		FOR BHF USE			

LL1

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

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

I.

IDPH License ID Number: 0056143

Facility Name: Sheridan Village Nrsg Rhb

Address: 5838 N Sheridan Road (Number) Chicago (City) 60660 (Zip Code)

County: Cook

Telephone Number: (773) 769-2230 **Fax #** (773) 769-3579

HFS ID Number:

Date of Initial License for Current Owners: 2019

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Joshua S. Banach Telephone Number: (847) 628-8784
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Denise A Leonard, CPA Partner
	(Firm Name & Address)	Plante Moran PLLC 1111 Superior Ave Suite 1250 Cleveland, OH 44114
	(Telephone)	(216) 274-6514 Fax # (248) 233-7349

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	63	Skilled (SNF)	63	23,058	1
2		Skilled Pediatric (SNF/PED)			2
3	128	Intermediate (ICF)	128	46,848	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	191	TOTALS	191	69,906	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		666	4,694	5,360	8
9	SNF/PED					9
10	ICF	53,831			53,831	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,831	666	4,694	59,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.67%

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

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2019 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 63 and days of care provided 4,114

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] 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: Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	441,141	56,577	21,627	519,345		519,345		519,345			1
2	Food Purchase		424,302		424,302		424,302		424,302			2
3	Housekeeping	308,776	63,841		372,617		372,617		372,617			3
4	Laundry	162,238	52,259		214,497		214,497		214,497			4
5	Heat and Other Utilities			255,749	255,749		255,749	(19,325)	236,424			5
6	Maintenance	88,506	189,069	20,612	298,187		298,187	(50,113)	248,074			6
7	Other (specify):*	98,637		52,888	151,525		151,525		151,525			7
8	**TOTAL General Services**	1,099,298	786,048	350,876	2,236,222		2,236,222	(69,438)	2,166,784			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	3,749,091	311,557	11,386	4,072,034		4,072,034	(80)	4,071,954			10
10a	Therapy	177,357		1,273,223	1,450,580		1,450,580		1,450,580			10a
11	Activities	147,037	14,546		161,583		161,583		161,583			11
12	Social Services	428,774	3,817	50,400	482,991		482,991		482,991			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,502,259	329,920	1,339,209	6,171,388		6,171,388	(80)	6,171,308			16
	C. General Administration											
17	Administrative	113,312			113,312		113,312		113,312			17
18	Directors Fees											18
19	Professional Services			940,641	940,641		940,641	(546,452)	394,189			19
20	Dues, Fees, Subscriptions & Promotions			33,482	33,482		33,482	(7,511)	25,971			20
21	Clerical & General Office Expenses	282,403	44,605	22,105	349,113		349,113	(2,146)	346,967			21
22	Employee Benefits & Payroll Taxes			941,226	941,226		941,226		941,226			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,921	6,921		6,921		6,921			24
25	Other Admin. Staff Transportation			7,737	7,737		7,737		7,737			25
26	Insurance-Prop.Liab.Malpractice			265,672	265,672		265,672		265,672			26
27	Other (specify):*			6,459	6,459		6,459	(6,459)				27
28	**TOTAL General Administration**	395,715	44,605	2,224,243	2,664,563		2,664,563	(562,568)	2,101,995			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,997,272	1,160,573	3,914,328	11,072,173		11,072,173	(632,086)	10,440,087			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 Sheridan Village Nrsg Rhb #0056143 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			4,200	4,200		4,200	146,542	150,742			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,705	38,705		38,705	434,242	472,947			32
33	Real Estate Taxes			344,834	344,834		344,834		344,834			33
34	Rent-Facility & Grounds			1,279,266	1,279,266		1,279,266	(1,269,785)	9,481			34
35	Rent-Equipment & Vehicles			24,819	24,819		24,819		24,819			35
36	Other (specify):*			5,358	5,358		5,358	(5,358)				36
37	TOTAL Ownership			1,697,182	1,697,182		1,697,182	(694,359)	1,002,823			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,720	108,829	124,549		124,549		124,549			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			452,812	452,812		452,812		452,812			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		15,720	561,641	577,361		577,361		577,361			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,997,272	1,176,293	6,173,151	13,346,716		13,346,716	(1,326,445)	12,020,271			45

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(19,325)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(35,429)	30		9
10	Interest and Other Investment Income	(3,603)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,298)	36		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(250)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,209)	27		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	(145,759)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (212,873)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,113,572)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,113,572)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,326,445)		37

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

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

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

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Sheridan Village Nrsg Rhb

ID# 0056143

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sheridan Shores Property- Management Fees	$ (14,250)	17	1
2	Sheridan Shores Property- Professional Fees	(4,300)	19	2
3	Sheridan Shores Property- Bank/Filing Charges	(269)	21	3
4	Sheridan Shores Property- Amortization	(43,493)	31	4
5	Jury Duty Income	(80)	10	5
6	Bank Charges	(2,779)	21	6
7	Amortization	(3,060)	36	7
8	Capitalized R&M	(11,995)	06	8
9	Business Development Costs	(2,241)	19	9
10	PAC Dues	(7,511)	20	10
11	Capitalized R&M	(38,118)	06	11
12	Non-Allowable Legal	(14,063)	19	12
13	PPP Consulting	(3,600)	19	13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(145,759)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(50,113)	0	0	0	0	0	0	0	0	0	0	(50,113)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(50,113)	0	0	0	0	0	0	0	0	0	0	(50,113)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(80)	0	0	0	0	0	0	0	0	0	0	(80)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(80)	0	0	0	0	0	0	0	0	0	0	(80)	16
	C. General Administration													
17	Administrative	(14,250)	14,250	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(24,204)	4,300	(526,548)	0	0	0	0	0	0	0	0	(546,452)	19
20	Fees, Subscriptions & Promotions	(7,511)	0	0	0	0	0	0	0	0	0	0	(7,511)	20
21	Clerical & General Office Expenses	(3,048)	269	633	0	0	0	0	0	0	0	0	(2,146)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(49,013)	18,819	(525,915)	0	0	0	0	0	0	0	0	(556,109)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(99,206)	18,819	(525,915)	0	0	0	0	0	0	0	0	(606,302)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(35,429)	181,971	0	0	0	0	0	0	0	0	0	146,542	30
31	Amortization of Pre-Op. & Org.	(43,493)	43,493	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	437,845	0	0	0	0	0	0	0	0	0	437,845	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,279,266)	9,481	0	0	0	0	0	0	0	0	(1,269,785)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(3,060)	0	0	0	0	0	0	0	0	0	0	(3,060)	36
37	**TOTAL Ownership**	(81,982)	(615,957)	9,481	0	0	0	0	0	0	0	0	(688,458)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(181,188)	(597,138)	(516,434)	0	0	0	0	0	0	0	0	(1,294,760)	45

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,279,266	Sheridan Shores Property, LLC	100.00%	$	$ (1,279,266)	1
2	V	33	Real Estate Taxes	333,436	Sheridan Shores Property, LLC	100.00%	333,436		2
3	V	17	Management Fees		Sheridan Shores Property, LLC	100.00%	14,250	14,250	3
4	V	19	Legal & Accounting Fees		Sheridan Shores Property, LLC	100.00%	4,300	4,300	4
5	V	21	Bank Charges & Fees		Sheridan Shores Property, LLC	100.00%	269	269	5
6	V	30	Depreciation		Sheridan Shores Property, LLC	100.00%	181,971	181,971	6
7	V	31	Amortization		Sheridan Shores Property, LLC	100.00%	43,493	43,493	7
8	V	32	Interest Expense		Sheridan Shores Property, LLC	100.00%	437,845	437,845	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,612,702			$ 1,015,564	$ * (597,138)	14

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

STATE OF ILLINOIS

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Yaacov Mashiach	23.335%	Tri-State Village Nursing & Rehab	Lansing, IL	Jade Financial	Chicago, IL	Consulting Co.	1
2	Yechiel Mashiach	23.335%	Little Village Nursing & Rehab	Chicago, IL	Sheridan Shores	Chicago, IL	Building Co.	2
3	Rita Lipshitz	10.000%	Kensington Place Nursing & Rehab	Chicago, IL	Property, LLC			3
4	Rhonda Mashiach	10.000%	Wheaton Village Nursing & Rehab	Wheaton, IL				4
5	Atied Assocaites	33.330%						5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		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	21	A&G Expenses	$	Jade Financial	100.00%	$ 633	$ 633	15
16	V	19	Professional Fees	527,266	Jade Financial	100.00%	718	(526,548)	16
17	V	34	Rent Expense		Jade Financial	100.00%	9,481	9,481	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			$ 527,266			$ 10,832	$ * (516,434)	39

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Yechiel Mashiach	Owner	Admissions	23.34%	See Attached	5.09	12.73%	Salary	$ 13,773	12-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 13,773		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 Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization: Jade Financial Services
Street Address: 2320 S. Lawndale Ave
City / State / Zip Code: Chicago, IL 60623
Phone Number: ( )
Fax Number: ( )

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	A&G Expenses	Resident Days	200,733	5	$ 2,146	$	59,191	$ 633	1
2	19	Professional Fees	Resident Days	200,733	5	2,435		59,191	718	2
3	34	Rent Expense	Resident Days	200,733	5	32,153		59,191	9,481	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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16										16
17										17
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 36,734	$		$ 10,832	25

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Mortgage			$	$			$ 21,351	1
2	International Bank		X	Mortgage				8,901,450			416,494	2
3												3
4												4
5												5
	Working Capital											
6	CIBC		X	Working Capital							25,475	6
7	Boulevard Property		X	Working Capital							13,230	7
8												8
9	TOTAL Facility Related						$	$ 8,901,450			$ 476,550	9
	B. Non-Facility Related*											
10	Interest Income		X								(3,603)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,603)	14
15	TOTALS (line 9+line14)						$	$ 8,901,450			$ 472,947	15

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

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

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	326,797	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.)	$	327,625	2
3. Under or (over) accrual (line 2 minus line 1).	$	828	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	344,006	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	344,834	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	255,245	8
2016	278,984	9
2017	299,851	10
2018	322,115	11
2019	327,625	12

2020 Accrual: $327,625 X 1.05 = $344,006

Beginning accrual was adjusted because there was no cost report filed in 2019

	FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2019 $	13
14	PLUS APPEAL COST FROM LINE 5 $	14
15	LESS REFUND FROM LINE 6 $	15
16	AMOUNT TO USE FOR RATE CALCULATION $	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Village Nrsg Rhb COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0056143

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (847) 628-8784 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)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	14-05-402-027-0000	Long Term Care Property	$ 163,812.51	$ 163,812.51
2.	14-05-402-028-0000	Long Term Care Property	$ 163,812.51	$ 163,812.51
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 327,625.02	$ 327,625.02

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000 B. General Construction Type: Exterior Brick Frame Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 690,923	1
2					2
3	TOTALS			$ 690,923	3

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	191		2019	1977	$ 4,446,256	$	39	$ 114,007	$ 114,007	$ 1,829,160	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Overhead Door Installation- Hoist/Mount- Exterior/Parking Lot			2019	3,435		20	172	172	344	9
10	Luxury Vinyl Plank Flooring- First Floor Rear Entrance Foyer			2019	3,150		20	158	158	315	10
11	Secuirity System Throughout Facility- Cabling and Switches			2019	14,342		20	717	717	1,434	11
12	Repaved Parking Lot			2020	6,792		20	340	340	340	12
13	Architect fees relating to Parking Deck Repairs/Paving			2020	5,845		20	292	292	292	13
14	Water Heater Repair, Replaced Mixing Valve & Chiller Pump			2020	5,980		20	299	299	299	14
15	Plumbing Repairs- Kitchen Area			2020	9,000		20	450	450	450	15
16	Cable Installation For Security/Fire Caulking- Floors 1-8			2020	14,539		20	727	727	727	16
17	Smoke/Fire Damper Repair - Throughout Facilitiy			2020	17,300		20	865	865	865	17
18	Fire Rated Doors & Frames-Rear Exit, Janitor Room, Laundry			2020	10,638		20	532	532	532	18
19	Cabling for Overhead Paging System Throughout Facility			2020	4,703		20	235	235	235	19
20	Annunciators, Switches and Call Lights- 5th Floor Bathrooms			2020	10,238		20	512	512	512	20
21	Repairs to Generator- Heater, Battery, and Engine			2020	2,755		20	138	138	138	21
22	Generator-Control Board,Module Board,Expansion Board & Key			2020	3,106		20	155	155	155	22
23	Condensor Pump Repair-Bearing Assembly, Motor Mounts, Seal			2020	2,674		20	134	134	134	23
24	Cooling Tower/Chiller Repair-Boiler Relay,Contactors,Pump			2020	4,697		20	235	235	235	24
25	Air Flow System w/ Air Curtain for Smoke Redirection on Patio			2020	2,655		20	133	133	133	25
26	9.5K BTU 115V Cool- HVAC Units Throughout Whole Facility			2020	12,967		20	648	648	648	26
27	Sink Replacement in Kitchen-Including Welding,Piping,Drains			2020	4,000		20	200	200	200	27
28											28
29											29
30											30
31											31
32											32
33											33
34	Financial Statement Depreciation- Sheridan Village Nursing & Rehab					4,200			(4,200)		34
35	Financial Statement Depreciation- Sheridan Shores Property					181,971			(181,971)		35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39	Sheridan Shores Property, LLC								39
40	Tuckpointing	2013	505,000		20	25,250	25,250	202,000	40
41	Resurface Parking Deck	2014	47,570		20	2,379	2,379	16,653	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	70

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

STATE OF ILLINOIS

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	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
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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)		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	34

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	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
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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)		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	34

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	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
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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)		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	34

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	34

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	34

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	34

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	34

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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27									27
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,137,641	$ 186,171		$ 148,576	$ (37,595)	$ 2,055,800	34

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$	10	$	71
72	Current Year Purchases	21,669		2,167	2,167	10	2,167	72
73	Fully Depreciated Assets					10		73
74	See Attached	587,284				10	587,284	74
75	TOTALS	$ 608,953	$	$ 2,167	$ 2,167		$ 589,451	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)	$ 6,437,517	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 186,171	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 150,742	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (35,429)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,645,251	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number: Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated From Jade Financial				9,481			5
6								6
7	TOTAL				$ 9,481 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 9,558 Description: $5,518 Copiers; $3,127 Postage; $913 Other Rentals
    (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	Facility	Through TCF National	$	$ 15,262	17
18					18
19					19
20					20
21	TOTAL		$	$ 15,262	21

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

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A	hrs	$	7,432	$ 557,415	$	7,432	$ 557,415	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,411	105,822		1,411	105,822	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		8,133	609,986		8,133	609,986	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	177,357					177,357	8
9	Pharmacy	V39	# of prescrpts				82,516		82,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					26,313		26,313	12
13	Other (specify): BILLABLE SUPPLIES	V39					6,479		6,479	13
14	TOTAL			$ 177,357	16,976	$ 1,273,223	$ 115,308	16,976	$ 1,565,888	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 Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,329,232	$ 2,485,106	1
2	Cash-Patient Deposits	45,470	45,470	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,998,378	1,998,378	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	119,370	119,370	6
7	Other Prepaid Expenses	4,150	4,150	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		159,746	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,496,600	$ 4,812,220	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		680,077	13
14	Buildings, at Historical Cost		4,896,287	14
15	Leasehold Improvements, at Historical Cost	96,987	196,376	15
16	Equipment, at Historical Cost	22,384	609,668	16
17	Accumulated Depreciation (book methods)	(4,550)	(3,246,651)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	15,304	656,400	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,060)	(522,873)	20
21	Restricted Funds	323,242	323,242	21
22	Other Long-Term Assets (spe See Attached			22
23	Other(specify): See Attached		6,486,467	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 450,307	$ 10,078,993	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,946,907	$ 14,891,213	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 848,463	$ 848,463	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	112,163	112,163	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	389,296	389,296	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,798	34,798	31
32	Accrued Real Estate Taxes(Sch.IX-B)	344,006	344,006	32
33	Accrued Interest Payable		19,322	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	1,521,637	1,844,879	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,250,363	$ 3,592,928	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,901,450	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	289,636	289,636	43
44	See Attached			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 289,636	$ 9,191,086	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,539,999	$ 12,784,014	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,406,908	$ 2,107,199	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,946,907	$ 14,891,213	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3	Prior Year Income/Equity (No 2019 Cost Report Filed)	4,277	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,277	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,402,631	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,402,631	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)**	$ 1,406,908	24 *

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,001,953	1
2	Discounts and Allowances for all Levels	(3,555,414)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,446,539	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,987,739	6
7	Oxygen	2,598	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,990,337	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	76,387	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,093	19
20	Radiology and X-Ray	11,480	20
21	Other Medical Services	24,200	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 142,160	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,603	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,603	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		1,166,708	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,166,708	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,749,347	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,236,222	31
32	Health Care	6,171,388	32
33	General Administration	2,664,563	33
	B. Capital Expense		
34	Ownership	1,697,182	34
	C. Ancillary Expense		
35	Special Cost Centers	124,549	35
36	Provider Participation Fee	452,812	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,346,716	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,402,631	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,402,631	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,501,943	44
45	Private Pay - Net Inpatient Revenue	139,617	45
46	Medicare - Net Inpatient Revenue	570,356	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	21,275	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(786,652)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,446,539	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 Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 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	1,941	2,140	$ 119,724	$ 55.95	1
2	Assistant Director of Nursing	1,811	2,088	126,344	60.51	2
3	Registered Nurses	18,809	21,209	847,547	39.96	3
4	Licensed Practical Nurses	29,114	32,352	1,003,061	31.00	4
5	CNAs & Orderlies	73,283	86,931	1,623,117	18.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,769	6,387	177,357	27.77	8
9	Activity Director	1,689	1,846	30,499	16.52	9
10	Activity Assistants	6,870	7,151	116,538	16.30	10
11	Social Service Workers	16,917	17,736	428,774	24.18	11
12	Dietician					12
13	Food Service Supervisor	3,932	4,281	83,103	19.41	13
14	Head Cook	20,217	21,334	358,038	16.78	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,646	3,962	88,506	22.34	17
18	Housekeepers	17,513	19,063	308,776	16.20	18
19	Laundry	8,305	8,894	162,238	18.24	19
20	Administrator	2,404	2,280	113,312	49.70	20
21	Assistant Administrator					21
22	Other Administrative	7,961	8,868	282,403	31.85	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,769	1,906	29,298	15.37	31
32	Other Health Care(specify)	5,503	5,810	98,637	16.98	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	227,453	254,238	$ 5,997,272 *	$ 23.59	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	379	$ 21,627	V01-03	35
36	Medical Director	Monthly Fee	4,200	V09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fee	11,386	V10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly Fee	15,600	V12-03	45
46	Other(specify)				46
47	Psycho-Social Consultant	Monthly Fee	12,000	V12-03	47
48	Psychiatrist	Monthly Fee	22,800	V12-03	48
49	TOTAL (lines 35 - 48)	379	$ 87,613		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 Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Della Andrew Richardson	Administrator	0.00%	$ 113,312
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 113,312

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Business Development Bureau	Business Develop (Adj)	$ 2,241
IIT/Source Tech	IT Consulting	605
Propay	Payroll Management	28,506
Matrix Care	Data Processing/Software	47,138
National Data Care Corp	Resident Funds Management	4,322
On Shift Inc.	HR Consulting	3,908
See Attached	Legal Services	28,646
Marcum	Accounting Services	541
Plante and Moran	Accounting Services	20,466
Personnel Planners	Unemployment Consulting	1,508
See Supplemental Page 21		802,760
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 940,641

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,478
Unemployment Compensation Insurance	39,477
FICA Taxes	463,168
Employee Health Insurance	293,063
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	316
Pension Expense	60,686
Other Employee Benefits	5,038
TOTAL (agree to Schedule V, line 22, col.8)	$ 941,226

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,494
Advertising: Employee Recruitment	4,054
Health Care Worker Background Check	4,689
(Indicate # of checks performed 469)	
Patient Background Checks	
Dues & Subscriptions	12,591
Licenses & Fees	3,143
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,971

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,921
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,921

**See instructions.

Facility Name & ID Number: Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Extended Care Consulting	Consulting Fees	$ 155,597
Jade Financial	Consulting Fees	527,266
Terrill Consulting	AR Consulting	54,966
GCHMO	Managed Care Consulting	47,738
Haeger Engineering	Engineering Services	2,572
Wiss, Janney, Elstner	Engineering Services	4,764
Sher LLP	PPP Consulting (Adjusted)	3,600
Pinnacle Quality Insight	Customer Satisfaction	11
Legat Architects	Architecture Services	1,706
Maemar	Engineering Services	4,540
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 802,760

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,478
Unemployment Compensation Insurance	39,477
FICA Taxes	463,168
Employee Health Insurance	293,063
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	316
Pension Expense	60,686
Other Employee Benefits	5,038
TOTAL (agree to Schedule V, line 22, col.8)	$ 941,226

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

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

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $15,022**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,621** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **452,812**
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. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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%ln14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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