

		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>0056200</u></p> <p>Facility Name: <u>Lake Cook Rehab Healthcare</u></p> <p>Address: <u>4101 Lake Cook Road</u> <u>Northbrook</u> <u>60062</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 562-1770</u> Fax # <u>(847) 562-1909</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 style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width: 33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width: 33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <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>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p style="text-align: center;">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 style="text-align: center;">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="border: none; padding: 5px;"> (Signed) _____ (Type or Print Name) <u>David Trimble</u> (Title) <u>Vice President, Reimbursement</u> </td> </tr> <tr> <td style="border: 1px solid black; width: 15%; padding: 5px;">Paid Preparer</td> <td style="border: none; padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p style="text-align: center;">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) <u>David Trimble</u> (Title) <u>Vice President, Reimbursement</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David Trimble</u> (Title) <u>Vice President, Reimbursement</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Lake Cook Rehab Healthcare

0056200 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	147	Skilled (SNF)	147	49,245	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	147	TOTALS	147	49,245	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	22,853	1,607	4,096	28,556	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,853	1,607	4,096	28,556	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.99%

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 147 and days of care provided 2,829

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 Lake Cook Rehab Healthcare # 0056200 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	145,229	13,335	282,394	440,958		440,958	6,649	447,607		1
2	Food Purchase		213,460		213,460		213,460		213,460		2
3	Housekeeping		132	287,229	287,361		287,361		287,361		3
4	Laundry		4,687	128,179	132,866		132,866		132,866		4
5	Heat and Other Utilities			177,700	177,700		177,700	(10,629)	167,071		5
6	Maintenance	41,106	2,890	81,456	125,452		125,452	6,458	131,910		6
7	Other (specify):*										7
8	TOTAL General Services	186,335	234,504	956,958	1,377,797		1,377,797	2,478	1,380,275		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	2,949,747	655,201	212,097	3,817,045		3,817,045	140,247	3,957,292		10
10a	Therapy		685	1,111,346	1,112,031		1,112,031	(1,067,599)	44,432		10a
11	Activities	114,132	4,629	1,114	119,875		119,875		119,875		11
12	Social Services	92,009			92,009		92,009		92,009		12
13	CNA Training										13
14	Program Transportation			6,920	6,920		6,920		6,920		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,155,888	660,515	1,345,877	5,162,280		5,162,280	(927,352)	4,234,928		16
	C. General Administration										
17	Administrative	98,507		485,779	584,286		584,286	133,798	718,084		17
18	Directors Fees										18
19	Professional Services			17,754	17,754		17,754		17,754		19
20	Dues, Fees, Subscriptions & Promotions			16,290	16,290		16,290	(1,718)	14,572		20
21	Clerical & General Office Expenses	202,760	25,506	356,296	584,562		584,562	(219,054)	365,508		21
22	Employee Benefits & Payroll Taxes			484,423	484,423		484,423		484,423		22
23	Inservice Training & Education			1,477	1,477		1,477		1,477		23
24	Travel and Seminar			10,049	10,049		10,049		10,049		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			165,162	165,162		165,162		165,162		26
27	Other (specify):*										27
28	TOTAL General Administration	301,267	25,506	1,537,230	1,864,003		1,864,003	(86,974)	1,777,029		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,643,490	920,525	3,840,065	8,404,080		8,404,080	(1,011,848)	7,392,232		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

Lake Cook Rehab Healthcare

#0056200

Report Period Beginning:

2/1/2020

Ending:

12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							407,912	407,912			30
31	Amortization of Pre-Op. & Org.			271	271		271	(271)				31
32	Interest			141,437	141,437		141,437	1,310,667	1,452,104			32
33	Real Estate Taxes			523,511	523,511		523,511	191,078	714,589			33
34	Rent-Facility & Grounds			1,325,784	1,325,784		1,325,784	(1,305,148)	20,636			34
35	Rent-Equipment & Vehicles			6,829	6,829		6,829		6,829			35
36	Other (specify):*											36
37	TOTAL Ownership			1,997,832	1,997,832		1,997,832	604,238	2,602,070			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,836	11,269	117,105		117,105	1,071,304	1,188,409			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,498	228,498		228,498		228,498			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		105,836	239,767	345,603		345,603	1,071,304	1,416,907			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,643,490	1,026,361	6,077,664	10,747,515		10,747,515	663,694	11,411,209			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				4
5	Telephone, TV & Radio in Resident Rooms	(10,629)	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	(2,377)	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	(21,264)	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	(209,797)	21		24
25	Fund Raising, Advertising and Promotional	(1,718)	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	190,612			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,173)		\$	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)	718,867		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 718,867		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 663,694		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	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		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

Lake Cook Rehab Healthcare

ID# 0056200

Report Period Beginning: 2/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Rev Vending	\$ (50)	1	1
2	Misc Rev Other	(145)	21	2
3	Amortization of Operating Rights	(271)	31	3
4	Real Estate Tax to Actual	191,078	33	4
5	Medicare Therapy Costs	1,071,304	39	5
6	Medicare Therapy Costs	(1,071,304)	10a	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	190,612		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Cook Rehab Healthcare# 0056200

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

	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	(50)	6,699	0	0	0	0	0	0	0	0	0	6,649	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	(10,629)	0	0	0	0	0	0	0	0	0	0	(10,629)	5
6	Maintenance	0	6,458	0	0	0	0	0	0	0	0	0	6,458	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,679)	13,157	0	0	0	0	0	0	0	0	0	2,478	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	140,247	0	0	0	0	0	0	0	0	0	140,247	10
10a	Therapy	(1,071,304)	3,705	0	0	0	0	0	0	0	0	0	(1,067,599)	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	(1,071,304)	143,952	0	0	0	0	0	0	0	0	0	(927,352)	16
	C. General Administration													
17	Administrative	0	133,798	0	0	0	0	0	0	0	0	0	133,798	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	(1,718)	0	0	0	0	0	0	0	0	0	0	(1,718)	20
21	Clerical & General Office Expenses	(231,206)	12,152	0	0	0	0	0	0	0	0	0	(219,054)	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	(232,924)	145,950	0	0	0	0	0	0	0	0	0	(86,974)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,314,907)	303,059	0	0	0	0	0	0	0	0	0	(1,011,848)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lake Cook Rehab Healthcare# 0056200

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	407,912	0	0	0	0	0	0	0	0	0	407,912	30
31	Amortization of Pre-Op. & Org.	(271)	0	0	0	0	0	0	0	0	0	0	(271)	31
32	Interest	(2,377)	1,313,044	0	0	0	0	0	0	0	0	0	1,310,667	32
33	Real Estate Taxes	191,078	0	0	0	0	0	0	0	0	0	0	191,078	33
34	Rent-Facility & Grounds	0	(1,305,148)	0	0	0	0	0	0	0	0	0	(1,305,148)	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	188,430	415,808	0	0	0	0	0	0	0	0	0	604,238	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	1,071,304	0	0	0	0	0	0	0	0	0	0	1,071,304	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	1,071,304	0	0	0	0	0	0	0	0	0	0	1,071,304	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(55,173)	718,867	0	0	0	0	0	0	0	0	0	663,694	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
4101 Lake Cook Road 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
		Elgin NH LLC	Elgin,IL	Greystone Home Health	Clearwater, FL	Home Health
		Inverness NH LLC	Inverness,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 Home Office Cost - Admin	\$ 427,391	Greystone Healthcare Management Corp.	0.00%	\$ 510,162	\$ 82,771	1	
2	V	10 Home Office Cost - Nursing		Greystone Healthcare Management Corp.	0.00%	139,429	139,429	2	
3	V	1 Home Office Cost - Dietary		Greystone Healthcare Management Corp.	0.00%	6,139	6,139	3	
4	V	10a Home Office Cost - Ancillary		Greystone Healthcare Management Corp.	0.00%	3,705	3,705	4	
5	V	34 Home Office Cost - Property		Greystone Healthcare Management Corp.	0.00%	20,636	20,636	5	
6	V	34 Rent	1,325,784	4101 Lake Cook Road LLC	0.00%		(1,325,784)	6	
7	V	32 Interest		4101 Lake Cook Road LLC	0.00%	1,313,044	1,313,044	7	
8	V	30 Depreciation/Amortization		4101 Lake Cook Road LLC	0.00%	407,912	407,912	8	
9	V	17 Other Administrative		4101 Lake Cook Road LLC	0.00%	51,027	51,027	9	
10	V	1 Expense Equip - Dietary		4101 Lake Cook Road LLC	0.00%	560	560	10	
11	V	6 Expense Equip - Maintenance		4101 Lake Cook Road LLC	0.00%	6,458	6,458	11	
12	V	10 Expense Equip - Nursing		4101 Lake Cook Road LLC	0.00%	818	818	12	
13	V	21 Expense Equip - Admin		4101 Lake Cook Road LLC	0.00%	12,152	12,152	13	
14	Total		\$ 1,753,175			\$ 2,472,042	\$ *	718,867	14

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

Facility Name & ID Number

Lake Cook Rehab Healthcare

0056200

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

Lake Cook Rehab Healthcare

0056200

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 Lake Cook Rehab Healthcare # 0056200 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 Lake Cook Rehab Healthcare

0056200

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	\$ 10,315,206	\$ 139,429	1
2	1	Dietary	Accumulated Costs	465,656,695	44	277,112	10,315,206	6,139	2
3	10a	Ancillary	Accumulated Costs	460,282,346	42	165,316	10,315,206	3,705	3
4	34	Property	Accumulated Costs	481,058,730	50	962,398	10,315,206	20,636	4
5	17	Admin	Accumulated Costs	481,058,730	50	23,791,846	10,315,206	510,162	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	\$	\$ 680,071	25

Facility Name & ID Number

Lake Cook Rehab Healthcare

0056200

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	\$ 20,326,017	\$ 20,326,017	2/1/2045	0.0700	\$ 1,313,044	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Mizuho Capital Markets LLC		X	Line of Credit		2/1/2020	2,197,560	2,197,560	2/1/2025	0.0700	141,437	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 22,523,577	\$ 22,523,577			\$ 1,454,481	9						
B. Non-Facility Related*																		
10	Interest Income/Misc Rev Interest		X								(2,377)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (2,377)	14						
15	TOTALS (line 9+line14)						\$ 22,523,577	\$ 22,523,577			\$ 1,452,104	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.)		\$	779,552	2
3. Under or (over) accrual (line 2 minus line 1).		\$	779,552	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(64,963)	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.		\$	714,589	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	352,096	8
	2016	380,037	9
	2017	405,248	10
	2018	416,945	11
	2019	779,552	12

\$779,552 * (11/12) = \$714,589 RE Tax Accrual for CR Period 2/1/20-12/31/20

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 Lake Cook Rehab Healthcare COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0056200

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>04-06-101-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>409,302.35</u>	\$ <u>409,302.35</u>
2. <u>04-06-101-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>370,249.65</u>	\$ <u>370,249.65</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>779,552.00</u></u>	\$ <u><u>779,552.00</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 Lake Cook Rehab Healthcare

0056200

Report Period Beginning:

2/1/2020

Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,834 B. General Construction Type: Exterior Brick Veneer Frame Steel 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).

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Rows include Nursing Facility Land, Nursing Facility, and TOTALS.

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	147		2020	1998	\$ 16,553,201	\$ 389,071		\$ 389,071	\$ 39	\$ 389,071	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Asphalt		2020		31,040	1,552	15	1,552		1,552	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

*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)

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	118,416	17,289	17,289		5-7	17,289	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 118,416	\$ 17,289	\$ 17,289	\$		\$ 17,289	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)	\$ 19,752,657	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 407,912	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 407,912	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)	\$ 407,912	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	61,772	92
93			93
94			94
95		\$ 61,772	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 Lake Cook Rehab Healthcare

0056200

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	\$		\$ 472,605	\$		\$ 472,605	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			97,648			97,648	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			501,050			501,050	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 prescripts				105,836		105,836	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Consolidated Billing</u>	39-3				254			254	12
13	Other (specify): <u>Lab/X-Ray</u>	39-3				11,015			11,015	13
14	TOTAL			\$		\$ 1,082,573	\$ 105,836		\$ 1,188,409	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.

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	\$ 66,973	\$ 121,155	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 170,956)	1,173,738	1,173,738	3
4	Supply Inventory (priced at cost)	15,003	15,003	4
5	Short-Term Investments			5
6	Prepaid Insurance	20,222	20,222	6
7	Other Prepaid Expenses	11,697	11,697	7
8	Accounts Receivable (owners or related parties)	19,595	221,210	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,307,228	\$ 1,563,025	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,050,000	13
14	Buildings, at Historical Cost		16,553,201	14
15	Leasehold Improvements, at Historical Cost		31,040	15
16	Equipment, at Historical Cost		138,404	16
17	Accumulated Depreciation (book methods)		(409,850)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	17,680	159,389	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(271)	(26,217)	20
21	Restricted Funds		1,592,007	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP		61,772	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,409	\$ 21,149,746	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,324,637	\$ 22,712,771	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,600,757	\$ 1,620,989	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,998	187,998	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,086	6,814	31
32	Accrued Real Estate Taxes(Sch.IX-B)	94,758	94,758	32
33	Accrued Interest Payable		119,415	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	49,497	61,047	36
37	Accounts Payable - Related Parties	887,605	1,706,783	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,826,701	\$ 3,797,804	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		20,326,017	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)	\$	\$ 20,326,017	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,826,701	\$ 24,123,821	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,502,064)	\$ (1,411,050)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,324,637	\$ 22,712,771	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)	(957,049)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,749,972	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(4,294,987)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,502,064)	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)	\$ (1,502,064)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lake Cook Rehab Healthcare

0056200

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	\$ 5,948,897	1
2	Discounts and Allowances for all Levels	(694,625)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,254,272	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,179,895	6
7	Oxygen	1,408	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,181,303	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	1,242,596	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	50	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	89,244	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,094	19
20	Radiology and X-Ray	9,385	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,352,369	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,377	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,377	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Rev Other</u>	145	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 145	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,790,466	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,377,797	31
32	Health Care	5,162,280	32
33	General Administration	1,864,003	33
B. Capital Expense			
34	Ownership	1,997,832	34
C. Ancillary Expense			
35	Special Cost Centers	117,105	35
36	Provider Participation Fee	228,498	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,747,515	40
41	Income before Income Taxes (line 30 minus line 40)**	(957,049)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (957,049)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,874,641	44
45	Private Pay - Net Inpatient Revenue	305,436	45
46	Medicare - Net Inpatient Revenue	(353,924)	46
47	Other-(specify) <u>HMO/Ins</u>	69,771	47
48	Other-(specify) <u>Hospice</u>	358,348	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,254,272	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 Lake Cook Rehab Healthcare

0056200

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	1,594	1,705	\$ 92,937	\$ 54.51	1
2	Assistant Director of Nursing	1,818	1,962	94,214	48.02	2
3	Registered Nurses	21,120	22,722	957,911	42.16	3
4	Licensed Practical Nurses	23,387	25,691	859,734	33.46	4
5	CNAs & Orderlies	42,924	45,652	845,954	18.53	5
6	CNA Trainees	496	504	5,229	10.38	6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	2,136	2,277	48,305	21.21	9
10	Activity Assistants	4,738	5,036	65,827	13.07	10
11	Social Service Workers	3,659	4,011	92,009	22.94	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	890	927	25,080	27.06	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	7,432	7,730	120,149	15.54	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,563	1,630	41,106	25.22	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	1,662	1,783	98,507	55.25	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	5,349	5,724	129,257	22.58	22
23	Office Manager	1,766	1,914	50,654	26.46	23
24	Clerical	3,586	3,793	50,965	13.44	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	1,797	1,880	34,611	18.41	31
32	Other Health Care(specify)	1,647	1,775	31,040	17.49	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	127,564	136,716	\$ 3,643,489 *	\$ 26.65	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	14,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	123	9,568	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	15	814	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	226	\$ 24,782		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	227	\$ 19,320	10-3	50
51	Licensed Practical Nurses	39	2,297	10-3	51
52	Certified Nurse Assistants/Aides	4,817	156,221	10-3	52
53	TOTAL (lines 50 - 52)	5,083	\$ 177,838		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				
Rebecca Granrath	Administrator	0	\$ 12,543	Workers' Compensation Insurance	\$ 79,046	IDPH License Fee	\$				
Jo Marie Silver	Administrator	0	13,843	Unemployment Compensation Insurance	49,269	Advertising: Employee Recruitment	5,253				
John Hurley	Administrator	0	24,174	FICA Taxes	261,524	Health Care Worker Background Check	981				
Anna Johnson	Administrator	0	47,947	Employee Health Insurance	77,981	(Indicate # of checks performed 96)					
				Employee Meals		Patient Background Checks	71 744				
				Illinois Municipal Retirement Fund (IMRF)*		Recruiting Fees	3,614				
				Dental Insurance	5,692	Informational Advertising	1,281				
				Life Insurance	1,511	Promotional Advertising	1,718				
				Other Benefits	3,812	Dues & Subscriptions	2,699				
				Employment Screening	5,589						
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 98,507								
(List each licensed administrator separately.)											
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description				Description				Description			
Amount				Line #				Amount			
Management Fees			\$ 427,391				\$	Out-of-State Travel	\$		
Agency - Adminsitrator (Anna Johnson/Kathleen Carver)			58,388								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 485,779					In-State Travel			
(Attach a copy of any management service agreement)								Travel Lodging	5,251		
								Travel Auto/Meals	2,970		
								Travel Airline	1,261		
								Seminar Expense	567		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 17,754	TOTAL	\$			Entertainment Expense	()		
(For legal fee disclosure, see page 39 of instructions)								(agree to Sch. V, line 24, col. 8)			
								TOTAL	\$ 10,049		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lake Cook Rehab Healthcare# 0056200Report 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? 5.17
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,927 Line 10-2
- (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. \$ 228,498
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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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? N/A**
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? N/A
- (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.