		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0055053

Facility Name: South Holland Manor Hth Rhb

Address: 2145 East 170th St (Number) South Holland (City) 60473 (Zip Code)

County: Cook

Telephone Number: (708) 895-3255 **Fax #** (708) 895-3315

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2018

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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) ______ (Date)
(Type or Print Name) ______
(Title) ______

Paid Preparer
(Signed) ______ 05/23/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

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

STATE OF ILLINOIS

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	216	Skilled (SNF)	216	79,056	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	79,056	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,220	2,483	12,123	38,826	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,220	2,483	12,123	38,826	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.11%

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 10/1/2018

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2018 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 216 and days of care provided 7,294

Medicare Intermediary Novitas Solutions

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 South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	461,820	48,775	20,433	531,028		531,028	686	531,714			1
2	Food Purchase		301,090		301,090		301,090	(97)	300,993			2
3	Housekeeping	245,449	61,630		307,079		307,079	1,257	308,336			3
4	Laundry	60,129	31,842		91,971		91,971		91,971			4
5	Heat and Other Utilities			243,148	243,148		243,148	(13,303)	229,845			5
6	Maintenance	141,020		191,607	332,627		332,627	1,202	333,829			6
7	Other (specify):*							3,424	3,424			7
8	**TOTAL General Services**	908,418	443,337	455,188	1,806,943		1,806,943	(6,831)	1,800,112			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	4,381,505	557,992	8,173	4,947,670		4,947,670	17,820	4,965,490			10
10a	Therapy			30,902	30,902		30,902		30,902			10a
11	Activities	100,175	8,329		108,504		108,504		108,504			11
12	Social Services	244,437		32,013	276,450		276,450	14,676	291,126			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							20,755	20,755			15
16	**TOTAL Health Care and Programs**	4,726,117	566,321	83,088	5,375,526		5,375,526	53,251	5,428,777			16
	C. General Administration											
17	Administrative	138,170			138,170		138,170	109,356	247,526			17
18	Directors Fees											18
19	Professional Services			760,587	760,587	(2,515)	758,072	(613,554)	144,518			19
20	Dues, Fees, Subscriptions & Promotions			133,014	133,014		133,014	(12,056)	120,958			20
21	Clerical & General Office Expenses	184,811	25,550	453,101	663,462		663,462	(247,147)	416,315			21
22	Employee Benefits & Payroll Taxes			996,810	996,810		996,810	(30,498)	966,312			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,794	1,794		1,794	704	2,498			24
25	Other Admin. Staff Transportation			1,293	1,293		1,293	636	1,929			25
26	Insurance-Prop.Liab.Malpractice			695,793	695,793		695,793	1,741	697,534			26
27	Other (specify):*							43,964	43,964			27
28	**TOTAL General Administration**	322,981	25,550	3,042,392	3,390,923	(2,515)	3,388,408	(746,854)	2,641,554			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,957,516	1,035,208	3,580,668	10,573,392	(2,515)	10,570,877	(700,434)	9,870,443			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			10,936	10,936		10,936	311,572	322,508			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,109	80,109		80,109	482,379	562,488			32
33	Real Estate Taxes			697,349	697,349	2,515	699,864	4,825	704,689			33
34	Rent-Facility & Grounds			516,000	516,000		516,000	(516,000)				34
35	Rent-Equipment & Vehicles			295	295		295	232	527			35
36	Other (specify):*											36
37	TOTAL Ownership			1,304,689	1,304,689	2,515	1,307,204	283,008	1,590,212			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,494,459	470,240	62,731	2,027,430		2,027,430	(38,221)	1,989,209			39
40	Barber and Beauty Shops			1,707	1,707		1,707		1,707			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			296,379	296,379		296,379		296,379			42
43	Other (specify):*			30,144	30,144		30,144	(30,144)				43
44	TOTAL Special Cost Centers	1,494,459	470,240	390,961	2,355,660		2,355,660	(68,365)	2,287,295			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,451,975	1,505,448	5,276,318	14,233,741		14,233,741	(485,791)	13,747,950			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 South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,664)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(495,093)	30		9
10	Interest and Other Investment Income	(1,531)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(190)	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	(38,853)	21		18
19	Entertainment				19
20	Contributions	(250)	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	(270,234)	21		24
25	Fund Raising, Advertising and Promotional	(7,388)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	143,673			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (684,530)		$	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)	198,739		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 198,739		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (485,791)		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

South Holland Manor Hth Rhb

ID# 0055053

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (72)	10	1
2	Theft Loss	(250)	21	2
3	Collection Expense	(83,575)	21	3
4	Marketing Consultant	(30,144)	43	4
5	Building Company - Bank Fees	(91)	21	5
6	Building Company - Amortization	(11,652)	36	6
7	Late Fee - Real Estate Taxes	(19,616)	21	7
8	Capitalized R&M	(16,025)	6	8
9	PAC Dues	(7,560)	20	9
10	Real Estate Tax - Remove Entry relating to Prior Owner	312,658	33	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	143,673		49

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

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

STATE OF ILLINOIS **Page 5B**

South Holland Manor Hth Rhb

ID# 0055053

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			127	559								686	1
2	Food Purchase	(190)		93									(97)	2
3	Housekeeping			1,109	148								1,257	3
4	Laundry													4
5	Heat and Other Utilities	(14,664)		1,215	146								(13,303)	5
6	Maintenance	(16,025)		17,080	147								1,202	6
7	Other (specify):*			3,342	82								3,424	7
8	**TOTAL General Services**	(30,879)		22,966	1,082								(6,831)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(72)			32,496	(11,883)	(2,721)						17,820	10
10a	Therapy													10a
11	Activities													11
12	Social Services				14,676								14,676	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				20,755								20,755	15
16	**TOTAL Health Care and Programs**	(72)			67,927	(11,883)	(2,721)						53,251	16
	C. General Administration													
17	Administrative			15,888	93,468								109,356	17
18	Directors Fees													18
19	Professional Services			(378,002)	(235,552)								(613,554)	19
20	Fees, Subscriptions & Promotions	(15,198)		2,069	1,073								(12,056)	20
21	Clerical & General Office Expenses	(412,619)	91	116,568	48,813								(247,147)	21
22	Employee Benefits & Payroll Taxes			(30,498)									(30,498)	22
23	Inservice Training & Education													23
24	Travel and Seminar			337	367								704	24
25	Other Admin. Staff Transportation			636									636	25
26	Insurance-Prop.Liab.Malpractice			1,363	378								1,741	26
27	Other (specify):*			23,382	20,582								43,964	27
28	**TOTAL General Administration**	(427,817)	91	(248,257)	(70,871)								(746,854)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(458,768)	91	(225,291)	(1,862)	(11,883)	(2,721)						(700,434)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 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 D. Ownership	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)	
30	Depreciation	(495,093)	804,391	2,139	135								311,572	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,531)	476,142	7,645	123								482,379	32
33	Real Estate Taxes	312,658	(312,657)	4,255	569								4,825	33
34	Rent-Facility & Grounds		(516,000)										(516,000)	34
35	Rent-Equipment & Vehicles			232									232	35
36	Other (specify):*	(11,652)	11,652											36
37	**TOTAL Ownership**	(195,618)	463,528	14,271	827								283,008	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(38,221)						(38,221)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(30,144)											(30,144)	43
44	**TOTAL Special Cost Centers**	(30,144)					(38,221)						(68,365)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(684,530)	463,619	(211,020)	(1,035)	(11,883)	(40,942)						(485,791)	45

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 516,000	Paradox South Holland Property, LLC		$	$ (516,000)	1
2	V	33	Real Estate Tax	716,965	Paradox South Holland Property, LLC		404,308	(312,657)	2
3	V	21	Bank Services Charges		Paradox South Holland Property, LLC		91	91	3
4	V	30	Depreciation		Paradox South Holland Property, LLC		804,391	804,391	4
5	V	36	Amortization		Paradox South Holland Property, LLC		11,652	11,652	5
6	V	32	Interest Expense		Paradox South Holland Property, LLC		476,142	476,142	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,232,965			$ 1,696,584	$ * 463,619	14

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

STATE OF ILLINOIS — Page 6-Supplemental

Facility Name & ID Number: South Holland Manor Hth Rhb # 0055053 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	ATTIED ASSOCIATES	99.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	PARADOX SOUTH HOLLAND PI	SOUTH HOLLAND	BUILDING COMPANY	1
2	B & Z GRANDCHILDREN TRUST	1.00%	BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	DES PLAINES	PHARMACY	7
8			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				8
9			MAJOR HOSPITAL DYER	DYER, IN				9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		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	01	Dietary	$	Extended Care Consulting, LLC		$ 127	$ 127	15
16	V	02	Food		Extended Care Consulting, LLC		93	93	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,109	1,109	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,215	1,215	18
19	V	06	Maintenance		Extended Care Consulting, LLC		2,420	2,420	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	382,948	Extended Care Consulting, LLC		4,946	(378,002)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		2,069	2,069	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		10,892	10,892	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		337	337	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		636	636	25
26	V	26	Insurance		Extended Care Consulting, LLC		1,363	1,363	26
27	V	30	Depreciation		Extended Care Consulting, LLC		2,139	2,139	27
28	V	32	Interest		Extended Care Consulting, LLC		7,645	7,645	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		4,255	4,255	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		232	232	30
31	V	06	Maintenance Salaries	3,667	Extended Care Consulting, LLC		18,327	14,660	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		3,342	3,342	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		15,888	15,888	33
34	V	21	Office and Clerical Salaries	6,646	Extended Care Consulting, LLC		112,322	105,676	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		23,382	23,382	35
36	V	22	Employee Benefits	30,498	Extended Care Consulting, LLC			(30,498)	36
37	V								37
38	V								38
39	Total			$ 423,759			$ 212,739	$ * (211,020)	39

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	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	1	Dietary Salary	$	Extended Care Clinical, LLC		$ 559	$ 559	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		148	148	16
17	V	5	Utilities		Extended Care Clinical, LLC		146	146	17
18	V	6	Maintenance		Extended Care Clinical, LLC		147	147	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		82	82	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		31,676	31,676	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		820	820	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		14,676	14,676	22
23	V	15	Emp. Ben, - Direct Alloc.		Extended Care Clinical, LLC		13,943	13,943	23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		6,812	6,812	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		93,468	93,468	25
26	V	19	Professional Fees	240,000	Extended Care Clinical, LLC		1,298	(238,702)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC		3,150	3,150	27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		1,073	1,073	28
29	V	21	Office Salary		Extended Care Clinical, LLC		46,581	46,581	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		2,232	2,232	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		367	367	31
32	V	26	Insurance		Extended Care Clinical, LLC		378	378	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		20,582	20,582	33
34	V	30	Depreciation		Extended Care Clinical, LLC		135	135	34
35	V	32	Interest		Extended Care Clinical, LLC		123	123	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		569	569	36
37	V								37
38	V								38
39	Total			$ 240,000			$ 238,965	$ * (1,035)	39

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		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	Various Equipment	17,196	Vent Lease LLC		5,313	$ (11,883)	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			$ 17,196			$ 5,313	$ * (11,883)	39

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		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	$ 29,116	MAC Rx, LLC		$ 26,395	$ (2,721)	15
16	V	39	Ancillary	408,963	MAC Rx, LLC		370,742	(38,221)	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			$ 438,078			$ 397,136	$ * (40,942)	39

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		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.

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		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.

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		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.

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		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.

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

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	01	Dietary	Patient Days	1,219,947	38	$ 3,992	$	38,826	$ 127	1
2	02	Food	Patient Days	1,219,947	38	2,910		38,826	93	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856		38,826	1,109	3
4	05	Utilities	Patient Days	1,219,947	38	38,173		38,826	1,215	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040		38,826	2,420	5
6	17	Administrative	Patient Days	1,219,947	38			38,826		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408		38,826	4,946	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998		38,826	2,069	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251		38,826	10,892	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602		38,826	337	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988		38,826	636	11
12	26	Insurance	Patient Days	1,219,947	38	42,836		38,826	1,363	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209		38,826	2,139	13
14	32	Interest	Patient Days	1,219,947	38	240,208		38,826	7,645	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701		38,826	4,255	15
16	35	Rent - Equipment	Patient Days	1,219,947	38	7,304		38,826	232	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	575,856	38,826	18,327	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021		38,826	3,342	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	499,202	38,826	15,888	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	3,529,267	38,826	112,322	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685		38,826	23,382	21
22										22
23										23
24										24
25	TOTALS					$ 6,684,506	$ 4,604,325		$ 212,739	25

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Salary	Patient Days	603,308	20	$ 8,692	$ 8,692	38,826	$ 559	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		38,826	148	2
3	5	Utilities	Patient Days	603,308	20	2,264		38,826	146	3
4	6	Maintenance	Patient Days	603,308	20	2,283		38,826	147	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		38,826	82	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	38,826	31,676	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		38,826	820	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	38,826	14,676	8
9	15	Emp. Ben, - Direct Alloc.	Direct Allocation		4	44,957			13,943	9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		38,826	6,812	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	38,826	93,468	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		38,826	1,298	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220			3,150	13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		38,826	1,073	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	38,826	46,581	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		38,826	2,232	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		38,826	367	17
18	26	Insurance	Patient Days	603,308	20	5,874		38,826	378	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		38,826	20,582	19
20	30	Depreciation	Patient Days	603,308	20	2,099		38,826	135	20
21	32	Interest	Patient Days	603,308	20	1,914		38,826	123	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		38,826	569	22
23										23
24										24
25	TOTALS					$ 3,507,824	$ 2,905,144		$ 238,965	25

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization	Vent Lease, LLC
Street Address	2201 Main Street
City / State / Zip Code	Evanston, Illinois 60202
Phone Number	(847) 674-1180
Fax Number	(847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Various Equipment	Direct Allocation						5,313	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					$	$		$ 5,313	25

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization	MAC Rx, LLC
Street Address	2307 S. Mount Prospect Road
City / State / Zip Code	Des Plaines, IL 60018
Phone Number	(224)220-2700
Fax Number	(224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 26,395	1
2	39	Ancillary	Direct Allocation						370,742	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					$	$		$ 397,136	25

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 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 [ ]

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 South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 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 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 South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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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 South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Huntington Bank		X	Mortgage			$	$ 7,781,655			$ 476,143	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Daiwa		X	Line of Credit				3,173,357			80,109	6
7												7
8												8
9	TOTAL Facility Related						$	$ 10,955,012			$ 556,252	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,531)	10
11	Alloc from Extended Care Consulting										7,645	11
12	Alloc from Extended Care Clinical										123	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 6,237	14
15	TOTALS (line 9+line14)						$	$ 10,955,012			$ 562,489	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.)

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 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.

Line	Description		Amount	Line
1	Real Estate Tax accrual used on 2019 report.	$	981,486	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.)	$	1,274,187	2
3	Under or (over) accrual (line 2 minus line 1).	$	292,701	3
4	Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	409,472	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.)**	$	2,515	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.	$	704,688	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	1,218,304	8
2016	1,258,761	9
2017	1,310,144	10
2018	934,749	11
2019	818,944	12

2020 Accrual = $818,944 x 1.05 - $450,419 prepayment of 2020 taxes = $409,472

Line 2 includes $450,419 for the prepayment of 2020 taxes.

Allocated from Extended Care Consulting $4,255

Allocated from Extended Care Clinical $569

	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 South Holland Manor Hth Rhb COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055053

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-25-200-006-0000	Long Term Care Property	$ 818,944.02	$ 818,944.02
2.	See Attached	Alloc from Extended Care Consulting	$ 197,162.69	$ 4,255.17
3.	See Attached	Alloc from Extended Care Clinical	$ 197,162.69	$ 568.55
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,213,269.40	$ 823,767.74

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 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 South Holland Manor Hth Rhb COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055053

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,792 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2018	$ 1,366,509	1
2	Allocated from Care Center Building			20,062	2
3	TOTALS			$ 1,386,571	3

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	216		2018	1988	$ 8,314,722	$ 804,391	35	$ 237,563	$ (566,828)	$ 511,126	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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		99,785	1,548		1,548		70,410	68
69	Financial Statement Depreciation			10,936			(10,936)		69
70	TOTAL (lines 4 thru 69)		$ 8,414,507	$ 816,875		$ 239,111	$ (577,764)	$ 581,536	70

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,414,507	$ 816,875		$ 239,111	$ (577,764)	$ 581,536	1
2	Air Handler Unit	2019	7,400		20	370	370	524	2
3	12,000 Btu Ptac	2019	2,520		20	126	126	252	3
4	Generator - Replace Fuel Injector	2019	4,417		20	221	221	442	4
5	Sprinkler Leak - Replace Pipe	2019	2,859		20	143	143	286	5
6	Repipe Existing R102-3 System	2019	3,444		20	172	172	344	6
7	Dining Room - Replace 4" Pipe In Ceiling	2019	2,512		20	126	126	252	7
8	Water Softener System Installation	2020	3,000		20	150	150	150	8
9	Hvac - Outdoor Condensor	2020	5,800		20	290	290	290	9
10	Ats Repair - Replace Lugs, Operating Handle, Contact Assembly	2020	3,519		20	176	176	176	10
11	Replace 4" Leaking Pipe Near Fire Alarm Hall	2020	3,860		20	193	193	193	11
12	Sprinkler Pipe Replacement	2020	2,746		20	137	137	137	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,456,583	$ 816,875		$ 241,215	$ (575,660)	$ 584,582	34

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,456,583	$ 816,875		$ 241,215	$ (575,660)	$ 584,582	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,456,583	$ 816,875		$ 241,215	$ (575,660)	$ 584,582	34

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,456,583	$ 816,875		$ 241,215	$ (575,660)	$ 584,582	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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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)		$ 8,456,583	$ 816,875		$ 241,215	$ (575,660)	$ 584,582	34

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,456,583	$ 816,875		$ 241,215	$ (575,660)	$ 584,582	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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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)		$ 8,456,583	$ 816,875		$ 241,215	$ (575,660)	$ 584,582	34

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	3,258	84	35	84		1,528	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	7,638	169	35	169		2,284	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	24,388	625	35	625		11,438	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	20,146		20			20,146	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	23,742		20			23,742	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,180		20			1,180	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	213	11	20	11		128	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,043	102	20	102		715	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	336	17	20	17		217	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,326	66	20	66		331	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,299	115	20	115		460	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,054	53	20	53		158	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	397	20	20	20		40	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	106	5	20	5		5	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,692		20			2,692	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2003	3,172		20			3,172	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2005	158		20			158	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2009	28	1	20	1		17	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2014	264	13	20	13		93	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2015	45	2	20	2		29	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2016	177	9	20	9		44	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2017	307	15	20	15		61	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2018	141	7	20	7		21	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2019	53	3	20	3		5	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2020	14	1	20	1		1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 95,177	$ 1,318		$ 1,318	$	$ 68,665	34

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 95,177	$ 1,318		$ 1,318	$	$ 68,665	1
2									2
3									3
4									4
5									5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting	2007	146	7	20	7		102	8
9	Allocated from Extended Care Consulting	2009	88	4	20	4		53	9
10	Allocated from Extended Care Consulting	2010	859	43	20	43		472	10
11	Allocated from Extended Care Consulting	2011	309	15	20	15		155	11
12	Allocated from Extended Care Consulting	2012	102	5	20	5		46	12
13	Allocated from Extended Care Consulting	2014	1,412	71	20	71		494	13
14	Allocated from Extended Care Consulting	2016	1,692	85	20	85		423	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 99,785	$ 1,548		$ 1,548	$	$ 70,410	34

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 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	$ 812,922	$ 725	$ 81,292	$ 80,567	10	$ 186,631	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	97,864				10	97,864	73
74								74
75	TOTALS	$ 910,786	$ 725	$ 81,292	$ 80,567		$ 284,495	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. Extended Care Clinical	2012	$ 3,306	$	$	$	5	$ 3,306	76
77		Alloc. Extended Care Consulting	2014	810				5	810	77
78										78
79										79
80	TOTALS			$ 4,116	$	$	$		$ 4,116	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)	$ 10,758,056	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 817,600	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 322,507	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (495,093)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 873,193	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 South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .
9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 527 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

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

3. CLINICAL PORTION:

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

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	39 - 01	hrs	$ 891,021		$	$		$ 891,021	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	84,170					84,170	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	519,268					519,268	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				416,708		416,708	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					62,731	53,532		116,263	13
14	TOTAL			$ 1,494,459		$ 62,731	$ 470,240		$ 2,027,430	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 South Holland Manor Hth Rhb # 0055053 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 53,164	$ 53,164	1
2	Cash-Patient Deposits	35,410	35,410	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	5,361,905	5,361,905	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	154,326	154,326	6
7	Other Prepaid Expenses	7,459	7,459	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	2,455	2,455	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,614,719	$ 5,614,719	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,039,804	13
14	Buildings, at Historical Cost		6,581,434	14
15	Leasehold Improvements, at Historical Cost		482,826	15
16	Equipment, at Historical Cost	58,380	2,390,235	16
17	Accumulated Depreciation (book methods)	(21,440)	(2,176,612)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	889,908	125,621	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 926,848	$ 8,443,308	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,541,567	$ 14,058,027	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 478,767	$ 392,766	26
27	Officer's Accounts Payable	1,100	1,100	27
28	Accounts Payable-Patient Deposits	34,995	34,995	28
29	Short-Term Notes Payable	3,173,357	3,173,357	29
30	Accrued Salaries Payable	648,981	648,981	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,595	25,595	31
32	Accrued Real Estate Taxes(Sch.IX-B)	409,472	409,472	32
33	Accrued Interest Payable		42,024	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,873,044	1,873,044	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,645,311	$ 6,601,334	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,781,655	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,548,843	1,555,843	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,548,843	$ 9,337,498	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,194,154	$ 15,938,832	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,652,587)	$ (1,880,805)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,541,567	$ 14,058,027	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,495,891)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,495,892)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(156,695)	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)**	$ (156,695)	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)**	$ (1,652,587)	24 *

* This must agree with page 17, line 47.

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,303,109	1
2	Discounts and Allowances for all Levels	(3,995,088)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,308,021	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,714,425	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,714,425	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	2,296	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	412,225	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	55,277	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 469,798	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,531	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,531	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	1,583,271	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,583,271	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,077,046	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,806,943	31
32	Health Care	5,375,526	32
33	General Administration	3,390,923	33
	B. Capital Expense		
34	Ownership	1,304,689	34
	C. Ancillary Expense		
35	Special Cost Centers	2,059,281	35
36	Provider Participation Fee	296,379	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,233,741	40
41	**Income before Income Taxes (line 30 minus line 40)****	(156,695)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (156,695)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,561,633	44
45	Private Pay - Net Inpatient Revenue	741,442	45
46	Medicare - Net Inpatient Revenue	1,999,270	46
47	Other-(specify) Hospice	242,507	47
48	Other-(specify) Insurance	763,169	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,308,021	49

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,099	3,026	$ 176,300	$ 58.26	1
2	Assistant Director of Nursing	2,015	2,502	99,354	39.71	2
3	Registered Nurses	31,673	34,584	1,440,492	41.65	3
4	Licensed Practical Nurses	32,228	35,428	1,181,312	33.34	4
5	CNAs & Orderlies	75,180	80,839	1,390,853	17.21	5
6	CNA Trainees					6
7	Licensed Therapist	32,648	36,836	1,494,459	40.57	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,588	1,779	36,925	20.76	9
10	Activity Assistants	4,863	5,238	63,250	12.08	10
11	Social Service Workers	9,454	10,549	244,437	23.17	11
12	Dietician					12
13	Food Service Supervisor	2,530	2,842	76,309	26.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,264	10,256	162,024	15.80	15
16	Dishwashers	17,082	18,497	223,487	12.08	16
17	Maintenance Workers	5,567	6,220	141,020	22.67	17
18	Housekeepers	17,632	19,643	245,449	12.50	18
19	Laundry	4,494	5,020	60,129	11.98	19
20	Administrator	2,042	2,243	138,170	61.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,545	8,397	184,811	22.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,090	2,337	40,633	17.39	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,665	2,977	52,561	17.66	33
34	TOTAL (lines 1 - 33)	262,659	289,213	$ 7,451,975 *	$ 25.77	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	315	$ 20,433	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,173	10-03	39
40	Physical Therapy Consultant	Monthly	29,189	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	1,713	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	32,013	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	315	$ 103,521		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pamela Chappell	Administrator	0	$ 138,170
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 138,170

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
Marcum LLP	Accounting	$ 13,800
Extended Care Consulting	Home Office Expense	382,948
Extended Care Clinical	Home Office Expense	240,000
GCHMO	Liason Service	1,800
Midcap	LOC Audit	12,151
Pinnacle Quality Insight	Customer Satisfaction	1,364
Red Eyed Moose Technologies	Software Support	4,406
Achieve Technology	Data Processing	23,098
Ability Network	Medicare Billing	11,352
MatrixCare	Billing Software	18,057
See Attached	Legal	7,028
See Supplemental Schedule		44,581
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 760,585

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 147,744
Unemployment Compensation Insurance	71,266
FICA Taxes	533,081
Employee Health Insurance	202,689
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	200
Other Employee Welfare	11,332
TOTAL (agree to Schedule V, line 22, col.8)	$ 966,312

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	$ 1,990
Advertising: Employee Recruitment	72,518
Health Care Worker Background Check (Indicate # of checks performed 469)	4,688
Patient Background Checks	
Dues & Subscriptions	33,490
Licenses & Fees	5,130
See Supplemental Schedule	3,142
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 120,958

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,794
See Supplemental Schedule	704
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,498

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $15,120**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **86,739** 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. $ **296,379**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **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% 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 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