		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0054361

Facility Name: LOFT REHABILITATION NURSING

Address: 700 N MAIN STREET (Number) EUREKA (City) 61530 (Zip Code)

County: WOODFORD

Telephone Number: (309) 467-2387 **Fax #** (309) 467-9011

HFS ID Number:

Date of Initial License for Current Owners: 8/9/2016

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: KATHLEEN MCNAMARA **Telephone Number:** (847) 675-3585
Email Address:

#REF!

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 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) DANIEL AARON
(Title) CFO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) KATHLEEN MCNAMARA, VICE-PRESIDENT
(Firm Name & Address) KBKB, LTD, 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-3585

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 LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	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	92	Skilled (SNF)	92	33,672	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	12	Intermediate/DD	12	4,392	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	38,064	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			2,740	2,740	8
9	SNF/PED					9
10	ICF	18,279	4,980		23,259	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,279	4,980	2,740	25,999	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.30%

#REF!

D. How many bed reserve days during this year were paid by the Department?
0 (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 8/9/16

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 8/9/16 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 92 and days of care provided 2,740

Medicare Intermediary WISCONSIN PHYSICIAN SERVICE

IV. ACCOUNTING BASIS

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

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 LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	161,640	3,935	63,012	228,587		228,587		228,587			1
2	Food Purchase		179,059		179,059		179,059		179,059			2
3	Housekeeping	129,931	28,901	42,803	201,635		201,635		201,635			3
4	Laundry	37,450	7,115	18,161	62,726		62,726		62,726			4
5	Heat and Other Utilities			150,198	150,198		150,198		150,198			5
6	Maintenance	94,359		42,983	137,342		137,342	3,600	140,942			6
7	Other (specify):*			13,344	13,344		13,344		13,344			7
8	TOTAL General Services	423,380	219,010	330,501	972,891		972,891	3,600	976,491			8
	B. Health Care and Programs											
9	Medical Director			11,028	11,028		11,028		11,028			9
10	Nursing and Medical Records	2,001,635	134,444	154,776	2,290,855		2,290,855		2,290,855			10
10a	Therapy											10a
11	Activities	91,049	4,698	1,775	97,522		97,522		97,522			11
12	Social Services	29,590		1,524	31,114		31,114		31,114			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,122,274	139,142	169,103	2,430,519		2,430,519		2,430,519			16
	C. General Administration											
17	Administrative	82,082		238,648	320,730		320,730	(133,991)	186,739			17
18	Directors Fees											18
19	Professional Services			171,319	171,319		171,319	8,474	179,793			19
20	Dues, Fees, Subscriptions & Promotions			14,662	14,662		14,662	(10,489)	4,173			20
21	Clerical & General Office Expenses	241,972	19,148	135,823	396,943		396,943	(202,926)	194,017			21
22	Employee Benefits & Payroll Taxes			404,233	404,233		404,233		404,233			22
23	Inservice Training & Education			1,392	1,392		1,392		1,392			23
24	Travel and Seminar			8,975	8,975		8,975		8,975			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,511	48,511		48,511	94,871	143,382			26
27	Other (specify):*			100,092	100,092		100,092	(76,619)	23,473			27
28	TOTAL General Administration	324,054	19,148	1,123,655	1,466,857		1,466,857	(320,680)	1,146,177			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,869,708	377,300	1,623,259	4,870,267		4,870,267	(317,080)	4,553,187			29

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

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# LOFT REHABILITATION NURSING **#0054361 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,956	
	REPAIRS & MAINTENANCE		0	
	CONTRACTED DIETARY SERVICES		54,056	
				63,012
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		42,803	
				42,803
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	CONTRACTED LAUNDRY SERVICES		18,161	
				18,161
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		34,466	
	ELECTRICITY		57,315	
	WATER		45,315	
	CABLE TV - LOBBY		13,102	
				150,198
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,026	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		28,006	
	ELEVATOR MAINTENANCE & REPAIR		8,471	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,480	
	FIRE SERVICE		0	
				42,983
7	**OTHER**			
	SCAVENGER		13,344	
	SECURITY SERVICE		0	
				13,344
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		11,028	11,028

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	141,672	
	LABORATORY & XRAY EXPENSE		3,288	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,493	
	PHARMACY CONSULTANT	XVIII B 39-2	8,323	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				154,776
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,775	
				1,775
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,524	
				1,524
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID# LOFT REHABILITATION NURSING **#0054361 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	238,648	238,648
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	105,302	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	66,017	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0	
				171,319
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	10,489	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F		
	LICENSES & PERMITS	XIX F	345	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	2,500	
	PATIENT BACKGROUND CHECKS	XIX F	1,328	
				14,662
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		9,530	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		108,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	9,909	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		8,384	
	MESSENGER SERVICE		0	
				135,823

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	213,479	
	UNEMPLOYMENT COMPENSATION	XIX D	30,529	
	WORKERS COMPENSATION INSURANCE	XIX D	87,532	
	HOSPITALIZATION INSURANCE	XIX D	72,515	
	EMPLOYEE BENEFITS - OTHER	XIX D	178	
	EMPLOYEE PHYSICAL EXAMS	XIX D		
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D		
				404,233
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		1,392	
				1,392
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	8,975	
				8,975
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		0	
				0
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		48,511	
				48,511
27	**OTHER**			
	BAD DEBTS	VI 24	100,092	
				100,092

GRAND TOTAL COLUMN 3 OTHER **1,623,259**

LOFT REHABILITATION NURSING
SCHEDULES
12/31/2020

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	179,059
LESS SALES TAX	0
NET FOOD	179,059
TOTAL PATIENT CENSUS	25,999
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	77,997
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	33,672
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	77,997
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	0
NET FOOD	179,059
DIVIDE TOTAL MEALS/YEAR	0
COST PER MEAL	#DIV/0!
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**#DIV/0!**

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number LOFT REHABILITATION NURSING #0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							130,889	130,889			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,941	5,941		5,941	179,577	185,518			32
33	Real Estate Taxes							95,764	95,764			33
34	Rent-Facility & Grounds			531,503	531,503		531,503	(531,503)				34
35	Rent-Equipment & Vehicles			32,987	32,987		32,987	641	33,628			35
36	Other (specify):*							26,384	26,384			36
37	TOTAL Ownership			570,431	570,431		570,431	(98,248)	472,183			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		76,468	573,210	649,678		649,678		649,678			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			191,508	191,508		191,508		191,508			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		76,468	764,718	841,186		841,186		841,186			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,869,708	453,768	2,958,408	6,281,884		6,281,884	(415,328)	5,866,556			45

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

#REF!

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(32,043)	30		9
10	Interest and Other Investment Income	(96)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(9,909)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,092)	27		24
25	Fund Raising, Advertising and Promotional	(10,489)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(85,017)	22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (237,646)		$	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)	(177,682)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (177,682)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (415,328)		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

LOFT REHABILITATION NURSING

ID# 0054361

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (85,017)	21	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				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**	(85,017)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	3,600	0	0	0	0	0	0	0	0	0	3,600	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	3,600	0	0	0	0	0	0	0	0	0	3,600	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(133,991)	0	0	0	0	0	0	0	0	(133,991)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,230	244	0	0	0	0	0	0	0	0	8,474	19
20	Fees, Subscriptions & Promotions	(10,489)	0	0	0	0	0	0	0	0	0	0	(10,489)	20
21	Clerical & General Office Expenses	(94,926)	0	(108,000)	0	0	0	0	0	0	0	0	(202,926)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	94,871	0	0	0	0	0	0	0	0	0	94,871	26
27	Other (specify):*	(100,092)	0	23,473	0	0	0	0	0	0	0	0	(76,619)	27
28	**TOTAL General Administration**	(205,507)	103,101	(218,274)	0	0	0	0	0	0	0	0	(320,680)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(205,507)	106,701	(218,274)	0	0	0	0	0	0	0	0	(317,080)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(32,043)	162,932	0	0	0	0	0	0	0	0	0	130,889	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(96)	179,673	0	0	0	0	0	0	0	0	0	179,577	32
33	Real Estate Taxes	0	95,764	0	0	0	0	0	0	0	0	0	95,764	33
34	Rent-Facility & Grounds	0	(531,503)	0	0	0	0	0	0	0	0	0	(531,503)	34
35	Rent-Equipment & Vehicles	0	0	641	0	0	0	0	0	0	0	0	641	35
36	Other (specify):*	0	26,384	0	0	0	0	0	0	0	0	0	26,384	36
37	**TOTAL Ownership**	(32,139)	(66,750)	641	0	0	0	0	0	0	0	0	(98,248)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(237,646)	39,951	(217,633)	0	0	0	0	0	0	0	0	(415,328)	45

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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	$ 531,503	SELECT POST ACUTE CARE REALTY LLC	100.00%	$	$ (531,503)	1
2	V								2
3	V	30	DEPRECIATION				162,932	162,932	3
4	V	32	INTEREST				179,673	179,673	4
5	V	33	REAL ESTATE TAX				95,764	95,764	5
6	V	19	ACCOUNTING FEES				8,230	8,230	6
7	V	26	INSURANCE-PROPERTY				94,871	94,871	7
8	V	36	INSURANCE-MIP				26,384	26,384	8
9	V	6	MAINTENANCE				3,600	3,600	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 531,503			$ 571,454	$ * 39,951	14

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

###

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	21	OUTSIDE CLERICAL SVC	$ 108,000		100.00%	$	$ (108,000)	15
16	V	17	MANAGEMENT FEES	238,648				(238,648)	16
17	V								17
18	V	17	ADMIN COMP-D AARON				28,766	28,766	18
19	V	17	ADMIN COMP-R AARON				28,766	28,766	19
20	V	17	ADMIN COMP-A AARON				11,626	11,626	20
21	V	17	ADMIN COMP-C ROW				35,499	35,499	21
22	V	19	DATA PROCESSING				244	244	22
23	V	27	HEALTH INSURANCE				14,596	14,596	23
24	V	27	PAYROLL TAXES				8,877	8,877	24
25	V	35	AUTO LEASE				641	641	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			$ 346,648			$ 129,015	$ * (217,633)	39

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

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Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BERGER FAMILY TRUST	4.95	THE LOFT REHABILITATION & NURSING (	CANTON	SELECT POST ACUTE CARE REALTY LLC		BUILDING	1
2	STERN FAMILY INVESTMENT	4.95	THE LOFT REHABILITATION & NURSING (	NORMAL	SELECT HEALTHCARE CONSULTANTS IN		MANAGEMENT	2
3	ISRAEL FAMILY INVESTMENT TRUST	2.475			MISTY MEADOWS F	METROPOLIS	SENIOR APTS	3
4	ISRAEL INVESTMENT TRUST	2.475						4
5	SUSAN STERN	4.95						5
6	DIANIA KUFTA	1.50						6
7	DENNIS NEHMER	1.50						7
8	BRITTANY AVERY	2.00						8
9	HOWARD ALTER	3.00						9
10	ESTHER MARYLES	2.475						10
11	CHANA MAUER	2.475						11
12	DANIEL AARON	16.813						12
13	ROBERT AARON	16.813						13
14	ADAM AARON	16.813						14
15	MICHAEL AARON	16.812						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 LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	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	DANIEL AARON	MEMBER	ADMINISTRATIV	16.81	SCHEDULE	15	30.00	SALARY	$ 28,766	17-7	1
2	ROBERT AARON	MEMBER	ADMINISTRATIV	16.81	ATTACHED	15	30.00	SALARY	28,766	17-7	2
3	ADAM AARON	MEMBER	ADMINISTRATIV	16.81		10	28.00	SALARY	11,626	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 69,158		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.

#REF!

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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: SELECT HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	17	ADMIN COMP-D AARON	HOURS	50	3	$ 95,885	$ 95,885	15	$ 28,766	1
2	17	ADMIN COMP-R AARON	HOURS	50	3	95,885	95,885	15	28,766	2
3	17	ADMIN COMP-A AARON	HOURS	35	3	40,692	40,692	10	11,626	3
4	17	ADMIN COMP-C ROW	HOURS	45	3	106,498	106,498	15	35,499	4
5	19	DATA PROCESSING	PATIENT DAYS	77,366	3	726		25,999	244	5
6	27	HEALTH INSURANCE	PATIENT DAYS	77,366	3	43,434		25,999	14,596	6
7	27	PAYROLL TAXES	PATIENT DAYS	77,366	3	26,417		25,999	8,877	7
8	35	AUTO LEASE	PATIENT DAYS	77,366	3	1,907		25,999	641	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					$ 411,444	$ 338,960		$ 129,015	25

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Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LANCASTER POLLARD		X	MORTGAGE	9/1/2016	9/1/16	$ 4,287,028	$ 3,914,990	9/1/2043	4.5300	$ 179,673	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL							5,941	6
7												7
8												8
9	TOTAL Facility Related				$42,614.00		$ 4,287,028	$ 3,914,990			$ 185,614	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,287,028	$ 3,914,990			$ 185,614	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,384 Line # 36

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

** 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 LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.**	$ 42,000	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.)		$ 67,764	2
3. Under or (over) accrual (line 2 minus line 1).		$ 25,764	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 95,764	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015		8
2016	41,403	9
2017	41,085	10
2018	41,150	11
2019	67,764	12

	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.

#REF!

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LOFT REHABILITATION NURSING COUNTY WOODFORD

FACILITY IDPH LICENSE NUMBER 0054361

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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.	13-12-201-030	NURSING HOME	$ 15,492.72	$ 15,492.72
2.	13-12-201-026	NURSING HOME	$ 52,271.12	$ 52,271.12
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 67,763.84	$ 67,763.84

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,837 B. General Construction Type: Exterior BRICK Frame BRICK & STEEL Number of Stories 2

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 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	NURSING HOME		2016	$ 37,179	1
2					2
3	TOTALS			$ 37,179	3

#REF!

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 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	104		2016		$ 3,001,595	$ 114,152	39	$ 76,964	$ (37,188)	$ 307,856	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENTS - LANDLORD										9
10	SELECT CARE SIGN			2017	32,210		15	2,147	2,147	8,588	10
11	HALL 6 MEDICARE ROOMS 600-612 - NEW FLOORING, DRYWALL, WALLPAPER, DOORS, PAINT, LIGHT FIXTURES, BATHROOMS TILE, FIXTURES, CUBI										11
12				2017	227,193		39	5,825	5,825	23,300	12
13	THERAPY ROOM - FLOORING, WALLCOVERING, LIGHTING, CABINETS, WALL PROTECTION										13
14				2017	154,298		39	3,956	3,956	15,824	14
15	SKYLIGHT			2017	1,913		39	49	49	196	15
16	ELECTRICAL WORK			2017	1,800		39	46	46	184	16
17	NEW AC SYSTEM			2017	11,000		39	282	282	846	17
18	POUR & FINISH CONCRETE SIDEWALK			2018	1,450		39	37	37	111	18
19	CONDENSING UNIT & COIL - HALL 1			2018	11,766		39	302	302	906	19
20	VINYL PLANK FLOORING			2018	17,905		39	459	459	1,377	20
21	40' OF SEWER LINE REPLACED			2018	32,500		39	833	833	2,499	21
22	GRADE GROUNG TO HANDLE MORE WATER CAPACITY			2020	7,600		39	195	195	195	22
23	INSTALL NEW SECTIONS OF PIPE AND FITTINGS			2020	52,500		39	1,346	1,346	1,346	23
24	FIX FLOODING OF THE BOILER ROOM AND HALL 6			2020	5,200		39	133	133	133	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35						13,800			(13,800)		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

#REF!

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,558,930	$ 127,952		$ 92,576	$ (35,376)	$ 363,363	70

#REF!

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

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 33,329	$	$ 3,333	$ 3,333	10 YRS	$ 19,998	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		34,980	34,980				74
75	TOTALS	$ 33,329	$ 34,980	$ 38,313	$ 3,333		$ 19,998	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,629,438	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 162,932	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 130,889	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (32,043)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 383,361	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

#REF!

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 LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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

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

16. Rental Amount for movable equipment: $ 24,527 Description: SEE ATTACHED SCHEDULE
(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	NURSING, ACTIVITIES	2016 FORD TRANSIT	$ 705.00	$ 8,460	17
18	MAINTENANCE	T350			18
19					19
20					20
21	TOTAL		$ 705.00	$ 8,460	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 LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 ____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

###

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 235,784	$		$ 235,784	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			91,605			91,605	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			245,821			245,821	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				66,830		66,830	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	LABORATORY Other (specify): TRANSPORTATION	39-2					4,207 5,431		4,207 5,431	13
14	TOTAL			$		$ 573,210	$ 76,468		$ 649,678	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.

#REF!

STATE OF ILLINOIS

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 414,239	$ 441,151	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	1,038,071	1,038,071	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,129	43,780	6
7	Other Prepaid Expenses	20,263	20,263	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ESCROWS		164,219	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,494,702	$ 1,707,484	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		338,724	13
14	Buildings, at Historical Cost		3,594,945	14
15	Leasehold Improvements, at Historical Cost		525,225	15
16	Equipment, at Historical Cost	33,329	530,526	16
17	Accumulated Depreciation (book methods)	(33,329)	(1,014,156)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 3,975,264	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,494,702	$ 5,682,748	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 517,370	$ 529,888	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	159,270	159,270	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,071	11,071	31
32	Accrued Real Estate Taxes(Sch.IX-B)		69,999	32
33	Accrued Interest Payable		15,100	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 687,711	$ 785,328	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	640,000	640,000	39
40	Mortgage Payable		3,914,991	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 640,000	$ 4,554,991	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,327,711	$ 5,340,319	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 166,991	$ 342,429	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,494,702	$ 5,682,748	48

#REF!

*(See instructions.)

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (771,523)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (771,523)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	938,514	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	( )	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)**	$ 938,514	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)**	$ 166,991	24 *

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

#REF!

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,597,575	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,597,575	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	442,066	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 442,066	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	40	13
14	Non-Patient Meals	360	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 400	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	96	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 96	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	STIMULUS PAYMENT	1,186,777	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,186,777	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,226,914	30

#REF!

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	972,891	31
32	Health Care	2,430,519	32
33	General Administration	1,466,857	33
	B. Capital Expense		
34	Ownership	570,431	34
	C. Ancillary Expense		
35	Special Cost Centers	649,678	35
36	Provider Participation Fee	191,508	36
	D. Other Expenses (specify):		
37	OUT OF PERIOD EXPENSES	6,516	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,288,400	40
41	**Income before Income Taxes (line 30 minus line 40)****	938,514	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 938,514	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,893,011	44
45	Private Pay - Net Inpatient Revenue	1,109,576	45
46	Medicare - Net Inpatient Revenue	1,276,612	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	318,376	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,597,575	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,008	2,080	$ 80,501	$ 38.70	1
2	Assistant Director of Nursing	1,464	1,464	72,689	49.65	2
3	Registered Nurses	13,932	15,007	523,555	34.89	3
4	Licensed Practical Nurses	10,673	11,096	318,039	28.66	4
5	CNAs & Orderlies	52,130	55,044	822,795	14.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,018	2,193	32,100	14.64	9
10	Activity Assistants	5,139	5,239	58,949	11.25	10
11	Social Service Workers	1,832	2,020	29,590	14.65	11
12	Dietician					12
13	Food Service Supervisor	1,365	1,365	18,684	13.69	13
14	Head Cook	4,557	4,722	54,205	11.48	14
15	Cook Helpers/Assistants	7,250	7,451	88,751	11.91	15
16	Dishwashers					16
17	Maintenance Workers	4,652	4,974	94,359	18.97	17
18	Housekeepers	9,251	9,580	129,931	13.56	18
19	Laundry	1,907	2,018	37,450	18.56	19
20	Administrator	1,696	1,776	82,082	46.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,450	9,235	241,972	26.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,967	2,131	37,472	17.58	31
32	Other Health C: CARE PLAN/RES	2,468	2,618	102,020	38.97	32
33	Other(specify) Admissions DIR	1,793	1,990	44,564	22.39	33
34	TOTAL (lines 1 - 33)	134,552	142,003	$ 2,869,708 *	$ 20.21	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	M	$ 8,956	1-3	35
36	Medical Director	O	11,028	9-3	36
37	Medical Records Consultant	N	1,493	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	8,323	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,775	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 31,575		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	780	$ 42,940	10-3	50
51	Licensed Practical Nurses	339	15,287	10-3	51
52	Certified Nurse Assistants/Aides	2,384	83,445	10-3	52
53	TOTAL (lines 50 - 52)	3,503	$ 141,672		53

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RYAN NETTESHEIM	ADMINISTRATOR	0	$ 68,949
TIMOTHY WILEY	ADMINISTRATOR	0	13,133
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 82,082

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 238,648
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 238,648

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		171,319
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 171,319

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,532
Unemployment Compensation Insurance	30,529
FICA Taxes	213,479
Employee Health Insurance	72,515
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	178
	0
	0
	0
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 404,233

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	2,500
(Indicate # of checks performed 250)	
Patient Background Checks 133	1,328
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	10,489
LICENSES/DUES/SUBSCRIPTIONS	345
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(10,489)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,173

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	8,975
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,975

* Attach copy of IMRF notifications

**See instructions.

#

LOFT REHABILITATION NURSING
SCHEDULE - LEGAL
12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
3/1/2020	CARD SERVICES		250.00
3/23/2020	MUCH SHELIST	ACQUISITION OF PROPERTY	500.00
4/1/2020	MUCH SHELIST	GENERAL COUNSELING	11.93
1/18/2020	POLSINELLI PC	IDPH SURVEY	2,440.14
1/14/2020	POLSINELLI PC	IDPH SURVEY	1,035.00
1/31/2020	STONE POGRUND & KOREY LLC	VARIOUS COLLECTIONS AND GUARDIANSHIPS	908.69
2/29/2020	STONE POGRUND & KOREY LLC	VARIOUS COLLECTIONS AND GUARDIANSHIPS	1,085.15
2/10/2020	SKIDELSKY & ASSOCIATES	REAL ESTATE TAX APPEAL	5,115.00
2/10/2020	SKIDELSKY & ASSOCIATES	REAL ESTATE TAX APPEAL	7,495.00
1/1/2020		ACCRUAL OF LEGAL FEES FOR SKIDELSKY	6,000.00
TOTAL			**24,840.91**

Facility Name & ID Number LOFT REHABILITATION NURSING # 0054361 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(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?

(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 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 6,972 Line 10-2

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

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 191,508
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.

#REF!

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? 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. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name:

(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.