	680.21	DUANE MORRIS LLP	LEGAL	14,563.65	-14,563.65	0.00
04/30/2020	680.21	DUANE MORRIS LLP	LEGAL	5,571.00	-5,571.00	0.00
04/30/2020	680.21	DUANE MORRIS LLP	LEGAL	37,674.96	-37,674.96	0.00
05/18/2020	680.21	DUANE MORRIS LLP	LEGAL	153.00	-153.00	0.00
05/18/2020	680.21	DUANE MORRIS LLP	LEGAL	6,064.65	-6,064.65	0.00
06/01/2020	680.21	DUANE MORRIS LLP	LEGAL	14,293.35	-14,293.35	0.00
06/04/2020	680.21	DUANE MORRIS LLP	LEGAL	29,971.35	-29,971.35	0.00
06/05/2020	680.21	DUANE MORRIS LLP	LEGAL	3,194.55	-3,194.55	0.00
07/08/2020	680.21	DUANE MORRIS LLP	LEGAL	5,511.60	-5,511.60	0.00
07/08/2020	680.21	DUANE MORRIS LLP	LEGAL	17,260.65	-17,260.65	0.00
08/01/2020	680.21	DUANE MORRIS LLP	LEGAL	23,449.95	-23,449.95	0.00
10/01/2020	680.21	DUANE MORRIS LLP	LEGAL	13,494.15	-13,494.15	0.00
10/16/2020	680.21	DUANE MORRIS LLP	LEGAL	14,139.90	-14,139.90	0.00
10/16/2020	680.21	DUANE MORRIS LLP	LEGAL	10,077.75	-10,077.75	0.00
10/16/2020	680.21	DUANE MORRIS LLP	LEGAL	15,128.55	-15,128.55	0.00
10/16/2020	680.21	DUANE MORRIS LLP	LEGAL	15,315.75	-15,315.75	0.00
10/16/2020	680.21	DUANE MORRIS LLP	LEGAL	7,733.25	-7,733.25	0.00
11/13/2020	680.21	DUANE MORRIS LLP	LEGAL	6,570.90	-6,570.90	0.00
11/13/2020	680.21	DUANE MORRIS LLP	LEGAL	18,887.92	-18,887.92	0.00
12/10/2020	680.21	DUANE MORRIS LLP	LEGAL	18,026.10	-18,026.10	0.00
12/10/2020	680.21	DUANE MORRIS LLP	LEGAL	20,003.40	-20,003.40	0.00
01/14/2021	680.21	DUANE MORRIS LLP	LEGAL	4,373.10	-4,373.10	0.00
01/14/2021	680.21	DUANE MORRIS LLP	LEGAL	15,318.80	-15,318.80	0.00
01/30/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	-5,000.00	5,000.00	0.00
02/07/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	7,188.64	-7,188.64	0.00
02/07/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	15,706.50	-15,706.50	0.00
03/12/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	3,999.00	-3,999.00	0.00
03/12/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	4,733.35	0.00	4,733.35
06/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	522.45	0.00	522.45
06/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	8,183.78	0.00	8,183.78
06/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	1,161.00	-1,161.00	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	3,008.50	0.00	3,008.50
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	7,789.66	0.00	7,789.66
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	525.60	0.00	525.60
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	2,854.80	-2,854.80	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	3,057.30	-3,057.30	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	1,044.90	-1,044.90	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	3,469.05	-3,469.05	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	2,537.07	-2,537.07	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	10,453.12	-10,453.12	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	1,949.40	-1,949.40	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	1,686.60	-1,686.60	0.00
10/09/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	23,555.39	-23,555.39	0.00
10/09/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	805.95	-805.95	0.00
10/09/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	1,164.15	-1,164.15	0.00
11/10/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	24,173.03	-24,173.03	0.00
11/09/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	2,475.45	-2,475.45	0.00
11/10/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	8,799.30	-8,799.30	0.00
12/07/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	3,772.80	-3,772.80	0.00
12/04/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	6,609.60	-6,609.60	0.00
01/07/2021	680.21	GREENBERG TRAURIG, LLP	LEGAL	262.50	-262.50	0.00
01/07/2021	680.21	GREENBERG TRAURIG, LLP	LEGAL	25,337.50	-25,337.50	0.00
03/31/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	5,885.50	-5,885.50	0.00
06/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	1,655.10	-1,655.10	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	24,369.39	-24,369.39	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	4,815.90	-4,815.90	0.00
10/01/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	4,259.50	-4,259.50	0.00
10/09/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	4,896.00	-4,896.00	0.00
12/04/2020	680.21	GREENBERG TRAURIG, LLP	LEGAL	11,407.50	-11,407.50	0.00
Total				**563,856.21**	**-539,092.87**	**24,763.34**

Children's Habilitation Center
0018424
Seminar Schedule
1/1/2020-12/31/2020

DATE	PAYEE	TOPIC	ATTENDEE	3 DESCRIPTI	CITY/STATE	FEE	Out ofState
03/02/20	First Merchant Corporations	Labor Conference	Annette Murray	DON	Fort Lauderdale, FL	1,654.46	$1,654.46
03/02/20	First Merchant Corporations	Labor Conference	Jessica Meyers-Hamer	HR	Fort Lauderdale, FL	1,684.46	$1,684.46
02/03/20	First Merchant Corporations	MicroSof Access Online Seminar	Jennie Shan-Martin	Controller	Harvey, IL	299.00	
07/24/20	Elio Padilla	NFPA Online Training	Elio Padilla	Building Engin	Harvey, IL	54.95	
01/23/20	New Shining Light	CHC Newly Hired Employees Orientation/Training	New Employees	Various	Harvey, IL	250.00	
11/03/20	New Shining Light	CHC Newly Hired Employees Orientation/Training	New Employees	Various	Harvey, IL	250.00	
11/16/20	New Shining Light	CHC Newly Hired Employees Orientation/Training	New Employees	Various	Harvey, IL	250.00	
12/15/20	New Shining Light	CHC Newly Hired Employees Orientation/Training	New Employees	Various	Harvey, IL	125.00	
Total						4,567.87	3,338.92

Out of State Seminar Expenses	3,338.92	ADJ
In-State Seminar Expenses	1,228.95	
Total	4,567.87	

Facility Name & ID Number Childrens Habilitation Ctr # 0018424 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $2189**

(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? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **51,080** 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. $ **176,878**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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? **Yes**
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? **Yes**
Firm Name: **FGMK, LLC**

(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.