

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0055145</u></p> <p>Facility Name: <u>Palos Heights Rehabilitation</u></p> <p>Address: <u>13259 S Central Ave</u> <u>Crestwood</u> <u>60418</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 597-1000</u> Fax # <u>(708) 389-9990</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/1/2019</u></p> <p>Type of Ownership:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width: 33%; vertical-align: top;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width: 20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ <u>04/07/2021</u> <i>* Subject to the attached Accountants' Consulting Report</i> (Date) (Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u> (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ <u>04/07/2021</u> <i>* Subject to the attached Accountants' Consulting Report</i> (Date) (Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u> (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ <u>04/07/2021</u> <i>* Subject to the attached Accountants' Consulting Report</i> (Date) (Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u> (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>							

Facility Name & ID Number Palos Heights Rehabilitation

0055145 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	53,070	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	193	TOTALS	193	70,638	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,273	3,539	12,443	26,255	8
9	SNF/PED					9
10	ICF	13,458	2,816	790	17,064	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,731	6,355	13,233	43,319	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.33%

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

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

I. On what date did you start providing long term care at this location?
Date started 3/1/2019

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/1/2019 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 145 and days of care provided 8,913

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Palos Heights Rehabilitation # 0055145 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	531,595	104,374	11,474	647,443		647,443		647,443		1
2	Food Purchase		311,037		311,037		311,037	(678)	310,359		2
3	Housekeeping	190,330	78,543		268,873		268,873	610	269,483		3
4	Laundry	72,318	53,816		126,134		126,134		126,134		4
5	Heat and Other Utilities			195,867	195,867		195,867	593	196,460		5
6	Maintenance	258,093	45	216,944	475,082		475,082	(25,214)	449,868		6
7	Other (specify):*										7
8	TOTAL General Services	1,052,336	547,815	424,285	2,024,436		2,024,436	(24,688)	1,999,748		8
	B. Health Care and Programs										
9	Medical Director			71,000	71,000		71,000		71,000		9
10	Nursing and Medical Records	4,411,871	408,593	38,125	4,858,589		4,858,589	35	4,858,624		10
10a	Therapy	107,144		27,566	134,710		134,710		134,710		10a
11	Activities	149,599	33,450	633	183,682		183,682		183,682		11
12	Social Services	230,937		244	231,181		231,181		231,181		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							997	997		15
16	TOTAL Health Care and Programs	4,899,551	442,043	137,568	5,479,162		5,479,162	1,033	5,480,195		16
	C. General Administration										
17	Administrative	204,187			204,187		204,187	53,391	257,578		17
18	Directors Fees										18
19	Professional Services			1,125,347	1,125,347	(50,007)	1,075,340	(691,682)	383,658		19
20	Dues, Fees, Subscriptions & Promotions			19,473	19,473		19,473	42	19,515		20
21	Clerical & General Office Expenses	234,538	6,173	844,396	1,085,107		1,085,107	(649,782)	435,325		21
22	Employee Benefits & Payroll Taxes			1,315,240	1,315,240		1,315,240		1,315,240		22
23	Inservice Training & Education										23
24	Travel and Seminar			328	328		328		328		24
25	Other Admin. Staff Transportation			710	710		710	657	1,367		25
26	Insurance-Prop.Liab.Malpractice			402,164	402,164		402,164	766	402,930		26
27	Other (specify):*							25,323	25,323		27
28	TOTAL General Administration	438,725	6,173	3,707,658	4,152,556	(50,007)	4,102,549	(1,261,283)	2,841,266		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,390,612	996,031	4,269,511	11,656,154	(50,007)	11,606,147	(1,284,939)	10,321,208		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 Palos Heights Rehabilitation

#0055145

Report Period Beginning:

01/01/20

Ending:

12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			11,964	11,964		11,964	623,496	635,460			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,419	33,419		33,419	895,698	929,117			32
33	Real Estate Taxes			1,465,219	1,465,219	50,007	1,515,226	2,314	1,517,540			33
34	Rent-Facility & Grounds			1,820,833	1,820,833		1,820,833	(1,820,833)				34
35	Rent-Equipment & Vehicles			18,239	18,239		18,239	1,833	20,072			35
36	Other (specify):*											36
37	TOTAL Ownership			3,349,674	3,349,674	50,007	3,399,681	(297,493)	3,102,188			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		468,746	1,327,672	1,796,418		1,796,418	(32,617)	1,763,801			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			317,613	317,613		317,613		317,613			42
43	Other (specify):*			5,774	5,774		5,774	(5,774)				43
44	TOTAL Special Cost Centers		468,746	1,651,059	2,119,805		2,119,805	(38,391)	2,081,414			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,390,612	1,464,777	9,270,244	17,125,633		17,125,633	(1,620,823)	15,504,810			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(385)	02		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	(40,594)	30		9
10	Interest and Other Investment Income	(576)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,572)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(456)	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	(441)	21		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	(803,929)	21		24
25	Fund Raising, Advertising and Promotional				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	(291,378)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,142,831)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(477,992)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (477,992)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,620,823)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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

Palos Heights Rehabilitation

ID# 0055145

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Bank Charges	\$ (8,132)	21	1
2	Theft Loss	(2,059)	21	2
3	Related Party Interest	(13,417)	32	3
4	Capitalized R&M	(26,062)	06	4
5	Non-Allowable Legal Fees	(32,957)	19	5
6	Building Company - Management Fee	(19,300)	19	6
7	Building Company - Professional Fees	(7,050)	19	7
8	Building Company - Misc. Admin. Expenses	(476)	21	8
9	Building Company - Amortization	(74,424)	36	9
10	Building Company - Intercompany Interest	(56,153)	32	10
11	Lawsuit Settlement	(40,073)	19	11
12	Website Design	(5,774)	43	12
13	Prior Year Professional Fee	(5,501)	19	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
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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	(291,378)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Palos Heights Rehabilitation

0055145

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(841)		163									(678)	2
3	Housekeeping			610									610	3
4	Laundry													4
5	Heat and Other Utilities			593									593	5
6	Maintenance	(26,062)		848									(25,214)	6
7	Other (specify):*													7
8	TOTAL General Services	(26,903)		2,215									(24,688)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,572)		7,473	(2,865)								35	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			997									997	15
16	TOTAL Health Care and Programs	(4,572)		8,470	(2,865)								1,033	16
	C. General Administration													
17	Administrative			53,391									53,391	17
18	Directors Fees													18
19	Professional Services	(104,881)	26,350	(613,151)									(691,682)	19
20	Fees, Subscriptions & Promotions	(500)		542									42	20
21	Clerical & General Office Expenses	(815,037)	476	164,779									(649,782)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			657									657	25
26	Insurance-Prop.Liab.Malpractice			766									766	26
27	Other (specify):*			25,323									25,323	27
28	TOTAL General Administration	(920,418)	26,826	(367,691)									(1,261,283)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(951,893)	26,826	(357,007)	(2,865)								(1,284,939)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Palos Heights Rehabilitation

0055145

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(40,594)	658,069	6,021									623,496	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(70,146)	965,343	501									895,698	32
33	Real Estate Taxes			2,314									2,314	33
34	Rent-Facility & Grounds		(1,820,833)										(1,820,833)	34
35	Rent-Equipment & Vehicles			1,833									1,833	35
36	Other (specify):*	(74,424)	74,424											36
37	TOTAL Ownership	(185,164)	(122,997)	10,668									(297,493)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(32,617)								(32,617)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(5,774)											(5,774)	43
44	TOTAL Special Cost Centers	(5,774)			(32,617)								(38,391)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,142,831)	(96,171)	(346,339)	(35,482)								(1,620,823)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,820,833	Freeport Property LLC		\$	(1,820,833)	1
2	V	33 Real Estate Tax	1,465,219	Freeport Property LLC		1,465,219		2
3	V	32 Interest	654	Freeport Property LLC		965,997	965,343	3
4	V	19 Management Fee		Freeport Property LLC		19,300	19,300	4
5	V	19 Professional Fee		Freeport Property LLC		7,050	7,050	5
6	V	21 Misc. Admin. Expense		Freeport Property LLC		476	476	6
7	V	30 Depreciation		Freeport Property LLC		658,069	658,069	7
8	V	36 Amortization		Freeport Property LLC		74,424	74,424	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,286,706			\$ 3,190,535	\$ * (96,171)	14

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

Facility Name & ID Number

Palos Heights Rehabilitation

0055145

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	Atied Associates, LLC	46.00%	Devon Gables Rehabilitation Center	Tucson, AZ	Freeport Property LLC	Crestwood	Building Company	1
2	William Rothner	40.00%	Foothills Rehabilitation Center	Tucson, AZ	Altitude Health Services	Evanston	Financial Services	2
3	Elaine Rothner Legacy Trust	6.00%	University Rehabilitation Center	Urbana	Care Centers Building	Evanston	Building Company	3
4	D&G Mishpacha Fund II, LLC	2.00%			MAC RX	DesPlaines	Pharmacy	4
5	Steven Miretzky	2.00%						5
6	Joe Zimmerman	2.00%						6
7	Keith Gibbons	2.00%						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

Palos Heights Rehabilitation

0055145

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	Altitude Health Service, Inc.		\$ 163	\$	163	15
16	V	3 Housekeeping		Altitude Health Service, Inc.		610		610	16
17	V	5 Utilities		Altitude Health Service, Inc.		593		593	17
18	V	6 Maintenance		Altitude Health Service, Inc.		848		848	18
19	V	10 Nursing - Salaries		Altitude Health Service, Inc.		7,413		7,413	19
20	V	10 Nursing - Other Expense		Altitude Health Service, Inc.		59		59	20
21	V	15 Employee Benefits-Nursing		Altitude Health Service, Inc.		997		997	21
22	V	17 Administrative Salaries		Altitude Health Service, Inc.		29,538		29,538	22
23	V	17 Management Fees		Altitude Health Service, Inc.		23,854		23,854	23
24	V	19 Professional Fees		Altitude Health Service, Inc.		6,143		6,143	24
25	V	19 Professional Fees - Direct Allocation		Altitude Health Service, Inc.		135,000		135,000	25
26	V	19 Professional Fees - Tax Appeal		Altitude Health Service, Inc.		7		7	26
27	V	20 Due, Fees, Subscriptions		Altitude Health Service, Inc.		542		542	27
28	V	21 Clerical / Office - Salaries		Altitude Health Service, Inc.		157,627		157,627	28
29	V	21 Clerical / Office - Other Expense		Altitude Health Service, Inc.		7,152		7,152	29
30	V	25 Auto & Travel		Altitude Health Service, Inc.		657		657	30
31	V	26 Insurance		Altitude Health Service, Inc.		766		766	31
32	V	27 Employee Benefits-Administrative		Altitude Health Service, Inc.		25,323		25,323	32
33	V	30 Depreciation		Altitude Health Service, Inc.		6,021		6,021	33
34	V	32 Interest		Altitude Health Service, Inc.		501		501	34
35	V	33 Real Estate Tax		Altitude Health Service, Inc.		2,314		2,314	35
36	V	35 Rent - Auto		Altitude Health Service, Inc.		737		737	36
37	V	35 Rent - Equipment		Altitude Health Service, Inc.		1,095		1,095	37
38	V	19 Home Office Fee	754,300	Altitude Health Service, Inc.				(754,300)	38
39	Total		\$ 754,300			\$ 407,961	\$ *	(346,339)	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Nursing and Medical Records	\$ 30,657	MAC Rx, LLC		\$ 27,792	\$ (2,865)
16	V	39 Ancillary	349,002	MAC Rx, LLC		316,385	(32,617)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 379,659			\$ 344,177	\$ * (35,482)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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

Palos Heights Rehabilitation

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Report Period Beginning:

01/01/20

Ending:

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	William Rothner	Owner	Administrative	40.00%	See Attached	6.83	13.66%	Sal/Mgmt Fee	\$ 34,157	17-07	1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 34,157		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 Palos Heights Rehabilitation

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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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Palos Heights Rehabilitation

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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

Altitude Health Services, Inc.

Street Address

2201 Main Street

City / State / Zip Code

Evanston, IL 60202

Phone Number

(847) 261-2400

Fax Number

(847) 261-2410

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	PATIENT DAYS	317,055	8	\$ 1,196	\$ 43,319	\$ 163	1	
2	3	Housekeeping	PATIENT DAYS	317,055	8	4,468	43,319	610	2	
3	5	Utilities	PATIENT DAYS	317,055	8	4,339	43,319	593	3	
4	6	Maintenance	PATIENT DAYS	317,055	8	6,207	43,319	848	4	
5	10	Nursing - Salaries	PATIENT DAYS	317,055	8	54,259	54,259	43,319	7,413	5
6	10	Nursing - Other Expense	PATIENT DAYS	317,055	8	434	43,319	59	6	
7	15	Employee Benefits-Nursing	PATIENT DAYS	317,055	8	7,300	43,319	997	7	
8	17	Administrative Salaries	PATIENT DAYS	317,055	8	216,187	216,187	43,319	29,538	8
9	17	Management Fees	PATIENT DAYS	317,055	8	174,587	43,319	23,854	9	
10	19	Professional Fees	PATIENT DAYS	317,055	8	44,958	43,319	6,143	10	
11	19	Professional Fees - Direct Allocati	DIRECT			135,000		135,000	11	
12	19	Professional Fees - Tax Appeal	PATIENT DAYS	317,055	8	50	43,319	7	12	
13	20	Due, Fees, Subscriptions	PATIENT DAYS	317,055	8	3,967	43,319	542	13	
14	21	Clerical / Office - Salaries	PATIENT DAYS	317,055	8	1,153,683	1,153,683	43,319	157,627	14
15	21	Clerical / Office - Other Expense	PATIENT DAYS	317,055	8	52,347	43,319	7,152	15	
16	25	Auto & Travel	PATIENT DAYS	317,055	8	4,811	43,319	657	16	
17	26	Insurance	PATIENT DAYS	317,055	8	5,607	43,319	766	17	
18	27	Employee Benefits-Administrative	PATIENT DAYS	317,055	8	185,344	43,319	25,323	18	
19	30	Depreciation	PATIENT DAYS	317,055	8	44,067	43,319	6,021	19	
20	32	Interest	PATIENT DAYS	317,055	8	3,668	43,319	501	20	
21	33	Real Estate Tax	PATIENT DAYS	317,055	8	16,933	43,319	2,314	21	
22	35	Rent - Auto	PATIENT DAYS	317,055	8	5,395	43,319	737	22	
23	35	Rent - Equipment	PATIENT DAYS	317,055	8	8,018	43,319	1,095	23	
24									24	
25	TOTALS					\$ 2,132,825	\$ 1,424,129	\$ 407,961	25	

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation		\$	\$		\$ 27,792	1
2	39	Ancillary	Direct Allocation					316,385	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				\$	\$		\$ 344,177	25

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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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Palos Heights Rehabilitation

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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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

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01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Palos Heights Rehabilitation

0055145

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Palos Heights Rehabilitation

0055145 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Palos Heights Rehabilitation

0055145

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Palos Heights Rehabilitation

0055145

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Palos Heights Rehabilitation

0055145

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	CIBC Bank		X	Mortgage			\$	\$ 16,000,000			\$	909,845	1					
2													2					
3													3					
4													4					
5													5					
Working Capital																		
6	CIBC Bank		X	Line of Credit								14,730	6					
7	Insurance		X									5,272	7					
8													8					
9	TOTAL Facility Related						\$	\$ 16,000,000			\$	929,847	9					
B. Non-Facility Related*																		
10	Interest Income		X									(576)	10					
11	Interest Income (Bldg Co)		X									(654)	11					
12	Alloc from Altitude Health Service											501	12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	(729)	14					
15	TOTALS (line 9+line14)						\$	\$ 16,000,000			\$	929,118	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.	\$	750,000	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.)	\$	1,093,533	2
3. Under or (over) accrual (line 2 minus line 1).	\$	343,533	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	1,124,000	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.)	\$	50,007	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.	\$	1,517,540	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	_____	8
	2016	_____	9
	2017	_____	10
	2018	_____	11
	2019	1,091,219	12

2020 Accrual = \$1,091,219 x 1.03 = \$1,124,000 (rounded)

Allocated from Altitude Health Service \$2,314

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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Palos Heights Rehabilitation COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055145

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>24-33-300-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,091,218.87</u>	\$ <u>1,091,218.87</u>
2. <u>See Attached</u>	<u>Alloc from Altitude Health Service</u>	\$ <u>197,162.69</u>	\$ <u>2,313.57</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>1,288,381.56</u></u>	\$ <u><u>1,093,532.44</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 Palos Heights Rehabilitation COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055145

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 Palos Heights Rehabilitation

0055145 Report Period Beginning:

01/01/20 Ending:

12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,845 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: _____ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	441,662	2019	\$ 1,173,156	1
2	Allocated from Altitude Health Service-Care Centers Building			9,622	2
3	TOTALS	441,662		\$ 1,182,778	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	193		2019	1960	\$ 18,098,695	\$ 658,069	35	\$ 517,106	\$ (140,963)	\$ 1,034,212	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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			91,705		3,038	3,038		49,139
69					11,964		(11,964)	
70			\$ 18,190,400		\$ 673,071	\$ 520,144	\$ (152,927)	\$ 1,083,351

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 18,190,400	\$ 673,071		\$ 520,144	\$ (152,927)	\$ 1,083,351	1
2	Sewage Injector System	2019	10,792		20	540	540	990	2
3	Phone System	2019	7,900		20	395	395	691	3
4	Sprinkler System	2019	6,739		20	337	337	590	4
5	Sprinkler Pump System	2019	6,580		20	329	329	576	5
6	Exterior Signs	2019	2,877		20	144	144	156	6
7	Interior Signs	2019	5,319		20	266	266	288	7
8	Changed Swamp Cooler Water Filter Panels	2019	3,280		20	164	164	328	8
9	Patch & Repaint Rooms	2019	2,550		20	128	128	256	9
10	Pipe Leak Repair- Laundry Room	2019	3,117		20	156	156	312	10
11	Control And Door Repair - West Entry	2019	2,629		20	131	131	262	11
12	Sewage Ejector System Pump Repair	2019	5,542		20	277	277	554	12
13	Elevator Maintenance	2019	2,659		20	133	133	266	13
14	Pedestrian Door Repair	2019	3,831		20	192	192	384	14
15	Submersible Sewage Pump	2020	4,500		20	225	225	225	15
16	85 Gallon Water Heater By Laundry Room, Including Installation	2020	8,884		20	444	444	444	16
17	New Ejector Pump In Basement	2020	9,353		20	468	468	468	17
18	Carrier Air Cooler Chiller Compressor Replacement	2020	15,347		20	767	767	767	18
19	Refurbish Zoeller Pump	2020	2,750		20	138	138	138	19
20	Roof Repair And Coat With Silicon	2020	129,000		20	6,450	6,450	6,450	20
21	Chimney Masonry Restoration	2020	4,500		20	225	225	225	21
22	Fire Alarm Repair	2020	5,034		20	252	252	252	22
23	Alarm Repairs: Heat Detectors, Batteries, Pull Stations	2020	2,803		20	140	140	140	23
24	Boiler: Replaced Hot Surface Ignitors And Flame Sensors	2020	5,216		20	261	261	261	24
25	Heating Repairs: Replaced Pressure Guages, Strainer, Thermostat	2020	3,262		20	163	163	163	25
26	Replaced Ignitors, Burner Assemblies And Gaskets On Boilers	2020	9,747		20	487	487	487	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 18,454,611	\$ 673,071		\$ 533,356	\$ (139,715)	\$ 1,099,024	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 18,454,611	\$ 673,071		\$ 533,356	\$ (139,715)	\$ 1,099,024	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		\$ 18,454,611	\$ 673,071		\$ 533,356	\$ (139,715)	\$ 1,099,024	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 18,454,611	\$ 673,071		\$ 533,356	\$ (139,715)	\$ 1,099,024	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		\$ 18,454,611	\$ 673,071		\$ 533,356	\$ (139,715)	\$ 1,099,024	34

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

Facility Name & ID Number Palos Heights Rehabilitation

0055145

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 18,454,611	\$ 673,071		\$ 533,356	\$ (139,715)	\$ 1,099,024	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		\$ 18,454,611	\$ 673,071		\$ 533,356	\$ (139,715)	\$ 1,099,024	34

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

Facility Name & ID Number Palos Heights Rehabilitation

0055145

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	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 Building Company		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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
31								31
32								32
33								33
34		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Altitude Health Service-Care Centers Building	2002	13,260	340	39	340		6,219	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Altitude Health Service-Care Centers Building	2002	10,954		20			10,854	9
10	Allocated from Altitude Health Service-Care Centers Building	2003	12,908		20			12,908	10
11	Allocated from Altitude Health Service-Care Centers Building	2005	641		20			641	11
12	Allocated from Altitude Health Service-Care Centers Building	2009	116	6	20	6		69	12
13	Allocated from Altitude Health Service-Care Centers Building	2013	50,826	2,541	20	2,541		17,789	13
14	Allocated from Altitude Health Service-Care Centers Building	2015	182	9	20	9		118	14
15	Allocated from Altitude Health Service-Care Centers Building	2016	721	36	20	36		180	15
16	Allocated from Altitude Health Service-Care Centers Building	2017	1,250	63	20	63		250	16
17	Allocated from Altitude Health Service-Care Centers Building	2019	573	29	20	29		86	17
18	Allocated from Altitude Health Service-Care Centers Building	2019	216	11	20	11		22	18
19	Allocated from Altitude Health Service-Care Centers Building	2020	58	3	20	3		3	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)		\$ 91,705	\$ 3,038		\$ 3,038	\$	\$ 49,139	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 91,705	\$ 3,038		\$ 3,038		\$ 49,139	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		\$ 91,705	\$ 3,038		\$ 3,038		\$ 49,139	34

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

Facility Name & ID Number Palos Heights Rehabilitation

0055145

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	\$ 1,021,054	\$ 2,984	\$ 102,105	\$ 99,121	10	\$ 218,480	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	3,672				10	3,672	73
74								74
75	TOTALS	\$ 1,024,726	\$ 2,984	\$ 102,105	\$ 99,121		\$ 222,152	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)	\$ 20,662,115	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 676,055	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 635,461	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (40,594)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,321,176	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	Architect-Dialysis Room	\$ 7,500	92
93			93
94			94
95		\$ 7,500	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.

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								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: _____ *

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: \$ 19,333 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	<u>Allocated from Altitude Health Service</u>		\$	\$ <u>737</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>737</u>	21

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 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 546,589	\$		\$ 546,589	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			195,404			195,404	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			557,696			557,696	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 prescripts				353,516		353,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Attached</u>					27,983	115,230		143,213	13
14	TOTAL			\$		\$ 1,327,672	\$ 468,746		\$ 1,796,418	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 Palos Heights Rehabilitation

0055145

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 3,423,970	\$ 4,646,472	1
2	Cash-Patient Deposits	370	370	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,206,851	2,206,851	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,178	80,178	6
7	Other Prepaid Expenses	12,102	12,102	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>		644,295	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,723,471	\$ 7,590,268	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,173,156	13
14	Buildings, at Historical Cost		18,098,695	14
15	Leasehold Improvements, at Historical Cost	163,782	163,782	15
16	Equipment, at Historical Cost	59,332	1,041,976	16
17	Accumulated Depreciation (book methods)	(17,057)	(2,178,831)	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): <u>See Attached</u>	361,863	374,268	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 567,920	\$ 18,673,046	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,291,391	\$ 26,263,314	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 3,916,382	\$ 3,916,381	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	473,373	473,373	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,265	23,265	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,124,000	1,124,000	32
33	Accrued Interest Payable		58,559	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached</u>	1,938,690	1,938,690	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,475,710	\$ 7,534,268	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached</u>	5,500	1,040,313	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,500	\$ 17,040,313	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,481,210	\$ 24,574,581	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,189,819)	\$ 1,688,733	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,291,391	\$ 26,263,314	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (391,000)	1
2	Restatements (describe):		2
3	Member Equity	(1,000,000)	3
4	Rounding	2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,390,998)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(798,821)	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) Member Equity	1,000,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 201,179	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,189,819)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 14,419,785	1
2	Discounts and Allowances for all Levels	(5,191,921)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,227,864	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,004,898	6
7	Oxygen	3,362	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,008,260	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		13
14	Non-Patient Meals	385	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	352,380	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,427	19
20	Radiology and X-Ray	20,087	20
21	Other Medical Services	58,987	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 460,266	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	576	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 576	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,629,846	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,629,846	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,326,812	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,024,436	31
32	Health Care	5,479,162	32
33	General Administration	4,152,556	33
B. Capital Expense			
34	Ownership	3,349,674	34
C. Ancillary Expense			
35	Special Cost Centers	1,802,192	35
36	Provider Participation Fee	317,613	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,125,633	40
41	Income before Income Taxes (line 30 minus line 40)**	(798,821)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (798,821)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,975,191	44
45	Private Pay - Net Inpatient Revenue	1,996,336	45
46	Medicare - Net Inpatient Revenue	1,823,361	46
47	Other-(specify) <u>Hospice</u>	375,060	47
48	Other-(specify) <u>Insurance</u>	57,916	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,227,864	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.

Facility Name & ID Number Palos Heights Rehabilitation

0055145

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,937	2,090	\$ 126,768	\$ 60.65	1
2	Assistant Director of Nursing	1,387	1,555	62,566	40.24	2
3	Registered Nurses	47,554	51,782	1,803,259	34.82	3
4	Licensed Practical Nurses	27,675	29,472	923,632	31.34	4
5	CNAs & Orderlies	84,066	89,954	1,391,629	15.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,116	5,561	107,144	19.27	8
9	Activity Director	1,915	2,093	38,857	18.57	9
10	Activity Assistants	8,601	9,011	110,742	12.29	10
11	Social Service Workers	8,851	9,707	230,937	23.79	11
12	Dietician					12
13	Food Service Supervisor	3,934	4,280	108,477	25.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,025	12,500	196,065	15.69	15
16	Dishwashers	16,998	18,032	227,053	12.59	16
17	Maintenance Workers	13,967	15,408	258,093	16.75	17
18	Housekeepers	13,972	15,194	190,330	12.53	18
19	Laundry	5,548	6,168	72,318	11.72	19
20	Administrator	2,804	3,139	133,353	42.48	20
21	Assistant Administrator	1,991	2,165	70,834	32.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,420	13,701	234,538	17.12	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	3,222	3,943	63,759	16.17	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,765	1,912	40,258	21.06	33
34	TOTAL (lines 1 - 33)	274,748	297,667	\$ 6,390,612 *	\$ 21.47	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	153	\$ 11,474	01-03	35
36	Medical Director	Monthly	71,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	346	25,850	10-03	38
39	Pharmacist Consultant	122	12,275	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	276	27,566	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	633	11-03	44
45	Social Service Consultant	4	244	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	911	\$ 149,042		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Palos Heights Rehabilitation

0055145

Report Period Beginning: 01/01/20

Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Anna Kaczor	Administrator	0	\$ 89,181	Workers' Compensation Insurance	\$ 136,662	IDPH License Fee	\$		
Laura Roberts	Administrator	0	44,172	Unemployment Compensation Insurance	112,602	Advertising: Employee Recruitment	2,170		
Julie Norton	Asst. Administrator	0	70,834	FICA Taxes	488,882	Health Care Worker Background Check	780		
				Employee Health Insurance	569,928	(Indicate # of checks performed <u>78</u>)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	7,400		
				Employee Physicals	679	Licenses & Fees	8,623		
				Other Employee Welfare	822	Allocated from Altitude Health Service, Inc.	542		
				Employee Enrichment	4,673				
				Holiday Expense	992				
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 204,187	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,315,240	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,515
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	328	
C. Professional Services									
Vendor/Payee	Type		Amount						
Marcum LLP	Accounting		\$ 10,856						
Ability Networks Inc.	Eligibility Software		9,416						
Beyond Trust Corporation	Cyber Security		1,094						
Comodo Security Solutions, Inc.	Cyber Security		2,727						
Matrixcare	Data Processing		24,288						
National Datacare Corp.	Resident Trust Fund Services		302						
Network Consulting Group LLC	I.T. Service		270						
Propay HR	Payroll Processing		38,108						
Provinet Solutions	Data Processing		94,755						
See Attached	Legal		79,941						
See Supplemental Schedule			863,589						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 1,125,346	TOTAL		\$	Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 328	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Palos Heights Rehabilitation

0055145

Report Period Beginning:

01/01/20

Ending:

12/31/20

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (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. \$ 91,059 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. \$ 317,613
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? 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? 100% Ln 14
- 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 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.