		FOR BHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0046201

Facility Name: Lemont Nrsg Rehab Center

Address: 12450 Walker Road (Number) Lemont (City) 60539 (Zip Code)

County: Cook

Telephone Number: (630) 243-0400 **Fax #** (630) 243-5063

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2003

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/20 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)
(Title)

Paid Preparer
(Signed)
* *Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 N/A

	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	173	Skilled (SNF)	173	63,318	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	173	TOTALS	173	63,318	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	19,202	4,425	14,143	37,770	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,202	4,425	14,143	37,770	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.65%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 02/01/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 173 and days of care provided 8,173

Medicare Intermediary National Government Services

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 Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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	301,310	51,964	21,288	374,562		374,562	668	375,230			1
2	Food Purchase		204,234		204,234		204,234	(149)	204,085			2
3	Housekeeping	213,966	53,768		267,734		267,734	1,223	268,957			3
4	Laundry	41,680	24,482		66,162		66,162		66,162			4
5	Heat and Other Utilities			179,637	179,637		179,637	(17,627)	162,010			5
6	Maintenance	104,154		307,334	411,488		411,488	(58,685)	352,803			6
7	Other (specify):*							3,331	3,331			7
8	TOTAL General Services	661,110	334,448	508,259	1,503,817		1,503,817	(71,239)	1,432,578			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	2,805,052	341,731	953,090	4,099,873		4,099,873	11,301	4,111,174			10
10a	Therapy	138,950			138,950		138,950		138,950			10a
11	Activities	108,118	9,040		117,158		117,158		117,158			11
12	Social Services	182,911			182,911		182,911	14,277	197,188			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,627	6,627			15
16	TOTAL Health Care and Programs	3,235,031	350,771	980,090	4,565,892		4,565,892	32,205	4,598,097			16
	C. General Administration											
17	Administrative	154,063			154,063		154,063	106,381	260,444			17
18	Directors Fees											18
19	Professional Services			804,852	804,852	(8,628)	796,224	(674,453)	121,771			19
20	Dues, Fees, Subscriptions & Promotions			184,517	184,517		184,517	(23,094)	161,423			20
21	Clerical & General Office Expenses	190,290	37,080	345,727	573,097		573,097	(130,124)	442,973			21
22	Employee Benefits & Payroll Taxes			610,297	610,297		610,297	(11,027)	599,270			22
23	Inservice Training & Education											23
24	Travel and Seminar			183	183		183	685	868			24
25	Other Admin. Staff Transportation			2,927	2,927		2,927	619	3,546			25
26	Insurance-Prop.Liab.Malpractice			421,631	421,631		421,631	1,694	423,325			26
27	Other (specify):*							42,769	42,769			27
28	TOTAL General Administration	344,353	37,080	2,370,134	2,751,567	(8,628)	2,742,939	(686,550)	2,056,389			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,240,494	722,299	3,858,483	8,821,276	(8,628)	8,812,648	(725,583)	8,087,065			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 Lemont Nrsg Rehab Center #0046201 Report Period Beginning: 01/01/20 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			120,991	120,991		120,991	343,022	464,013			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							539,086	539,086			32
33	Real Estate Taxes			482,373	482,373	8,628	491,001	4,692	495,693			33
34	Rent-Facility & Grounds			1,864,390	1,864,390		1,864,390	(1,860,000)	4,390			34
35	Rent-Equipment & Vehicles			12,300	12,300		12,300	226	12,526			35
36	Other (specify):*											36
37	TOTAL Ownership			2,480,054	2,480,054	8,628	2,488,682	(972,974)	1,515,708			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		482,478	1,011,190	1,493,668		1,493,668	(35,834)	1,457,834			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			274,100	274,100		274,100		274,100			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		482,478	1,285,290	1,767,768		1,767,768	(35,834)	1,731,934			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,240,494	1,204,777	7,623,827	13,069,098		13,069,098	(1,734,392)	11,334,706			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 Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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	(18,951)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(176,103)	30		9
10	Interest and Other Investment Income	(101,425)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(239)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(284,784)	21		24
25	Fund Raising, Advertising and Promotional	(16,771)	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	(120,881)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (719,654)		$	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)	(1,014,738)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,014,738)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,734,392)		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

Lemont Nrsg Rehab Center

ID# 0046201

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (96)	21	1
2	Jury Duty	(17)	10	2
3	Patient Clothing	(174)	10	3
4	Theft Loss	(700)	21	4
5	Collection Expense	(8,772)	21	5
6	Building Co. - Management Fees	(7,900)	19	6
7	Building Co. - Filing Fees	(75)	20	7
8	Building Co. - Amortization	(48,202)	36	8
9	Capitalized R&M	(42,254)	06	9
10	PAC Dues	(8,879)	20	10
11	Non-Allowable Legal	(692)	19	11
12	Duplicate Expense	(3,120)	21	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**	(120,881)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Lemont Nsg Rehab Center

IDF 00462O1

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			124	544								668	1
2	Food Purchase	(239)		90									(149)	2
3	Housekeeping			1,079	144								1,223	3
4	Laundry													4
5	Heat and Other Utilities	(18,951)		1,182	142								(17,627)	5
6	Maintenance	(42,254)		(16,574)	143								(58,685)	6
7	Other (specify):*			3,251	80								3,331	7
8	**TOTAL General Services**	(61,444)		(10,848)	1,053								(71,239)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(191)			31,613	(18,326)	(1,795)						11,301	10
10a	Therapy													10a
11	Activities													11
12	Social Services				14,277								14,277	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,627								6,627	15
16	**TOTAL Health Care and Programs**	(191)			52,517	(18,326)	(1,795)						32,205	16
	C. General Administration													
17	Administrative			15,455	90,926								106,381	17
18	Directors Fees													18
19	Professional Services	(8,592)	7,900	(505,957)	(167,804)								(674,453)	19
20	Fees, Subscriptions & Promotions	(26,225)	75	2,012	1,044								(23,094)	20
21	Clerical & General Office Expenses	(297,472)		119,863	47,485								(130,124)	21
22	Employee Benefits & Payroll Taxes			(11,027)									(11,027)	22
23	Inservice Training & Education													23
24	Travel and Seminar			328	357								685	24
25	Other Admin. Staff Transportation			619									619	25
26	Insurance-Prop.Liab.Malpractice			1,326	368								1,694	26
27	Other (specify):*			22,746	20,023								42,769	27
28	**TOTAL General Administration**	(332,289)	7,975	(354,635)	(7,601)								(686,550)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(393,924)	7,975	(365,483)	45,969	(18,326)	(1,795)						(725,583)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 **Report Period Beginning:** 01/01/20 **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	(176,103)	516,913	2,081	131								343,022	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(101,425)	632,954	7,437	120								539,086	32
33	Real Estate Taxes			4,139	553								4,692	33
34	Rent-Facility & Grounds		(1,860,000)										(1,860,000)	34
35	Rent-Equipment & Vehicles			226									226	35
36	Other (specify):*	(48,202)	48,202											36
37	**TOTAL Ownership**	(325,730)	(661,931)	13,883	804								(972,974)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(35,834)						(35,834)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(35,834)						(35,834)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(719,654)	(653,956)	(351,600)	46,773	(18,326)	(37,629)						(1,734,392)	45

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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
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. [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	34	Rent	$ 1,860,000	Lemont Property, LLC		$	$ (1,860,000)	1
2	V	33	Real Estate Taxes	458,673	Lemont Property, LLC		458,673		2
3	V	32	Interest	136,438	Lemont Property, LLC		769,392	632,954	3
4	V	19	Management Fees		Lemont Property, LLC		7,900	7,900	4
5	V	20	Filing Fees		Lemont Property, LLC		75	75	5
6	V	30	Depreciation		Lemont Property, LLC		516,913	516,913	6
7	V	36	Amortization		Lemont Property, LLC		48,202	48,202	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,455,111			$ 1,801,155	$ * (653,956)	14

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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	ROTHNER HEALTH VENTURES G II, LLC	100.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	LEMONT PROPERTY LLC	LEMONT	BUILDING COMPANY	1
2			BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTIN	EVANSTON	MGMT/BOOKKEEPING	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL DYER	DYER, IN				8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				13
14			MCKINLEY HEALTH CARE CENTER	CANTON, OH				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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)	
15	V	01	Dietary	$	Extended Care Consulting, LLC		$ 124	$ 124	15
16	V	02	Food		Extended Care Consulting, LLC		90	90	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,079	1,079	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,182	1,182	18
19	V	06	Maintenance		Extended Care Consulting, LLC		2,354	2,354	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	510,768	Extended Care Consulting, LLC		4,811	(505,957)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		2,012	2,012	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		10,596	10,596	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		328	328	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		619	619	25
26	V	26	Insurance		Extended Care Consulting, LLC		1,326	1,326	26
27	V	30	Depreciation		Extended Care Consulting, LLC		2,081	2,081	27
28	V	32	Interest		Extended Care Consulting, LLC		7,437	7,437	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		4,139	4,139	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		226	226	30
31	V	06	Maintenance Salaries	36,757	Extended Care Consulting, LLC		17,829	(18,928)	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		3,251	3,251	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		15,455	15,455	33
34	V	21	Office and Clerical Salaries		Extended Care Consulting, LLC		109,267	109,267	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		22,746	22,746	35
36	V	22	Employee Benefits	11,027	Extended Care Consulting, LLC			(11,027)	36
37	V								37
38	V								38
39	Total			$ 558,552			$ 206,952	$ * (351,600)	39

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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)	
15	V	1	Dietary Salary	$	Extended Care Clinical, LLC		$ 544	$ 544	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		144	144	16
17	V	5	Utilities		Extended Care Clinical, LLC		142	142	17
18	V	6	Maintenance		Extended Care Clinical, LLC		143	143	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		80	80	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		30,815	30,815	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		798	798	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		14,277	14,277	22
23	V	15	Emp. Ben, - Direct Alloc.		Extended Care Clinical, LLC				23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		6,627	6,627	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		90,926	90,926	25
26	V	19	Professional Fees	170,256	Extended Care Clinical, LLC		1,263	(168,993)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC		1,189	1,189	27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		1,044	1,044	28
29	V	21	Office Salary		Extended Care Clinical, LLC		45,314	45,314	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		2,171	2,171	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		357	357	31
32	V	26	Insurance		Extended Care Clinical, LLC		368	368	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		20,023	20,023	33
34	V	30	Depreciation		Extended Care Clinical, LLC		131	131	34
35	V	32	Interest		Extended Care Clinical, LLC		120	120	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		553	553	36
37	V								37
38	V								38
39	Total			$ 170,256			$ 217,029	$ * 46,773	39

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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)	
15	V	10	Various Equipment	24,720	Vent Lease LLC		6,394	$ (18,326)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 24,720			$ 6,394	$ * (18,326)	39

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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)	
15	V	10	Nursing and Medical Records	$ 19,205	MAC Rx, LLC		$ 17,410	$ (1,795)	15
16	V	39	Ancillary	383,427	MAC Rx, LLC		347,593	(35,834)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 402,632			$ 365,002	$ * (37,629)	39

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group		$ 295,332	$ 295,332	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	295,332	CCS Employee Benefits Group			(295,332)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 295,332			$ 295,332	$ *	39

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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	Adam Vales	Relative	Clerical	0	See Attached	1.47	3.68	Alloc Salary	$ 2,625	22-7	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	$ 2,625		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 Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 [ ] NO [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary	Patient Days	1,219,947	38	$ 3,992	$	37,770	$ 124	1
2	02	Food	Patient Days	1,219,947	38	2,910		37,770	90	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856		37,770	1,079	3
4	05	Utilities	Patient Days	1,219,947	38	38,173		37,770	1,182	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040		37,770	2,354	5
6	17	Administrative	Patient Days	1,219,947	38			37,770		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408		37,770	4,811	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998		37,770	2,012	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251		37,770	10,596	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602		37,770	328	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988		37,770	619	11
12	26	Insurance	Patient Days	1,219,947	38	42,836		37,770	1,326	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209		37,770	2,081	13
14	32	Interest	Patient Days	1,219,947	38	240,208		37,770	7,437	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701		37,770	4,139	15
16	35	Rent - Equipment	Patient Days	1,219,947	38	7,304		37,770	226	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	575,856	37,770	17,829	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021		37,770	3,251	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	499,202	37,770	15,455	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	3,529,267	37,770	109,267	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685		37,770	22,746	21
22										22
23										23
24										24
25	TOTALS					$ 6,684,506	$ 4,604,325		$ 206,952	25

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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: Extended Care Clinical, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Salary	Patient Days	603,308	20	$ 8,692	$ 8,692	37,770	$ 544	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		37,770	144	2
3	5	Utilities	Patient Days	603,308	20	2,264		37,770	142	3
4	6	Maintenance	Patient Days	603,308	20	2,283		37,770	143	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		37,770	80	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	37,770	30,815	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		37,770	798	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	37,770	14,277	8
9	15	Emp. Ben, - Direct Alloc.	Direct Allocation		4	44,957				9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		37,770	6,627	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	37,770	90,926	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		37,770	1,263	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220			1,189	13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		37,770	1,044	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	37,770	45,314	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		37,770	2,171	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		37,770	357	17
18	26	Insurance	Patient Days	603,308	20	5,874		37,770	368	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		37,770	20,023	19
20	30	Depreciation	Patient Days	603,308	20	2,099		37,770	131	20
21	32	Interest	Patient Days	603,308	20	1,914		37,770	120	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		37,770	553	22
23										23
24										24
25	TOTALS					$ 3,507,824	$ 2,905,144		$ 217,029	25

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	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	Various Equipment	Direct Allocation						6,394	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 6,394	25

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	Nursing And Medical Records	Direct Allocation			$	$		$ 17,410	1
2	39	Ancillary	Direct Allocation						347,593	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 365,002	25

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 295,332	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 295,332	25

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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	MB Financial		X	Mortgage Payable			$	$ 16,980,000			$ 769,392	1
2	MB Financial		X	Note Payable				187,500				2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 17,167,500			$ 769,392	9
	B. Non-Facility Related*											
10	Interest Income		X								(101,425)	10
11	Interest Income - Bldg Co.		X								(136,438)	11
12	Alloc from Extended Care Consulting										7,437	12
13	Alloc from Extended Care Clinical										120	13
14	TOTAL Non-Facility Related						$	$			$ (230,306)	14
15	TOTALS (line 9+line14)						$	$ 17,167,500			$ 539,086	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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.**	$ 444,855	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.)		$ 456,998	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,143	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 474,922	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.)		$ 8,628	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 $ 23,700 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.		$ 495,693	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	371,374	8
	2016	365,879	9
	2017	401,362	10
	2018	444,855	11
	2019	452,306	12

2020 Accrual = $452,306 x 1.05 = $474,922 (rounded)
Allocated from Extended Care Consulting $4139
Allocated from Extended Care Clinical $553

	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 Lemont Nrsg Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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.	22-27-300-076-0000	Long Term Care Property	$ 321,171.28	$ 321,171.28
2.	22-27-300-077-0000	Long Term Care Property	$ 131,135.08	$ 131,135.08
3.	See Attached	Alloc from Extended Care Consulting	$ 197,162.69	$ 4,139.44
4.	See Attached	Alloc from Extended Care Clinical	$ 197,162.69	$ 553.08
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 846,631.74	$ 456,998.88

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? X YES _____ 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Nrsg Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,662 B. General Construction Type: Exterior Brick Frame Masonry & Steel 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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2003	$ 823,094	1
2	Allocated from Care Center Building			19,516	2
3	TOTALS			$ 842,610	3

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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	158		2003	1995	$ 5,391,423	$ 516,913	35	$ 154,041	$ (362,872)	$ 4,373,658	4
5	15		2017	2017	6,640,000		35	189,714	189,714	758,856	5
6			2017	2017	1,041,901		35	29,769	29,769	119,076	6
7											7
8											8
	Improvement Type**										
9	Various			2003	48,664		20	2,269	2,269	43,468	9
10	Various			2004	35,166		20	1,267	1,267	30,523	10
11	Various			2005	7,375		20	369	369	5,870	11
12	Various			2007	30,675		20	1,534	1,534	24,526	12
13	Various			2008	46,456		20	2,324	2,324	29,121	13
14	Various			2010	120,716		20	6,038	6,038	63,562	14
15	Various			2011	280,158		20	13,516	13,516	135,983	15
16	Various			2012	169,980		20	5,237	5,237	109,353	16
17	Various			2013	139,294		20	6,838	6,838	55,048	17
18	Various			2014	140,062		20	7,004	7,004	47,937	18
19	Various			2015	70,618		20	3,532	3,532	23,159	19
20	Various			2016	40,312		20	2,016	2,016	9,395	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 Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		97,071	1,507		1,507		68,497	68
69	Financial Statement Depreciation			120,991			(120,991)		69
70	TOTAL (lines 4 thru 69)		$ 14,299,871	$ 639,411		$ 426,974	$ (212,437)	$ 5,898,031	70

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 14,299,871	$ 639,411		$ 426,974	$ (212,437)	$ 5,898,031	1
2	Air Curtain	2017	8,578		20	429	429	1,716	2
3	2 Sinks	2017	9,531		20	477	477	1,668	3
4	Call System For 1St Floor	2017	38,304		20	1,915	1,915	6,065	4
5	29 Blinds	2017	4,433		20	222	222	702	5
6	Fire Alarm And Sprinklers	2017	11,268		20	563	563	1,784	6
7	Phone System Wiring	2017	9,431		20	472	472	1,454	7
8	Signs - Resident Rooms & Throughout Faciilty	2017	5,648		20	282	282	917	8
9	Window Treatments - Cornices	2017	6,626		20	331	331	1,076	9
10	Sprinkler System - Replace Piping	2017	2,829		20	141	141	565	10
11	Resupply Power To Transfer Switch & Elevator	2017	5,000		20	250	250	875	11
12	Dining Room Wall Repair - Install Drywall, Prime, Paint	2018	22,250		20	1,113	1,113	3,245	12
13	Elevator Door Protection System	2018	4,609		20	230	230	556	13
14	Two Water Heaters	2018	17,849		20	892	892	2,454	14
15	Window Film Install, Apply Ceramic 50 To Dining Room Window	2018	7,525		20	376	376	1,066	15
16	Repair Metal Edge With Modified Strips In 4 Areas Of The Flat R	2018	2,500		20	125	125	323	16
17	Generator Repair-Replace Coolant, Battery, Jacket Water, Block	2018	3,612		20	181	181	527	17
18	Repaired Fire Alarm System	2018	2,518		20	126	126	336	18
19	Repaired Sprinkler System	2018	3,179		20	159	159	371	19
20	Replacement Of 3 Pipes In 1St Floor Dry System	2018	2,513		20	126	126	273	20
21	Repaired Fire Sprinkler Pipes	2018	4,129		20	206	206	430	21
22	Repair Water Damage	2019	23,600		20	1,180	1,180	1,278	22
23	Flush 3 Dry Systems	2019	4,927		20	246	246	492	23
24	Repair Pipe Break In Attic And Water Damage To Several Units	2019	28,628		20	1,431	1,431	2,862	24
25	Fire Sprinkler Repairs	2019	7,736		20	387	387	520	25
26	Installation Of Piping	2019	8,912		20	446	446	446	26
27	Repair Water Damage In Attic Space-Ceiling,Wall,Electircal Outl	2020	4,900		20	245	245	245	27
28	Installation Of Call Light System On 2Nd Floor	2020	25,838		20	1,292	1,292	1,292	28
29	C39 Booster Heater - Water Heater	2020	3,018		20	151	151	151	29
30	Sprinkler Repairs, Smoke Detector, Fire Alarm Devices Installatio	2020	46,378		20	2,319	2,319	2,319	30
31	Sprinkler Repairs, Smoke Detector, Fire Alarm Devices Installatio	2020	14,225		20	711	711	711	31
32	Sinkhole Repair - Build Trap, Cement Work	2020	4,000		20	200	200	200	32
33	Plumbing Work - Install Propress Ballvalve	2020	4,838		20	242	242	242	33
34	TOTAL (lines 1 thru 33)		$ 14,649,203	$ 639,411		$ 444,440	$ (194,971)	$ 5,935,192	34

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 14,649,203	$ 639,411		$ 444,440	$ (194,971)	$ 5,935,192	1
2	Propress Fitting Materials For Waterline	2020	2,555		20	128	128	128	2
3	Sprinkler System Work - Wet System/Dry Pendent Sprinkler Hea	2020	6,272		20	314	314	314	3
4	Repair Sprinkler Leak In Attic	2020	2,505		20	125	125	125	4
5	Dry System Repairs - Replace Leaking Pipes	2020	4,058		20	203	203	203	5
6	Dry Sprinkler Leak Repair	2020	3,326		20	166	166	166	6
7	Fire Alarm Panel Repair-Change Out 2 Zone Modules	2020	2,627		20	131	131	131	7
8	Repair Leak In 6" Sprinkler Pipe In Pump Room	2020	3,160		20	158	158	158	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
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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	TOTAL (lines 1 thru 33)		$ 14,673,707	$ 639,411		$ 445,665	$ (193,746)	$ 5,936,417	34

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 14,673,707	$ 639,411		$ 445,665	$ (193,746)	$ 5,936,417	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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19									19
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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	TOTAL (lines 1 thru 33)		$ 14,673,707	$ 639,411		$ 445,665	$ (193,746)	$ 5,936,417	34

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 14,673,707	$ 639,411		$ 445,665	$ (193,746)	$ 5,936,417	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,673,707	$ 639,411		$ 445,665	$ (193,746)	$ 5,936,417	34

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	23,724	608	35	608		11,127	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	7,430	165	35	165		2,222	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,170	81	35	81		1,487	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	19,598		20			19,598	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	23,096		20			23,096	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,148		20			1,148	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	207	10	20	10		124	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,987	99	20	99		696	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	326	16	20	16		211	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,290	64	20	64		322	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,237	112	20	112		447	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,025	51	20	51		154	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	386	19	20	19		39	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	103	5	20	5		5	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,619		20			2,619	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2003	3,086		20			3,086	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2005	153		20			153	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2009	28	1	20	1		17	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2014	257	13	20	13		90	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2015	44	2	20	2		28	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2016	172	9	20	9		43	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2017	299	15	20	15		60	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2018	137	7	20	7		21	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2019	52	3	20	3		5	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2020	14	1	20	1		1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 92,589	$ 1,283		$ 1,283	$	$ 66,799	34

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 92,589	$ 1,283		$ 1,283	$	$ 66,799	1
2									2
3									3
4									4
5									5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting	2007	142	7	20	7		100	8
9	Allocated from Extended Care Consulting	2009	85	4	20	4		51	9
10	Allocated from Extended Care Consulting	2010	835	42	20	42		459	10
11	Allocated from Extended Care Consulting	2011	301	15	20	15		150	11
12	Allocated from Extended Care Consulting	2012	99	5	20	5		45	12
13	Allocated from Extended Care Consulting	2014	1,373	69	20	69		481	13
14	Allocated from Extended Care Consulting	2016	1,646	82	20	82		412	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	TOTAL (lines 1 thru 33)		$ 97,071	$ 1,507		$ 1,507	$	$ 68,497	34

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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	$ 186,655	$ 706	$ 18,349	$ 17,643	10	$ 100,143	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	596,562				10	596,562	73
74								74
75	TOTALS	$ 783,217	$ 706	$ 18,349	$ 17,643		$ 696,705	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		Alloc. Extended Care Clinical	2012	$ 3,216	$	$	$	5	$ 3,216	76
77		Alloc. Extended Care Consulting	2014	788				5	788	77
78										78
79										79
80	TOTALS			$ 4,004	$	$	$		$ 4,004	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)	$ 16,303,539	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 640,117	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 464,014	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (176,103)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,637,126	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		$	92
93			93
94			94
95		$	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 Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Offsite Storage				4,390			5
6								6
7	TOTAL				$ 4,390 **			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: $ 12,526 Description: See Attached
(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 Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 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
   - [X] NO

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 - 03	hrs	$		$ 377,752	$		$ 377,752	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			137,830			137,830	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			425,847			425,847	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				391,620		391,620	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					69,761	90,858		160,619	13
14	TOTAL			$		$ 1,011,190	$ 482,478		$ 1,493,668	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 Lemont Nrsg Rehab Center **#** 0046201 **Report Period Beginning:** 01/01/20 **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	$ 4,462,530	$ 5,385,107	1
2	Cash-Patient Deposits	39,688	39,688	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	434,616	434,616	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,636	88,636	6
7	Other Prepaid Expenses	7,906	7,906	7
8	Accounts Receivable (owners or related parties)		13,123,338	8
9	Other(specify): See Attached	15,405,227	16,050,623	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 20,438,603	$ 35,129,914	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,400,748	13
14	Buildings, at Historical Cost		5,590,504	14
15	Leasehold Improvements, at Historical Cost	1,126,647	7,378,865	15
16	Equipment, at Historical Cost	641,418	1,777,194	16
17	Accumulated Depreciation (book methods)	(1,436,345)	(7,445,645)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	4,435,000	4,504,900	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,766,720	$ 13,206,566	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 25,205,323	$ 48,336,480	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 939,784	$ 939,785	26
27	Officer's Accounts Payable		5,113,296	27
28	Accounts Payable-Patient Deposits	23,556	23,556	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	277,281	277,281	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,172	8,172	31
32	Accrued Real Estate Taxes(Sch.IX-B)	474,922	474,922	32
33	Accrued Interest Payable		63,615	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,201,535	1,116,300	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,925,250	$ 8,016,927	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	187,500	187,500	39
40	Mortgage Payable		16,980,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,414,970	1,414,970	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,602,470	$ 18,582,470	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,527,720	$ 26,599,397	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 20,677,603	$ 21,737,083	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 25,205,323	$ 48,336,480	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 18,649,283	1
2	Restatements (describe):		2
3	Rounding	(4)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 18,649,279	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,112,324	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(84,000)	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)**	$ 2,028,324	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)**	$ 20,677,603	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	$ 12,541,928	1
2	Discounts and Allowances for all Levels	(6,437,644)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,104,284	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,756,602	6
7	Oxygen	424	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,757,026	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	370	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	381,757	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	119,236	19
20	Radiology and X-Ray	42,141	20
21	Other Medical Services	12,862	21
22	Laundry	2,861	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 559,227	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	101,425	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 101,425	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	2,659,460	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,659,460	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,181,422	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,503,817	31
32	Health Care	4,565,892	32
33	General Administration	2,751,567	33
	B. Capital Expense		
34	Ownership	2,480,054	34
	C. Ancillary Expense		
35	Special Cost Centers	1,493,668	35
36	Provider Participation Fee	274,100	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,069,098	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,112,324	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,112,324	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,163,796	44
45	Private Pay - Net Inpatient Revenue	1,030,553	45
46	Medicare - Net Inpatient Revenue	225,452	46
47	Other-(specify) Hospice	581,996	47
48	Other-(specify) Insurance	102,487	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,104,284	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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	2,087	3,017	$ 159,815	$ 52.98	1
2	Assistant Director of Nursing	642	720	26,567	36.88	2
3	Registered Nurses	17,127	18,740	660,645	35.25	3
4	Licensed Practical Nurses	28,317	30,458	1,074,369	35.27	4
5	CNAs & Orderlies	49,520	52,607	835,904	15.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,817	8,543	138,950	16.26	8
9	Activity Director	2,015	2,392	61,994	25.91	9
10	Activity Assistants	4,468	4,731	46,124	9.75	10
11	Social Service Workers	6,886	7,605	176,714	23.24	11
12	Dietician					12
13	Food Service Supervisor	2,017	3,735	82,868	22.18	13
14	Head Cook	7,932	8,974	151,006	16.83	14
15	Cook Helpers/Assistants	5,978	6,414	67,436	10.51	15
16	Dishwashers					16
17	Maintenance Workers	3,993	4,582	104,154	22.73	17
18	Housekeepers	15,916	17,483	213,966	12.24	18
19	Laundry	3,608	3,904	41,680	10.68	19
20	Administrator	1,682	2,010	104,393	51.94	20
21	Assistant Administrator	1,704	1,877	49,670	26.47	21
22	Other Administrative					22
23	Office Manager	1,754	1,944	30,002	15.43	23
24	Clerical	6,134	6,805	160,288	23.55	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	2,383	2,642	46,473	17.59	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	526	692	7,476	10.80	33
34	TOTAL (lines 1 - 33)	172,505	189,876	$ 4,240,494 *	$ 22.33	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	439	$ 21,288	01-03	35
36	Medical Director	Monthly	27,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,955	10-03	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
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	439	$ 56,243		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,160	$ 182,133	10-03	50
51	Licensed Practical Nurses	3,175	227,686	10-03	51
52	Certified Nurse Assistants/Aides	15,114	535,316	10-03	52
53	TOTAL (lines 50 - 52)	20,449	$ 945,135		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Niki Mehta	Administrator	0	$ 104,393
Alexander Tarr	Assistant Admin	0	49,670
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 154,063

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
ECC Clinical	Home Office Expense	$ 170,256
ECC Consulting	Home Office Expense	510,768
Marcum LLP	Accounting	27,650
ECC Consulting	Computer Services	24,790
Paycor	Payroll Processing	20,414
National Datacare Corp	Resident Fund Processing	971
Matrixcare	E.H.R Software	2,895
Personnel Planners	Unemployment Tax Consultant	1,470
Benefit Service Group	Benefit Administration	1,088
Kelleher, Helmrich	Management Consulting	873
See Attached	Legal	14,014
See Supplemental Schedule		29,663
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 804,852

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,168
Unemployment Compensation Insurance	19,128
FICA Taxes	324,398
Employee Health Insurance	157,266
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	56
Other Employee Welfare	11,731
Holiday Expense	1,523
TOTAL (agree to Schedule V, line 22, col.8)	$ 599,270

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	$ 1,492
Advertising: Employee Recruitment	101,267
Health Care Worker Background Check	
(Indicate # of checks performed 455)	4,909
Patient Background Checks	
Dues & Subscriptions	44,537
Licenses & Fees	6,162
See Supplemental Schedule	3,056
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 161,423

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	183
See Supplemental Schedule	685
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 868

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lemont Nrsg Rehab Center # 0046201 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $17,759**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **65,909** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **274,100**
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. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.