		FOR BHF USE					

LL1

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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0056226

Facility Name: Lakeside Rehab Healthcare

Address: 900 Centennial Drive (Number) East Peoria (City) 61611 (Zip Code)

County: Tazewell

Telephone Number: (309) 699-5400 **Fax #** (309) 699-1632

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2020

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: David Trimble **Telephone Number:** (813)675-2318
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 2/1/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) David Trimble
(Title) Vice President, Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	40,200	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	120	TOTALS	120	40,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,095	3,535	4,289	24,919	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,095	3,535	4,289	24,919	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.99%

D. How many bed reserve days during this year were paid by the Department?
_____ (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 2/1/2020

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 2,661

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	92,449	18,207	171,601	282,257		282,257	2,649	284,906			1
2	Food Purchase		168,372		168,372		168,372		168,372			2
3	Housekeeping			180,826	180,826		180,826		180,826			3
4	Laundry		4,207	81,494	85,701		85,701		85,701			4
5	Heat and Other Utilities			144,719	144,719		144,719	(11,911)	132,808			5
6	Maintenance	47,691	7,645	101,561	156,897		156,897	1,100	157,997			6
7	Other (specify):*											7
8	TOTAL General Services	140,140	198,431	680,201	1,018,772		1,018,772	(8,162)	1,010,610			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	1,783,114	520,846	584,722	2,888,682		2,888,682	93,238	2,981,920			10
10a	Therapy			481,313	481,313		481,313	(422,536)	58,777			10a
11	Activities	72,388	1,853	2,420	76,661		76,661		76,661			11
12	Social Services	36,330		2,420	38,750		38,750		38,750			12
13	CNA Training											13
14	Program Transportation			6,200	6,200		6,200		6,200			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,891,832	522,699	1,093,575	3,508,106		3,508,106	(329,298)	3,178,808			16
	C. General Administration											
17	Administrative	109,801		279,987	389,788		389,788	76,344	466,132			17
18	Directors Fees											18
19	Professional Services			9,912	9,912		9,912		9,912			19
20	Dues, Fees, Subscriptions & Promotions			9,906	9,906		9,906	(953)	8,953			20
21	Clerical & General Office Expenses	183,471	22,752	256,488	462,711		462,711	(119,607)	343,104			21
22	Employee Benefits & Payroll Taxes			280,085	280,085		280,085		280,085			22
23	Inservice Training & Education			1,736	1,736		1,736		1,736			23
24	Travel and Seminar			3,714	3,714		3,714		3,714			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			137,334	137,334		137,334		137,334			26
27	Other (specify):*											27
28	TOTAL General Administration	293,272	22,752	979,162	1,295,186		1,295,186	(44,216)	1,250,970			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,325,244	743,882	2,752,938	5,822,064		5,822,064	(381,676)	5,440,388			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 Lakeside Rehab Healthcare #0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			3,829	3,829		3,829	112,286	116,115			30
31	Amortization of Pre-Op. & Org.			226	226		226	(226)				31
32	Interest			118,483	118,483		118,483	318,367	436,850			32
33	Real Estate Taxes			73,040	73,040		73,040	(1,753)	71,287			33
34	Rent-Facility & Grounds			334,778	334,778		334,778	(321,968)	12,810			34
35	Rent-Equipment & Vehicles			15,645	15,645		15,645		15,645			35
36	Other (specify):*											36
37	**TOTAL Ownership**			546,001	546,001		546,001	106,706	652,707			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116,055	13,015	129,070		129,070	424,836	553,906			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			192,361	192,361		192,361		192,361			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		116,055	205,376	321,431		321,431	424,836	746,267			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,325,244	859,937	3,504,315	6,689,496		6,689,496	149,866	6,839,362			45

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

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,911)	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	(1,117)	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	(235)	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	(130,966)	21		24
25	Fund Raising, Advertising and Promotional	(953)	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	(4,844)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (150,026)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	299,892		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 299,892		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 149,866		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lakeside Rehab Healthcare

ID# 0056226

Report Period Beginning: 2/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Rev Vending	$ (1,729)	1	1
2	Misc Rev Other	(1,136)	21	2
3	Amortization of Operating Rights	(226)	31	3
4	Real Estate Tax to Actual	(1,753)	33	4
5	Medicare Therapy Costs	424,836	39	5
6	Medicare Therapy Costs	(424,836)	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**	(4,844)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(1,729)	4,378	0	0	0	0	0	0	0	0	0	2,649	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	(11,911)	0	0	0	0	0	0	0	0	0	0	(11,911)	5
6	Maintenance	0	1,100	0	0	0	0	0	0	0	0	0	1,100	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(13,640)	5,478	0	0	0	0	0	0	0	0	0	(8,162)	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	93,238	0	0	0	0	0	0	0	0	0	93,238	10
10a	Therapy	(424,836)	2,300	0	0	0	0	0	0	0	0	0	(422,536)	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	(424,836)	95,538	0	0	0	0	0	0	0	0	0	(329,298)	16
	C. General Administration													
17	Administrative	0	76,344	0	0	0	0	0	0	0	0	0	76,344	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	(953)	0	0	0	0	0	0	0	0	0	0	(953)	20
21	Clerical & General Office Expenses	(132,337)	12,730	0	0	0	0	0	0	0	0	0	(119,607)	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	(133,290)	89,074	0	0	0	0	0	0	0	0	0	(44,216)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(571,766)	190,090	0	0	0	0	0	0	0	0	0	(381,676)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 **Report Period Beginning:** 2/1/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	112,286	0	0	0	0	0	0	0	0	0	112,286	30
31	Amortization of Pre-Op. & Org.	(226)	0	0	0	0	0	0	0	0	0	0	(226)	31
32	Interest	(1,117)	319,484	0	0	0	0	0	0	0	0	0	318,367	32
33	Real Estate Taxes	(1,753)	0	0	0	0	0	0	0	0	0	0	(1,753)	33
34	Rent-Facility & Grounds	0	(321,968)	0	0	0	0	0	0	0	0	0	(321,968)	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**	(3,096)	109,802	0	0	0	0	0	0	0	0	0	106,706	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	424,836	0	0	0	0	0	0	0	0	0	0	424,836	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**	424,836	0	0	0	0	0	0	0	0	0	0	424,836	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(150,026)	299,892	0	0	0	0	0	0	0	0	0	149,866	45

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NH Operator Holdings VII LLC	100	Edwardsville NH LLC	Edwardsville,IL	Wood River NH LLC	Wood River, IL	Supportive Living F
900 Centennial Drive LLC	0	Rockford NH LLC	Rockford,IL	Springs of Lady Lake	Lady Lake,FL	Assisted Living Facil
Greystone Healthcare Management Corp	0	Moline NH LLC	Moline,IL	Greystone Home Healt	Orlando, FL	Home Health
		St. Charles NH LLC	St. Charles,IL	Greystone Home Healt	Sun City Center, FL	Home Health
		Elgin NH LLC	Elgin,IL	Greystone Home Healt	Clearwater, FL	Home Health
		Inverness NH LLC	Inverness,IL	Greystone Home Healt	The Villages, FL	Home Health
		See PG6-Supp	See PG6-Supp	See PG6-Supp	See PG6-Supp	See PG6-Supp

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Home Office Cost - Admin	$ 279,987	Greystone Healthcare Management Corp.	0.00%	$ 316,687	$ 36,700	1
2	V	10	Home Office Cost - Nursing		Greystone Healthcare Management Corp.	0.00%	86,552	86,552	2
3	V	1	Home Office Cost - Dietary		Greystone Healthcare Management Corp.	0.00%	3,811	3,811	3
4	V	10a	Home Office Cost - Ancillary		Greystone Healthcare Management Corp.	0.00%	2,300	2,300	4
5	V	34	Home Office Cost - Property		Greystone Healthcare Management Corp.	0.00%	12,810	12,810	5
6	V	34	Rent	334,778	900 Centennial Drive LLC	0.00%		(334,778)	6
7	V	32	Interest		900 Centennial Drive LLC	0.00%	319,484	319,484	7
8	V	30	Depreciation/Amortization		900 Centennial Drive LLC	0.00%	112,286	112,286	8
9	V	17	Other Administrative		900 Centennial Drive LLC	0.00%	39,644	39,644	9
10	V	1	Expense Equip - Dietary		900 Centennial Drive LLC	0.00%	567	567	10
11	V	6	Expense Equip - Maintenance		900 Centennial Drive LLC	0.00%	1,100	1,100	11
12	V	10	Expense Equip - Nursing		900 Centennial Drive LLC	0.00%	6,686	6,686	12
13	V	21	Expense Equip - Admin		900 Centennial Drive LLC	0.00%	12,730	12,730	13
14	Total			$ 614,765			$ 914,657	$ * 299,892	14

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

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Northbrook NH LLC	Northbrook,IL	Greystone Home Healt	Daytona Beach, FL	Home Health	1
2			Joliet NH LLC	Joliet,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 Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			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 Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Clinical Nursing	Accumulated Costs	462,711,567	43	$ 6,254,384	$	6,403,250	$ 86,552	1
2	1	Dietary	Accumulated Costs	465,656,695	44	277,112		6,403,250	3,811	2
3	10a	Ancillary	Accumulated Costs	460,282,346	42	165,316		6,403,250	2,300	3
4	34	Property	Accumulated Costs	481,058,730	50	962,398		6,403,250	12,810	4
5	17	Admin	Accumulated Costs	481,058,730	50	23,791,846		6,403,250	316,687	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	$		$ 422,160	25

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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	$ 4,959,492	$ 4,959,492	2/1/2045	0.0700	$ 319,484	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mizuho Capital Markets LLC		X	Line of Credit		2/1/2020	1,827,008	1,827,008	2/1/2025	0.0700	118,483	6
7												7
8												8
9	TOTAL Facility Related						$ 6,786,500	$ 6,786,500			$ 437,967	9
	B. Non-Facility Related*											
10	Interest Income/Misc Rev Interest		X								(1,117)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,117)	14
15	TOTALS (line 9+line14)						$ 6,786,500	$ 6,786,500			$ 436,850	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.)

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 77,767	2
3. Under or (over) accrual (line 2 minus line 1).		$ 77,767	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (6,480)	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.		$ 71,287	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	72,733	8
	2016	73,296	9
	2017	74,943	10
	2018	75,644	11
	2019	77,767	12

$77,767 * (11/12) = $71,287 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 Lakeside Rehab Healthcare COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0056226

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-01-24-100-024	Long Term Care Property	$ 77,767.30	$ 77,767.30
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,767.30	$ 77,767.30

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 Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,125 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility Land	303,178	2020	$ 706,198	1
2	Nursing Facility	39,125	2020		2
3	TOTALS	342,303		$ 706,198	3

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		2020	1989	$ 4,033,480	$ 94,804	39	$ 94,804	$	$ 94,804	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1 Water Heater			2020	3,000	357	7	357		357	9
10	Asphalt & Sealcoating			2020	43,700	1,457	15	1,457		1,457	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 Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	118,614	15,669	15,669		5-7	15,669	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 118,614	$ 15,669	$ 15,669	$		$ 15,669	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		2019 T150 XL Wagon	2020	$ 57,435	$ 3,829	$ 3,829	$	5	$ 3,829	76
77										77
78										78
79										79
80	TOTALS			$ 57,435	$ 3,829	$ 3,829	$		$ 3,829	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,962,427	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 116,116	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 116,116	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)	$ 116,116	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	$ 151,574	92
93			93
94			94
95		$ 151,574	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 Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 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.

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - ☐ YES
   - ☐ NO

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 161,179	$		$ 161,179	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			52,156			52,156	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			211,501			211,501	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				116,055		116,055	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Consolidated Billing	39-3				359			359	12
13	Other (specify): Lab/X-Ray	39-3				12,656			12,656	13
14	TOTAL			$		$ 437,851	$ 116,055		$ 553,906	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lakeside Rehab Healthcare # 0056226 Report Period Beginning: 2/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 58,934	$ 72,154	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,728)	963,198	963,198	3
4	Supply Inventory (priced at cost)	10,820	10,820	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,109	21,109	6
7	Other Prepaid Expenses	7,639	7,639	7
8	Accounts Receivable (owners or related parties)	7,897	57,437	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,069,597	$ 1,132,357	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		706,198	13
14	Buildings, at Historical Cost		4,033,480	14
15	Leasehold Improvements, at Historical Cost		43,700	15
16	Equipment, at Historical Cost	57,435	200,133	16
17	Accumulated Depreciation (book methods)	(3,829)	(118,390)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	15,680	50,257	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(226)	(6,557)	20
21	Restricted Funds		610,215	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP		151,574	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 69,060	$ 5,670,610	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,138,657	$ 6,802,967	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 682,411	$ 690,111	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,108	10,108	29
30	Accrued Salaries Payable	98,977	98,977	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,280	4,430	31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,040	73,040	32
33	Accrued Interest Payable		29,137	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	51,618	63,168	36
37	Accounts Payable - Related Parties	331,728	539,290	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,252,162	$ 1,508,261	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	44,208	44,208	39
40	Mortgage Payable			40
41	Bonds Payable		4,959,492	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)**	$ 44,208	$ 5,003,700	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,296,370	$ 6,511,961	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (157,713)	$ 291,006	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,138,657	$ 6,802,967	48

***(See instructions.)**

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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)	(178,081)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	2,917,665	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,897,297)	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)**	$ (157,713)	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)**	$ (157,713)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,945,034	1
2	Discounts and Allowances for all Levels	(976,512)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,968,522	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,455,315	6
7	Oxygen	3,426	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,458,741	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	911,007	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,729	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	145,068	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,464	19
20	Radiology and X-Ray	3,631	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,081,899	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,117	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,117	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Rev Other	1,136	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,136	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,511,415	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,018,772	31
32	Health Care	3,508,106	32
33	General Administration	1,295,186	33
	B. Capital Expense		
34	Ownership	546,001	34
	C. Ancillary Expense		
35	Special Cost Centers	129,070	35
36	Provider Participation Fee	192,361	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,689,496	40
41	**Income before Income Taxes (line 30 minus line 40)****	(178,081)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (178,081)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,660,015	44
45	Private Pay - Net Inpatient Revenue	660,086	45
46	Medicare - Net Inpatient Revenue	296,829	46
47	Other-(specify) HMO/Ins	66,088	47
48	Other-(specify) Hospice	285,504	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,968,522	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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,226	1,325	$ 71,065	$ 53.63	1
2	Assistant Director of Nursing	978	1,025	44,340	43.26	2
3	Registered Nurses	8,672	9,124	324,079	35.52	3
4	Licensed Practical Nurses	19,668	20,761	615,847	29.66	4
5	CNAs & Orderlies	41,199	43,016	668,972	15.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,154	2,315	36,690	15.85	9
10	Activity Assistants	3,234	3,361	35,698	10.62	10
11	Social Service Workers	1,728	1,912	36,330	19.00	11
12	Dietician					12
13	Food Service Supervisor	1,424	1,498	35,508	23.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,863	4,992	56,941	11.41	15
16	Dishwashers					16
17	Maintenance Workers	2,108	2,231	47,691	21.38	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,712	1,920	109,801	57.19	20
21	Assistant Administrator					21
22	Other Administrative	5,902	6,154	136,115	22.12	22
23	Office Manager	1,530	1,610	35,408	21.99	23
24	Clerical	3,068	3,159	36,310	11.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,323	1,332	25,348	19.03	31
32	Other Health Care(specify)	571	598	9,100	15.22	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	101,360	106,333	$ 2,325,243 *	$ 21.87	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	110	16,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	103	7,751	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	44	2,420	11-3	44
45	Social Service Consultant	44	2,420	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	301	$ 29,091		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,116	$ 217,686	10-3	50
51	Licensed Practical Nurses	577	29,944	10-3	51
52	Certified Nurse Assistants/Aides	10,921	297,228	10-3	52
53	TOTAL (lines 50 - 52)	14,614	$ 544,858		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Arnold	Administrator	0	$ 27,916
Cynthia Wegner	Administrator	0	81,885
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,801

B. Administrative - Other

Description	Amount
Management Fees	$ 279,987
TOTAL (agree to Schedule V, line 17, col. 3)	$ 279,987
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Moore Stephens Lovelace P.A.	Accounting Services	$ 8,583
See Attached	Legal Services	1,329
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 9,912

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,119
Unemployment Compensation Insurance	43,142
FICA Taxes	170,156
Employee Health Insurance	38,553
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	1,537
Life Insurance	1,039
Other Benefits	2,068
Employment Screening	3,470
TOTAL (agree to Schedule V, line 22, col.8)	$ 280,085

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,133
Health Care Worker Background Check	347
(Indicate # of checks performed 33)	
Patient Background Checks 135	1,405
Recruiting Fees	3,094
Informational Advertising	521
Promotional Advertising	953
Dues & Subscriptions	1,453
Less: Public Relations Expense	( )
Non-allowable advertising	(953)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,953

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel Lodging	913
Travel Auto	2,561
Travel Meals	240
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,714

* Attach copy of IMRF notifications

**See instructions.

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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? **5.29**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,591** 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. $ **192,361**
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? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
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.