

		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.

<p>I. IDPH License ID Number: <u>0052589</u></p> <p>Facility Name: <u>Elmhurst Extended Care Ctr</u></p> <p>Address: <u>200 East Lake Street</u> <u>Elmhurst</u> <u>60126</u> Number City Zip Code</p> <p>County: <u>DuPage</u></p> <p>Telephone Number: <u>(630) 516-5000</u> Fax # <u>(630) 834-0480</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/1/2014</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Andrew B. Cutler</u> Telephone Number: <u>(847) 940-3269</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director, Healthcare</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u> (Telephone) <u>(847) 940-3269</u> Fax # <u>(847) 964-5469</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director, Healthcare</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u> (Telephone) <u>(847) 940-3269</u> Fax # <u>(847) 964-5469</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input checked="" type="checkbox"/> "Sub-S" Corp.																												
	<input type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____																												
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director, Healthcare</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u> (Telephone) <u>(847) 940-3269</u> Fax # <u>(847) 964-5469</u>																												

Facility Name & ID Number Elmhurst Extended Care Ctr

0052589 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	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	108	TOTALS	108	39,528	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,775	468	3,599	5,842	8
9	SNF/PED					9
10	ICF	1,916	10,305		12,221	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,691	10,773	3,599	18,063	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.70%

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

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

I. On what date did you start providing long term care at this location?
Date started 12/31/2013

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/31/2013 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 108 and days of care provided 2,427

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL 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 Elmhurst Extended Care Ctr # 0052589 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	322,440	39,654		362,094		362,094	(4,163)	357,931		1
2	Food Purchase		151,279		151,279		151,279		151,279		2
3	Housekeeping	108,600	21,085		129,685		129,685		129,685		3
4	Laundry	42,181	1,756		43,937		43,937		43,937		4
5	Heat and Other Utilities			92,861	92,861		92,861		92,861		5
6	Maintenance	80,600		71,010	151,610		151,610	79,195	230,805		6
7	Other (specify):*										7
8	TOTAL General Services	553,821	213,774	163,871	931,466		931,466	75,032	1,006,498		8
	B. Health Care and Programs										
9	Medical Director			53,100	53,100		53,100		53,100		9
10	Nursing and Medical Records	2,035,048	171,093	185,906	2,392,047		2,392,047		2,392,047		10
10a	Therapy		410	65,367	65,777		65,777		65,777		10a
11	Activities	124,537	201	19,632	144,370		144,370		144,370		11
12	Social Services	50,424		1,645	52,069		52,069		52,069		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,210,009	171,704	325,650	2,707,363		2,707,363		2,707,363		16
	C. General Administration										
17	Administrative	185,870			185,870		185,870		185,870		17
18	Directors Fees										18
19	Professional Services			61,639	61,639		61,639	(10,598)	51,041		19
20	Dues, Fees, Subscriptions & Promotions			30,130	30,130		30,130	(12,949)	17,181		20
21	Clerical & General Office Expenses	204,134	6,769	156,298	367,201		367,201	(101,518)	265,683		21
22	Employee Benefits & Payroll Taxes			385,433	385,433		385,433		385,433		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,218	5,218		5,218		5,218		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			90,541	90,541		90,541	35,482	126,023		26
27	Other (specify):*										27
28	TOTAL General Administration	390,004	6,769	729,259	1,126,032		1,126,032	(89,583)	1,036,449		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,153,834	392,247	1,218,780	4,764,861		4,764,861	(14,551)	4,750,310		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

Elmhurst Extended Care Ctr

#0052589

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			42,020	42,020		42,020	116,609	158,629			30
31	Amortization of Pre-Op. & Org.							8,367	8,367			31
32	Interest							244,352	244,352			32
33	Real Estate Taxes			54,000	54,000		54,000	7,107	61,107			33
34	Rent-Facility & Grounds			549,618	549,618		549,618	(546,000)	3,618			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			645,638	645,638		645,638	(169,565)	476,073			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,474	670,467	816,941		816,941		816,941			39
40	Barber and Beauty Shops			1,259	1,259		1,259	(1,217)	42			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,883	154,883		154,883		154,883			42
43	Other (specify):*	20,482		127	20,609		20,609		20,609			43
44	TOTAL Special Cost Centers	20,482	146,474	826,736	993,692		993,692	(1,217)	992,475			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,174,316	538,721	2,691,154	6,404,191		6,404,191	(185,333)	6,218,858			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 Elmhurst Extended Care Ctr

0052589

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	3,479	30		9
10	Interest and Other Investment Income	(739)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,348)	21		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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(103,019)	21		24
25	Fund Raising, Advertising and Promotional	(10,515)	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	(32,781)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (147,923)		\$	30

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	2	
		Amount	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (147,923)		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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

Elmhurst Extended Care Ctr

ID# 0052589

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Vending Income Offset	\$ (4,163)	1	1
2	Non-Allowable Barber & Beauty Income Offset	(1,217)	40	2
3	Bank Charges	(11,551)	21	3
4	Misc. Income Offset	207	21	4
5	Non-Allowable Legal	(10,598)	19	5
6	Offset Non-Allowable Lobbying Exp. - IHCA	(2,434)	20	6
7	Capitalized R&M	(3,025)	6	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(32,781)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmhurst Extended Care Ctr

0052589

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(4,163)	0	0	0	0	0	0	0	0	0	0	(4,163)	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	(3,025)	82,220	0	0	0	0	0	0	0	0	0	79,195	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,188)	82,220	0	0	0	0	0	0	0	0	0	75,032	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	(10,598)	0	0	0	0	0	0	0	0	0	0	(10,598)	19
20	Fees, Subscriptions & Promotions	(12,949)	0	0	0	0	0	0	0	0	0	0	(12,949)	20
21	Clerical & General Office Expenses	(118,711)	17,193	0	0	0	0	0	0	0	0	0	(101,518)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	35,482	0	0	0	0	0	0	0	0	0	35,482	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(142,258)	52,675	0	0	0	0	0	0	0	0	0	(89,583)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(149,446)	134,895	0	0	0	0	0	0	0	0	0	(14,551)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmhurst Extended Care Ctr# 0052589

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	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	3,479	113,130	0	0	0	0	0	0	0	0	0	116,609	30
31	Amortization of Pre-Op. & Org.	0	8,367	0	0	0	0	0	0	0	0	0	8,367	31
32	Interest	(739)	245,091	0	0	0	0	0	0	0	0	0	244,352	32
33	Real Estate Taxes	0	7,107	0	0	0	0	0	0	0	0	0	7,107	33
34	Rent-Facility & Grounds	0	(546,000)	0	0	0	0	0	0	0	0	0	(546,000)	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	2,740	(172,305)	0	0	0	0	0	0	0	0	0	(169,565)	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	(1,217)	0	0	0	0	0	0	0	0	0	0	(1,217)	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	(1,217)	0	0	0	0	0	0	0	0	0	0	(1,217)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(147,923)	(37,410)	0	0	0	0	0	0	0	0	0	(185,333)	45

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
Love Dave	15%			LKNY, LLC		Bldg. Ptrshp.
Madhusudan Dave	60%					
Dipti Dave	25%					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 546,000	LKNY, LLC		\$	(546,000)	1
2	V	30 Depreciation Expense		LKNY, LLC		113,130	113,130	2
3	V	31 Amortization Expense		LKNY, LLC		8,367	8,367	3
4	V	32 Mortgage Interest		LKNY, LLC		245,091	245,091	4
5	V	33 Real Estate Tax Expense	54,000	LKNY, LLC		61,107	7,107	5
6	V	21 Professional Fees		LKNY, LLC		17,193	17,193	6
7	V	26 Mortgage Insurance		LKNY, LLC		35,482	35,482	7
8	V	6 Contracts - Professional Fees		LKNY, LLC		82,220	82,220	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 600,000			\$ 562,590	\$ * (37,410)	14

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

Facility Name & ID Number

Elmhurst Extended Care Ctr

0052589

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								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

Elmhurst Extended Care Ctr

0052589

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Love Dave	Owner	Administrative	15.00	None	40	100.00	Salary	\$ 97,332	17-1	1
2	Madhusudan Dave	Owner	Administrative	60.00	None	40	100.00	Salary	97,269	21-1	2
3	Dipti Dave	Owner	Bookkeeping	25.00	None	40	100.00	Salary	71,455	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 266,056		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 Elmhurst Extended Care Ctr

0052589

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

Elmhurst Extended Care Ctr

0052589

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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					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	HUD		X	Mortgage			\$ 5,570,336	\$ 5,477,557			\$ 245,091	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 5,570,336	\$ 5,477,557			\$ 245,091	9					
B. Non-Facility Related*																	
10	Interest Income		X								(739)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (739)	14					
15	TOTALS (line 9+line14)						\$ 5,570,336	\$ 5,477,557			\$ 244,352	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 35,482 Line # 26

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.		\$			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.)		\$	61,107		2
3. Under or (over) accrual (line 2 minus line 1).		\$	61,107		3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			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.		\$	61,107		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	48,281			8
	2016	48,844			9
	2017	58,818			10
	2018	59,846			11
	2019	61,107			12
No real estate tax accrual, as provider pays real estate tax as part of rent, and rent expense is fixed there no accrual is required.					
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 Elmhurst Extended Care Ctr COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0052589

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-36-309-043</u>	<u>Long Term Care Property</u>	\$ <u>61,106.86</u>	\$ <u>61,106.86</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>61,106.86</u></u>	\$ <u><u>61,106.86</u></u>

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 Elmhurst Extended Care Ctr

0052589 Report Period Beginning:

1/1/2020 Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,019 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 NO
If so, please complete the following:

1. Total Amount Incurred: 249,743 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 8,367 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Residential Care</u>	<u>41,851</u>	<u>2013</u>	<u>\$ 92,016</u>	<u>1</u>
2	<u>Parking Lot</u>		<u>2013</u>	<u>6,950</u>	<u>2</u>
3	TOTALS	41,851		\$ 98,966	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	108	2013		\$ 2,860,030	\$	27	\$ 105,927	\$ 105,927	\$ 683,268	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2014	84,438		20	4,221	4,221	26,468	9
10	Various		2015	99,493		20	8,377	8,377	45,413	10
11	Various		2016	20,450		20	1,023	1,023	4,091	11
12	Room renovations 2 East Flooring, painting		2017	23,095		5	4,619	4,619	15,397	12
13	Water Shut Off Valve Replacement		2017	2,900		20	145	145	495	13
14	Elevator Clutch Replacment Front/Rear Doors		2017	3,692		20	185	185	601	14
15	Elevator Pump Motor Replacement		2017	3,136		20	157	157	497	15
16	2 East Renovations - Patient rooms, Painting, Flooring, Lighting		2018	22,536		20	1,127	1,127	2,817	16
17	Elevator Repair Platform		2019	7,058		20	353	353	588	17
18	Replace 4" Drain Pipe - Plumbing Near Elevator		2020	3,025		20	101	101	101	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	Book Depreciation						155,150			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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,129,853	\$ 155,150		\$ 126,235	\$ 126,235	\$ 779,736	70

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

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	\$ 225,915	\$	\$ 32,394	\$ 32,394	5-7	\$ 137,184	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	2,434,581					2,434,581	73
74								74
75	TOTALS	\$ 2,660,496	\$	\$ 32,394	\$ 32,394		\$ 2,571,765	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,889,315	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 155,150	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 158,629	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,479	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,351,501	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	Construction in Progress	\$ 274,624	92
93			93
94			94
95		\$ 274,624	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 Elmhurst Extended Care Ctr

0052589

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	Office Storage Rental				3,618			5
6								6
7	TOTAL				\$ 3,618			7

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 \$ _____

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: _____ *

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: \$ 0 Description: N/A

(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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs				\$ 256,858				\$ 256,858	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				118,523				118,523	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				267,466				267,466	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescrpts					146,474			146,474	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Lab & X-Ray</u>	39-3					27,620				27,620	12
13	Other (specify):											13
14	TOTAL				\$		\$ 670,467	\$ 146,474		\$	816,941	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 Elmhurst Extended Care Ctr

0052589

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,232,483	\$ 2,378,767	1
2	Cash-Patient Deposits	980	980	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (10,214))	222,449	222,449	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,538	5,538	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,000	476,756	8
9	Other(specify): See Attached		267,866	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,464,450	\$ 3,352,356	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		493,227	13
14	Buildings, at Historical Cost		2,486,821	14
15	Leasehold Improvements, at Historical Cost	204,444	577,653	15
16	Equipment, at Historical Cost	162,009	2,660,134	16
17	Accumulated Depreciation (book methods)	(216,532)	(3,442,664)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 149,921	\$ 2,775,171	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,614,371	\$ 6,127,527	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 103,429	\$ 103,429	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		96,833	29
30	Accrued Salaries Payable	222,947	222,947	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,422	18,422	31
32	Accrued Real Estate Taxes(Sch.IX-B)		50,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached	518,625	518,625	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 863,423	\$ 1,010,256	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	790,817	790,817	39
40	Mortgage Payable		5,477,557	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached		(336,240)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 790,817	\$ 5,932,134	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,654,240	\$ 6,942,390	46
47	TOTAL EQUITY(page 18, line 24)	\$ 960,131	\$ (814,863)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,614,371	\$ 6,127,527	48

*(See instructions.)

Elmhurst Extended Care Center
0052589
Page 17 Supplemental
1/1/2020 - 12/31/2020

A. Current Assets	Operating	After Consolidation
9 HUD Escrow	-	46,321
Replacement Reserve	-	152,953
Other Reserves	-	68,592
	<u>-</u>	<u>267,866</u>
B. Long-Term Assets		
	Amount	
23	-	-
	<u>-</u>	<u>-</u>
	<u>-</u>	<u>-</u>
Other Current Liabilities		
	Amount	
36 Due to LKNY	473,756	473,756
Overpayment BCBS	44,869	44,869
	<u>518,625</u>	<u>518,625</u>
Other Long-Term Liabilities		
	Amount	
43 HUD Loan Offset S	-	(96,833)
Mortgage Loan Fee	-	(239,407)
	<u>-</u>	<u>(336,240)</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 618,602	1
2	Restatements (describe):		2
3	<u>Rounding</u>	<u>2</u>	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 618,604	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	381,458	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	(39,931)	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)	\$ 341,527	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)	\$ 960,131	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elmhurst Extended Care Ctr

0052589

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.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,178,755	1
2	Discounts and Allowances for all Levels	(3,377,692)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,801,063	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,986,741	6
7	Oxygen	11,732	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,998,473	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	1,217	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	141,659	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,615	19
20	Radiology and X-Ray	7,315	20
21	Other Medical Services	89,787	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 258,593	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	739	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 739	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other Income</u>	20,224	28
28a	<u>HHS PRF</u>	706,557	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 726,781	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,785,649	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	931,466	31
32	Health Care	2,707,363	32
33	General Administration	1,126,032	33
B. Capital Expense			
34	Ownership	645,638	34
C. Ancillary Expense			
35	Special Cost Centers	838,809	35
36	Provider Participation Fee	154,883	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,404,191	40
41	Income before Income Taxes (line 30 minus line 40)**	381,458	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 381,458	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 534,130	44
45	Private Pay - Net Inpatient Revenue	2,962,301	45
46	Medicare - Net Inpatient Revenue	257,978	46
47	Other-(specify) <u>Hospice</u>	33,197	47
48	Other-(specify) <u>Insurance</u>	13,457	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,801,063	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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 Elmhurst Extended Care Ctr

0052589

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,720	2,872	\$ 141,894	\$ 49.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,254	14,902	453,811	30.45	3
4	Licensed Practical Nurses	14,771	16,263	458,373	28.19	4
5	CNAs & Orderlies	59,214	65,075	916,568	14.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,032	2,256	67,672	30.00	9
10	Activity Assistants	2,934	3,869	56,865	14.70	10
11	Social Service Workers	1,517	1,645	50,424	30.65	11
12	Dietician	2,056	2,232	78,098	34.99	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,102	12,235	173,881	14.21	15
16	Dishwashers	5,233	5,433	70,461	12.97	16
17	Maintenance Workers	2,201	2,473	80,600	32.59	17
18	Housekeepers	4,291	5,020	108,600	21.63	18
19	Laundry	2,241	2,498	42,181	16.89	19
20	Administrator	2,088	2,280	97,332	42.69	20
21	Assistant Administrator	2,080	2,240	88,538	39.53	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,864	6,602	204,134	30.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,952	3,952	64,402	16.30	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	568	568	20,482	36.06	33
34	TOTAL (lines 1 - 33)	139,118	152,415	\$ 3,174,316 *	\$ 20.83	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	53,100	10-3	36
37	Medical Records Consultant	20	1,170	10-3	37
38	Nurse Consultant	38	4,128	10-3	38
39	Pharmacist Consultant	Monthly	4,173	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,118	11-3	44
45	Social Service Consultant	29	1,645	12-3	45
46	Other(specify)				46
47	<u>Point Click Care (EHR)</u>	Monthly	61,299	10-3	47
48					48
49	TOTAL (lines 35 - 48)	107	\$ 126,633		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	274	\$ 12,892	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	4,260	102,244	10-3	52
53	TOTAL (lines 50 - 52)	4,534	\$ 115,136		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Love Dave	Administrator	15%	\$ 97,333	Workers' Compensation Insurance	\$ 44,803	IDPH License Fee	\$ 3,980		
Jayne Maher	Asst. Administrator	0	88,538	Unemployment Compensation Insurance	11,486	Advertising: Employee Recruitment	4,282		
				FICA Taxes	242,370	Health Care Worker Background Check (Indicate # of checks performed <u>38</u>)	380		
				Employee Health Insurance	72,186	Patient Background Checks	1,710		
				Employee Meals		Marketing	10,515		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	5,749		
				401 K Match	14,045	COVID Dues	1,080		
				Employee Physicals	543				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 185,871	TOTAL (agree to Schedule V, line 22, col.8)		\$ 385,433	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,181
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	5,218	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 5,218
C. Professional Services									
Vendor/Payee	Type		Amount						
Talx	Unemployment Consultant		\$ 927						
FGMK, LLC	Accounting/Consulting		33,175						
Cantata Health LLC	Data Processing		2,828						
Aldrich Technology Solutions	Data Processing		13,138						
Keith Goldberg (ADJ P.5)	Legal		9,673						
MPRO	Legal		1,898						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 61,639						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Elmhurst Extended Care Ctr# 0052589Report Period Beginning: 1/1/2020Ending: 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 - \$5,749
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,309 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. \$ 154,883
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? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted 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. No
Attach invoices and a summary of services for all architect and appraisal fees.