

		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.

<p>I. IDPH License ID Number: <u>0056242</u></p> <p>Facility Name: <u>Fox River Rehab Healthcare</u></p> <p>Address: <u>2355 Royal Blvd</u> <u>Elgin</u> <u>60123</u> Number City Zip Code</p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>(847) 888-9585</u> Fax # <u>(847) 888-4173</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>2/1/2020</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" 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>	<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 type="checkbox"/> "Sub-S" Corp.			<input checked="" 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>2/1/2020</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"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David Trimble</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Vice President, Reimbursement</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>David Trimble</u>			(Title) <u>Vice President, Reimbursement</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Firm Name & Address) _____																																									
	(Telephone) <u>()</u> Fax # <u>()</u>																																									
<p>In the event there are further questions about this report, please contact: Name: <u>David Trimble</u> Telephone Number: <u>(813)675-2318</u> Email Address: _____</p>	<p>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>																																									

Facility Name & ID Number Fox River Rehab Healthcare

0056242 Report Period Beginning: 2/1/2020 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

	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	139	Skilled (SNF)	139	46,565	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	139	TOTALS	139	46,565	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,031	5,781	4,642	23,454	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,031	5,781	4,642	23,454	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.37%

D. How many bed reserve days during this year were paid by the Department?
N/A (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)
N/A

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 2/1/2020

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/2020 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 139 and days of care provided 3,640

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Fox River Rehab Healthcare # 0056242 Report Period Beginning: 2/1/2020 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	104,463	11,238	250,346	366,047		366,047	4,669	370,716		1
2	Food Purchase		192,988		192,988		192,988		192,988		2
3	Housekeeping		303	202,973	203,276		203,276		203,276		3
4	Laundry		8,815	90,574	99,389		99,389		99,389		4
5	Heat and Other Utilities			154,651	154,651		154,651	(14,131)	140,520		5
6	Maintenance	50,229	9,910	74,744	134,883		134,883	1,470	136,353		6
7	Other (specify):*										7
8	TOTAL General Services	154,692	223,254	773,288	1,151,234		1,151,234	(7,992)	1,143,242		8
	B. Health Care and Programs										
9	Medical Director			22,000	22,000		22,000		22,000		9
10	Nursing and Medical Records	2,138,124	521,560	129,649	2,789,333		2,789,333	96,701	2,886,034		10
10a	Therapy	5,044	228	447,283	452,555		452,555	(384,303)	68,252		10a
11	Activities	54,844	485	1,104	56,433		56,433		56,433		11
12	Social Services	30,426		2,379	32,805		32,805		32,805		12
13	CNA Training										13
14	Program Transportation			2,878	2,878		2,878		2,878		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,228,438	522,273	605,293	3,356,004		3,356,004	(287,602)	3,068,402		16
	C. General Administration										
17	Administrative	97,359		371,907	469,266		469,266	57,526	526,792		17
18	Directors Fees										18
19	Professional Services			11,660	11,660		11,660		11,660		19
20	Dues, Fees, Subscriptions & Promotions			11,748	11,748		11,748	(2,359)	9,389		20
21	Clerical & General Office Expenses	182,903	21,335	258,047	462,285		462,285	(125,074)	337,211		21
22	Employee Benefits & Payroll Taxes			444,857	444,857		444,857		444,857		22
23	Inservice Training & Education			1,173	1,173		1,173		1,173		23
24	Travel and Seminar			4,800	4,800		4,800		4,800		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			156,280	156,280		156,280		156,280		26
27	Other (specify):*										27
28	TOTAL General Administration	280,262	21,335	1,260,472	1,562,069		1,562,069	(69,907)	1,492,162		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,663,392	766,862	2,639,053	6,069,307		6,069,307	(365,501)	5,703,806		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

Fox River Rehab Healthcare

#0056242

Report Period Beginning:

2/1/2020

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							211,894	211,894			30
31	Amortization of Pre-Op. & Org.			226	226		226	(226)				31
32	Interest			134,371	134,371		134,371	620,631	755,002			32
33	Real Estate Taxes			143,227	143,227		143,227	(4,287)	138,940			33
34	Rent-Facility & Grounds			636,632	636,632		636,632	(622,603)	14,029			34
35	Rent-Equipment & Vehicles			10,615	10,615		10,615		10,615			35
36	Other (specify):*											36
37	TOTAL Ownership			925,071	925,071		925,071	205,409	1,130,480			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		145,544	20,308	165,852		165,852	386,822	552,674			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			186,127	186,127		186,127		186,127			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		145,544	206,435	351,979		351,979	386,822	738,801			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,663,392	912,406	3,770,559	7,346,357		7,346,357	226,730	7,573,087			45

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

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	(69)	1		4
5	Telephone, TV & Radio in Resident Rooms	(14,131)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,485)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(507)	21		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	(138,829)	21		24
25	Fund Raising, Advertising and Promotional	(2,359)	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	(4,767)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (162,147)		\$	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)	388,877		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 388,877		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 226,730		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

Fox River Rehab Healthcare

ID# 0056242

Report Period Beginning: 2/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Rev Other	\$ (254)	21	1
2	Amortization of Operating Rights	(226)	31	2
3	Real Estate Tax to Actual	(4,287)	33	3
4	Medicare Therapy Costs	386,822	39	4
5	Medicare Therapy Costs	(386,822)	10a	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
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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	(4,767)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fox River Rehab Healthcare# 0056242 Report Period Beginning:2/1/2020Ending: 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	(69)	4,738	0	0	0	0	0	0	0	0	0	4,669	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	(14,131)	0	0	0	0	0	0	0	0	0	0	(14,131)	5
6	Maintenance	0	1,470	0	0	0	0	0	0	0	0	0	1,470	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(14,200)	6,208	0	0	0	0	0	0	0	0	0	(7,992)	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	96,701	0	0	0	0	0	0	0	0	0	96,701	10
10a	Therapy	(386,822)	2,519	0	0	0	0	0	0	0	0	0	(384,303)	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	(386,822)	99,220	0	0	0	0	0	0	0	0	0	(287,602)	16
	C. General Administration													
17	Administrative	0	57,526	0	0	0	0	0	0	0	0	0	57,526	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,359)	0	0	0	0	0	0	0	0	0	0	(2,359)	20
21	Clerical & General Office Expenses	(139,590)	14,516	0	0	0	0	0	0	0	0	0	(125,074)	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	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	(141,949)	72,042	0	0	0	0	0	0	0	0	0	(69,907)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(542,971)	177,470	0	0	0	0	0	0	0	0	0	(365,501)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fox River Rehab Healthcare

0056242

Report Period Beginning:

2/1/2020

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	0	211,894	0	0	0	0	0	0	0	0	0	211,894	30
31	Amortization of Pre-Op. & Org.	(226)	0	0	0	0	0	0	0	0	0	0	(226)	31
32	Interest	(1,485)	622,116	0	0	0	0	0	0	0	0	0	620,631	32
33	Real Estate Taxes	(4,287)	0	0	0	0	0	0	0	0	0	0	(4,287)	33
34	Rent-Facility & Grounds	0	(622,603)	0	0	0	0	0	0	0	0	0	(622,603)	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	(5,998)	211,407	0	0	0	0	0	0	0	0	0	205,409	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	386,822	0	0	0	0	0	0	0	0	0	0	386,822	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	386,822	0	0	0	0	0	0	0	0	0	0	386,822	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(162,147)	388,877	0	0	0	0	0	0	0	0	0	226,730	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
NH Operator Holdings VII LLC	100	Edwardsville NH LLC	Edwardsville,IL	Wood River NH LLC	Wood River, IL	Supportive Living Facility
2355 Royal Blvd LLC	0	Rockford NH LLC	Rockford,IL	Springs of Lady Lake	Lady Lake,FL	Assisted Living Facility
Greystone Healthcare Management Corp	0	Moline NH LLC	Moline,IL	Greystone Home Health	Orlando, FL	Home Health
		St. Charles NH LLC	St. Charles,IL	Greystone Home Health	Sun City Center, FL	Home Health
		Inverness NH LLC	Inverness,IL	Greystone Home Health	Clearwater, FL	Home Health
		Northbrook NH LLC	Northbrook,IL	Greystone Home Health	The Villages, FL	Home Health
		See Page 6 - Supplemental	See Page 6 - Supplemental	See Page 6 - Supplemental	See Page 6 - Supplemental	See Page 6 - Supplemental

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	17	\$ 331,907	Greystone Healthcare Management Corp.	0.00%	\$ 346,823	\$ 14,916	1	
2	V	10		Greystone Healthcare Management Corp.	0.00%	94,788	94,788	2	
3	V	1		Greystone Healthcare Management Corp.	0.00%	4,173	4,173	3	
4	V	10a		Greystone Healthcare Management Corp.	0.00%	2,519	2,519	4	
5	V	34		Greystone Healthcare Management Corp.	0.00%	14,029	14,029	5	
6	V	34	636,632	2355 Royal Blvd LLC	0.00%		(636,632)	6	
7	V	32		2355 Royal Blvd LLC	0.00%	622,116	622,116	7	
8	V	30		2355 Royal Blvd LLC	0.00%	211,894	211,894	8	
9	V	17		2355 Royal Blvd LLC	0.00%	42,610	42,610	9	
10	V	1		2355 Royal Blvd LLC	0.00%	565	565	10	
11	V	6		2355 Royal Blvd LLC	0.00%	1,470	1,470	11	
12	V	10		2355 Royal Blvd LLC	0.00%	1,913	1,913	12	
13	V	21		2355 Royal Blvd LLC	0.00%	14,516	14,516	13	
14	Total		\$ 968,539			\$ 1,357,416	\$ *	388,877	14

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

Facility Name & ID Number

Fox River Rehab Healthcare

0056242

Report Period Beginning:

2/1/2020

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			Joliet NH LLC	Joliet,IL	Greystone Home Health	Daytona Beach, FL	Home Health	1
2			East Peoria NH LLC	East Peoria,IL	Solana Home Health A	Sarasota, FL	Home Health	2
3			Alton NH LLC	Alton,IL				3
4			Peoria NH LLC	Peoria,IL				4
5			St. Louis NH LLC	St. Louis,MO				5
6			Alhambra NH, L.L.C.	Saint Petersburg,FL				6
7			Greenbrook NH, L.L.C.	Saint Petersburg,FL				7
8			LP Orlando LLC	Apopka,FL				8
9			Carlton Shores NH LLC	Daytona Beach,FL				9
10			Greenbriar NH, L.L.C.	Bradeenton,FL				10
11			Isle Health NH LLC	Orange Park,FL				11
12			La Mer LLC	Miami,FL				12
13			Lady Lake NH, L.L.C.	Lady Lake,FL				13
14			Lehigh Acres NH LLC	Lehigh Acres,FL				14
15			Colonial Care NH, L.L.C.	Saint Petersburg,FL				15
16			Heritage NH, L.L.C.	North Miami Beach,FL				16
17			North Rehab NH, L.L.C.	Saint Petersburg,FL				17
18			The Oaks NH, L.L.C.	Gainesville,FL				18
19			Ridgecrest NH, L.L.C.	Deland,FL				19
20			Riverwood Health NH LLC	Starke,FL				20
21			Rockledge NH, L.L.C.	Rockledge,FL				21
22			Venice NH, L.L.C.	Venice,FL				22
23			Terrace Health NH LLC	Gainesville,FL				23
24			Mulberry Grove NH LLC	The Villages,FL				24
25			Gardens Health NH LLC	Daytona Beach,FL				25
26			Citrus Hills NH LLC	Hernando,FL				26
27			Innovative Medical Management Solutions LLC	Clermont,FL				27
28			New Horizon NH, L.L.C.	Ocala,FL				28
29			Ponce NH LLC	St. Augustine,FL				29
30			See PG6-Supp (2)	See PG6-Supp (2)				30

Facility Name & ID Number

Fox River Rehab Healthcare

0056242

Report Period Beginning:

2/1/2020

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			Jackson Heights NH, L.L.C.	Miami,FL				1
2			Viera NH LLC	Viera,FL				2
3			Villa Health NH LLC	Deland,FL				3
4			Village Place NH LLC	Port Charlotte,FL				4
5			Palm Court NH, L.L.C.	Wilton Manors,FL				5
6			Woodland Grove NH LLC	Jacksonville,FL				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

Fox River Rehab Healthcare

0056242

Report Period Beginning:

2/1/2020

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Fox River Rehab Healthcare

0056242

Report Period Beginning:

2/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Greystone Healthcare Management Corp

Street Address

4042 Park Oaks Blvd., Suite 300

City / State / Zip Code

Tampa, FL 33610

Phone Number

(813)675-2318

Fax Number

(813) 635-0008

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	10	Clinical Nursing	Accumulated Costs	462,711,567	43	\$ 6,254,384	\$ 7,012,578	\$ 94,788	1
2	1	Dietary	Accumulated Costs	465,656,695	44	277,112	7,012,578	4,173	2
3	10a	Ancillary	Accumulated Costs	460,282,346	42	165,316	7,012,578	2,519	3
4	34	Property	Accumulated Costs	481,058,730	50	962,398	7,012,578	14,029	4
5	17	Admin	Accumulated Costs	481,058,730	50	23,791,846	7,012,578	346,823	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					\$ 31,451,056	\$	\$ 462,332	25

Facility Name & ID Number

Fox River Rehab Healthcare

0056242

Report Period Beginning:

2/1/2020

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	Mizuho Capital Markets LLC		X	Mortgage		2/1/2020	\$ 9,630,404	\$ 9,630,404	2/1/2045	0.0700	\$ 622,116	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Mizuho Capital Markets LLC		X	Line of Credit		2/1/2020	2,087,767	2,087,767	2/1/2025	0.0700	134,371	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 11,718,171	\$ 11,718,171			\$ 756,487	9								
B. Non-Facility Related*																				
10	Interest Income/Misc Rev Int		X								(1,485)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (1,485)	14								
15	TOTALS (line 9+line14)						\$ 11,718,171	\$ 11,718,171			\$ 755,002	15								

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

* 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.)		\$	151,571	2
3. Under or (over) accrual (line 2 minus line 1).		\$	151,571	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(12,631)	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.		\$	138,940	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	143,991	8	
	2016	144,479	9	
	2017	139,676	10	
	2018	133,500	11	
	2019	151,571	12	
\$151,571 * (11/12) = \$138,940 RE Tax Accrual for CR Period 2/1/20-12/31/20 (Sch V Line 33)				
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 Fox River Rehab Healthcare COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0056242

CONTACT PERSON REGARDING THIS REPORT David Trimble

TELEPHONE (813) 675 - 2318 FAX #: (813) 635 - 0008

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>06-09-100-021</u>	<u>Long Term Care Property</u>	\$ <u>151,570.88</u>	\$ <u>151,570.88</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>151,570.88</u></u>	\$ <u><u>151,570.88</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 Fox River Rehab Healthcare

0056242 Report Period Beginning:

2/1/2020 Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,268 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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).

N/A

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Facility Land</u>	<u>206,817</u>	<u>2020</u>	<u>\$ 1,400,000</u>	<u>1</u>
2	<u>Nursing Facility</u>	<u>43,268</u>	<u>2020</u>		<u>2</u>
3	TOTALS	250,085		\$ 1,400,000	3

Facility Name & ID Number Fox River Rehab Healthcare

0056242

Report Period Beginning:

2/1/2020

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	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	139		2020	1994	\$ 7,726,199	\$ 181,599	39	\$ 181,599	\$	\$ 181,599	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1 Range Oven		2020		5,985	142	7	142		142	9
10	Parking Lot Resurface		2020		89,491	4,475	15	4,475		4,475	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

*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 Fox River Rehab Healthcare

0056242

Report Period Beginning:

2/1/2020

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	242,229	25,678	25,678		5-7	25,678	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 242,229	\$ 25,678	\$ 25,678	\$		\$ 25,678	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)	\$ 9,463,904	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 211,894	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 211,894	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 211,894	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	CIP	\$ 626,491	92
93			93
94			94
95		\$ 626,491	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 Fox River Rehab Healthcare

0056242

Report Period Beginning: 2/1/2020

Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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					_____			5
6					_____			6
7	TOTAL				\$ _____			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: \$ _____ Description: _____

(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 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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 151,976	\$		\$ 151,976	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			85,561			85,561	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			149,285			149,285	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			440			440	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				145,544		145,544	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				19,868			19,868	12
13	Other (specify):									13
14	TOTAL			\$		\$ 407,130	\$ 145,544		\$ 552,674	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.

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	\$ 10,913	\$ 36,584	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>132,710</u>)	1,469,105	1,469,105	3
4	Supply Inventory (priced at <u>cost</u>)	2,683	2,683	4
5	Short-Term Investments			5
6	Prepaid Insurance	18,756	18,756	6
7	Other Prepaid Expenses	7,503	7,503	7
8	Accounts Receivable (owners or related parties)	3,004	100,194	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,511,964	\$ 1,634,825	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,400,000	13
14	Buildings, at Historical Cost		7,726,199	14
15	Leasehold Improvements, at Historical Cost		89,491	15
16	Equipment, at Historical Cost		266,678	16
17	Accumulated Depreciation (book methods)		(214,196)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	15,680	82,821	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(226)	(12,519)	20
21	Restricted Funds		1,033,571	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP</u>		626,491	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,454	\$ 10,998,536	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,527,418	\$ 12,633,361	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,000,852	\$ 1,404,958	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	134,385	134,385	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,352	5,021	31
32	Accrued Real Estate Taxes(Sch.IX-B)	143,227	143,227	32
33	Accrued Interest Payable		56,579	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	42,351	53,901	36
37	<u>Accounts Payable - Related Parties</u>	248,387	642,834	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,573,554	\$ 2,440,905	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		9,630,404	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)	\$	\$ 9,630,404	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,573,554	\$ 12,071,309	46
47	TOTAL EQUITY(page 18, line 24)	\$ (46,136)	\$ 562,052	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,527,418	\$ 12,633,361	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	755,827	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,213,749	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(4,015,712)	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)	\$ (46,136)	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)	\$ (46,136)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fox River Rehab Healthcare

0056242

Report Period Beginning: 2/1/2020

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	\$ 5,216,651	1
2	Discounts and Allowances for all Levels	(229,743)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,986,908	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,424,565	6
7	Oxygen	4,035	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,428,600	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	1,466,668	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	69	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	181,504	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,101	19
20	Radiology and X-Ray	9,595	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,684,937	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,485	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,485	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Rev Other</u>	254	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 254	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,102,184	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,151,234	31
32	Health Care	3,356,004	32
33	General Administration	1,562,069	33
B. Capital Expense			
34	Ownership	925,071	34
C. Ancillary Expense			
35	Special Cost Centers	165,852	35
36	Provider Participation Fee	186,127	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,346,357	40
41	Income before Income Taxes (line 30 minus line 40)**	755,827	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 755,827	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,263,051	44
45	Private Pay - Net Inpatient Revenue	1,265,799	45
46	Medicare - Net Inpatient Revenue	971,482	46
47	Other-(specify) <u>HMO/Ins</u>	216,824	47
48	Other-(specify) <u>Hospice</u>	269,752	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,986,908	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? In Process 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 Fox River Rehab Healthcare

0056242

Report Period Beginning: 2/1/2020

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	1,608	2,012	\$ 103,184	\$ 51.28	1
2	Assistant Director of Nursing	1,738	1,851	89,132	48.15	2
3	Registered Nurses	23,971	25,545	890,666	34.87	3
4	Licensed Practical Nurses	14,245	15,313	445,741	29.11	4
5	CNAs & Orderlies	29,107	30,602	511,751	16.72	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	147	147	5,044	34.31	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	2,028	2,171	36,102	16.63	9
10	Activity Assistants	1,700	1,767	18,743	10.61	10
11	Social Service Workers	1,281	1,393	30,426	21.84	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	898	939	23,934	25.49	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	5,988	6,182	80,529	13.03	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,956	2,195	50,229	22.88	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	1,410	1,695	97,359	57.44	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	4,046	4,277	103,775	24.26	22
23	Office Manager	2,132	2,313	48,614	21.02	23
24	Clerical	3,169	3,269	49,162	15.04	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	2,270	2,364	48,498	20.52	31
32	Other Health Care(specify)	1,416	1,517	30,502	20.11	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	99,110	105,552	\$ 2,663,391 *	\$ 25.23	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	88	22,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	118	8,448	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	19	1,035	11-3	44
45	Social Service Consultant	43	2,379	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	268	\$ 33,861		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	387	\$ 23,634	10-3	50
51	Licensed Practical Nurses	6	316	10-3	51
52	Certified Nurse Assistants/Aides	2,224	65,089	10-3	52
53	TOTAL (lines 50 - 52)	2,617	\$ 89,039		53

Facility Name & ID Number Fox River Rehab Healthcare# 0056242Report Period Beginning: 2/1/2020Ending: 12/31/2020**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5.40
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,841 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? N/A 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. \$ 186,127
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? Yes Indicate the amount. \$ 69
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm In Process
Firm Name: _____
- (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. Yes
Attach invoices and a summary of services for all architect and appraisal fees.