FOR BHF USE

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

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

I. IDPH License ID Number: 0047126

Facility Name: St Anthonys Nsg Rehab Ctr

Address: 767 30th Street (Number) Rock Island (City) 61201 (Zip Code)

County: Rock Island

Telephone Number: 309.788.7631 **Fax #** 309.788.9823

HFS ID Number:

Date of Initial License for Current Owners: 5/19/05

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	52	Skilled (SNF)	52	19,032	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,548	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,580	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			5,185	5,185	8
9	SNF/PED					9
10	ICF	24,859	563		25,422	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,859	563	5,185	30,607	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.33%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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 05/19/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/19/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 52 and days of care provided 4,636

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	259,497	16,378	14,099	289,974		289,974	7,985	297,959			1
2	Food Purchase		269,968		269,968		269,968		269,968			2
3	Housekeeping	188,689	30,785		219,474		219,474		219,474			3
4	Laundry	45,891	20,016		65,907		65,907		65,907			4
5	Heat and Other Utilities			155,461	155,461		155,461	1,207	156,668			5
6	Maintenance	154,767	52,978	84,293	292,038		292,038	97	292,135			6
7	Other (specify):* Waste Rem./Mgmt Co. Benefi			23,606	23,606		23,606	1,180	24,786			7
8	**TOTAL General Services**	648,844	390,125	277,459	1,316,428		1,316,428	10,469	1,326,897			8
	B. Health Care and Programs											
9	Medical Director			22,800	22,800		22,800		22,800			9
10	Nursing and Medical Records	2,861,525	289,550	6,451	3,157,526		3,157,526	73,759	3,231,285			10
10a	Therapy											10a
11	Activities	46,946	2,556		49,502		49,502		49,502			11
12	Social Services	35,075	43	1,915	37,033		37,033		37,033			12
13	CNA Training											13
14	Program Transportation			3,499	3,499		3,499		3,499			14
15	Other (specify):* Mgmt Co Benefits Alloc							10,904	10,904			15
16	**TOTAL Health Care and Programs**	2,943,546	292,149	34,665	3,270,360		3,270,360	84,663	3,355,023			16
	C. General Administration											
17	Administrative	101,506		356,364	457,870		457,870	(263,507)	194,363			17
18	Directors Fees											18
19	Professional Services			120,689	120,689		120,689	60,810	181,499			19
20	Dues, Fees, Subscriptions & Promotions			32,593	32,593		32,593	8,755	41,348			20
21	Clerical & General Office Expenses	142,273	90,423	43,543	276,239		276,239	224,445	500,684			21
22	Employee Benefits & Payroll Taxes			407,683	407,683		407,683		407,683			22
23	Inservice Training & Education			999	999		999		999			23
24	Travel and Seminar			67	67		67	12,646	12,713			24
25	Other Admin. Staff Transportation			1,284	1,284		1,284	846	2,130			25
26	Insurance-Prop.Liab.Malpractice			445,333	445,333		445,333	11,865	457,198			26
27	Other (specify):* Mgmt Co Benefits Alloc							44,012	44,012			27
28	**TOTAL General Administration**	243,779	90,423	1,408,555	1,742,757		1,742,757	99,872	1,842,629			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,836,169	772,697	1,720,679	6,329,545		6,329,545	195,004	6,524,549			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Anthonys Nsg Rehab Ctr #0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			8,364	8,364		8,364	377,015	385,379			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,932	3,932		3,932	483,228	487,160			32
33	Real Estate Taxes							57,363	57,363			33
34	Rent-Facility & Grounds			1,068,000	1,068,000		1,068,000	(1,045,428)	22,572			34
35	Rent-Equipment & Vehicles			5,646	5,646		5,646	2,171	7,817			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,085,942	1,085,942		1,085,942	(125,651)	960,291			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,592	855,918	936,510		936,510		936,510			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,468	248,468		248,468		248,468			42
43	Other (specify):* See Att Sch 4A	44,331	2,218	148,325	194,874		194,874	(172,317)	22,557			43
44	**TOTAL Special Cost Centers**	44,331	82,810	1,252,711	1,379,852		1,379,852	(172,317)	1,207,535			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,880,500	855,507	4,059,332	8,795,339		8,795,339	(102,964)	8,692,375			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

St Anthonys Nsg Rehab Ctr

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			14,517	14,517		14,517		14,517			
	Radiology Expenses			8,040	8,040		8,040		8,040			
	Non-Allowable Expenses	44,331	2,218	125,768	172,317		172,317	(172,317)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	44,331	2,218	148,325	194,874	0	194,874	(172,317)	22,557			

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(20,247)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,621)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(30,224)	43		18
19	Entertainment	(649)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,648)	43		24
25	Fund Raising, Advertising and Promotional	(2,218)	43		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 See Page 5A	(43,120)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (189,727)		$	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)	86,763		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 86,763		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (102,964)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

St Anthonys Nsg Rehab Ctr

ID# 0047126

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income Against Expense	$ (72)	21	1
2	Marketing Wages	(44,331)	43	2
3	Expense Repairs under $2,500	1,367	21	3
4	Offset Medical Records Income Against Expense	(84)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(43,120)		49

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	19	Professional Fees	$	St. Anthony's Property Partners, LLC	100.00%	$ 13,900	$ 13,900	1
2	V	20	Dues, Fees, Subscriptions & Promotions		St. Anthony's Property Partners, LLC	100.00%	75	75	2
3	V	30	Depreciation		St. Anthony's Property Partners, LLC	100.00%	395,636	395,636	3
4	V	32	Interest		St. Anthony's Property Partners, LLC	100.00%	483,098	483,098	4
5	V	33	Real Estate Taxes		St. Anthony's Property Partners, LLC	100.00%	57,363	57,363	5
6	V	34	Rent	1,068,000	St. Anthony's Property Partners, LLC	100.00%		(1,068,000)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,068,000			$ 950,072	$ * (117,928)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	SAK Management Services LLC	100.00%	$ 7,985	$ 7,985	15
16	V	5	Heat and Other Utilities		SAK Management Services LLC	100.00%	1,207	1,207	16
17	V	6	Maintenance		SAK Management Services LLC	100.00%	97	97	17
18	V	7	Emp Benefit Alloc-Dietary		SAK Management Services LLC	100.00%	1,180	1,180	18
19	V	10	Nursing and Medical Records		SAK Management Services LLC	100.00%	73,759	73,759	19
20	V	15	Emp Benefit Alloc-Healthcare		SAK Management Services LLC	100.00%	10,904	10,904	20
21	V	17	Administrative	356,364	SAK Management Services LLC	100.00%	92,857	(263,507)	21
22	V	19	Professional Services		SAK Management Services LLC	100.00%	46,910	46,910	22
23	V	20	Dues, Fees, Subs & Promo		SAK Management Services LLC	100.00%	8,680	8,680	23
24	V	21	Clerical & Gen Office Expenses		SAK Management Services LLC	100.00%	223,234	223,234	24
25	V	24	Travel and Seminar		SAK Management Services LLC	100.00%	12,646	12,646	25
26	V	25	Other Admin. Staff Trans		SAK Management Services LLC	100.00%	846	846	26
27	V	26	Insurance-Prop.Liab.Malpractice		SAK Management Services LLC	100.00%	11,865	11,865	27
28	V	27	Emp Benefit Alloc-Admin		SAK Management Services LLC	100.00%	44,012	44,012	28
29	V	32	Interest		SAK Management Services LLC	100.00%	130	130	29
30	V	34	Rent-Facility & Grounds		SAK Management Services LLC	100.00%	22,572	22,572	30
31	V	35	Equipment Rental		SAK Management Services LLC	100.00%	2,171	2,171	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 356,364			$ 561,055	$ * 204,691	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Suzanne Koenig	90%	Lena Living Center	Lena	St. Anthony's			1
2	Gary Weintraub	10%	Bria of Belleville	Belleville	Property, LLC	Rock Island, Illinois	Bldg. Partnership	2
3					Lena Property			3
4					Partners, LLC	Lena, Illinois	Bldg. Partnership	4
5					SAK Management LL	Riverwoods, Illinois	Mgmt. Company	5
6					SAK Texas, LLC	Riverwoods, Illinois	Mgmt. Company	6
7					SAK SCC, LLC	Riverwoods, Illinois	Mgmt. Company	7
8					SAK Ohio, LLC	Riverwoods, Illinois	Mgmt. Company	8
9					SAK NM, LLC	Riverwoods, Illinois	Mgmt. Company	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SAK Management Services, LLC
Street Address: 300 Saunders Rd, Suite 300
City / State / Zip Code: Riverwoods, IL 60015
Phone Number: (847) 446 - 8400
Fax Number: (847) 446 - 8432

	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	Percentage of Revenues	100	6	$ 52,430	$ 52,430	15.23	$ 7,985	1
2	5	Heat and Other Utilities	Percentage of Revenues	100	6	7,927		15.23	1,207	2
3	6	Maintenance	Percentage of Revenues	100	6	640		15.23	97	3
4	7	Emp Benefit Alloc-Dietary	Percentage of Revenues	100	6	7,751		15.23	1,180	4
5	10	Nursing and Medical Records	Percentage of Revenues	100	6	484,294	484,294	15.23	73,759	5
6	15	Emp Benefit Alloc-Healthcare	Percentage of Revenues	100	6	71,593		15.23	10,904	6
7	17	Administrative	Percentage of Revenues	100	6	609,695	609,695	15.23	92,857	7
8	19	Professional Services	Percentage of Revenues	100	6	308,009		15.23	46,910	8
9	20	Dues, Fees, Subs & Promo	Percentage of Revenues	100	6	56,993		15.23	8,680	9
10	21	Clerical & Gen Office Expenses	Percentage of Revenues	100	6	1,465,728	1,345,112	15.23	223,234	10
11	24	Travel and Seminar	Percentage of Revenues	100	6	83,035		15.23	12,646	11
12	25	Other Admin. Staff Trans	Percentage of Revenues	100	6	5,557		15.23	846	12
13	26	Insurance-Prop.Liab.Malpractice	Percentage of Revenues	100	6	77,902		15.23	11,865	13
14	27	Emp Benefit Alloc-Admin	Percentage of Revenues	100	6	288,979		15.23	44,012	14
15	32	Interest	Percentage of Revenues	100	6	855		15.23	130	15
16	34	Rent-Facility & Grounds	Percentage of Revenues	100	6	148,210		15.23	22,572	16
17	35	Equipment Rental	Percentage of Revenues	100	6	14,256		15.23	2,171	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,683,854	$ 2,491,531		$ 561,055	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage	$86,884.57	9/17/12	$ 11,995,400	$ 11,279,239	1/1/2048	4.5000	$ 483,098	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit							3,932	6
7												7
8												8
9	TOTAL Facility Related				$86,884.57		$ 11,995,400	$ 11,279,239			$ 487,030	9
	B. Non-Facility Related*											
10												10
11												11
12								Allocated from SAK Management LLC			130	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 130	14
15	TOTALS (line 9+line14)						$ 11,995,400	$ 11,279,239			$ 487,160	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 131,725	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.)	2019	$ 57,363	2
3. Under or (over) accrual (line 2 minus line 1).		$ (74,362)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 131,725	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 57,363	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	76,767	8
2016	82,234	9
2017	84,063	10
2018	55,344	11
2019	57,363	12

Accrual based on prior year tax bill.
Prior year ending accrual adjusted

	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Anthonys Nsg Rehab Ctr COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0047126

CONTACT PERSON REGARDING THIS REPORT Jerry Januszewski

TELEPHONE (618) 294-8696 FAX #: (618) 294-8699

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.	07-364-21-002	Long Term Care Facility	$ 5,449.08	$ 5,449.08
2.	07-364-21-001	Long Term Care Facility	$ 50,679.28	$ 50,679.28
3.	07-363-55-002	Long Term Care Facility	$ 1,234.20	$ 1,234.20
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 57,362.56	$ 57,362.56

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 149,308 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 5

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).

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	319,300	2005	$ 155,000	1
2					2
3	TOTALS	319,300		$ 155,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	130		2005		$ 2,050,000	$	35	$ 58,571	$ 58,571	$ 937,136	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2011	12,075		20	604	604	6,326	9
10	Water Heater			2013	16,698		10	1,670	1,670	13,360	10
11	Fire Protection System			2014	26,285		20	1,314	1,314	9,198	11
12	Boiler Pump - Parts and Repairs			2014	3,963		10	396	396	2,772	12
13	Fire Panel			2016	4,936		20	247	247	1,235	13
14	Door and Knob Hardware			2016	5,196		20	260	260	1,300	14
15	Sliding/Kithen/Fire Door			2017	6,748		20	337	337	1,348	15
16	Basement electrical panel			2017	4,936		20	247	247	988	16
17	Water Heaters/Boilers			2017	78,601		10	7,860	7,860	31,440	17
18	Parking Lot Sink Hole			2017	6,727		20	336	336	1,344	18
19	Fire Sprinkler			2017	1,804		20	90	90	360	19
20	Servewell Buffet			2017	3,226		20	161	161	644	20
21	Load and Pressure Test Hydraulic Cylinder			2019	7,290		20	365	365	730	21
22	Repair Frozen Pipes & Sprinkler			2019	2,571		20	129	129	258	22
23	Replace Hoist Rope-Passenger Elevator #2			2019	10,694		20	535	535	1,070	23
24	Repair Elevator			2020	12,700		20	318	318	318	24
25	Repair Boiler			2020	13,030		20	326	326	326	25
26											26
27	St. Anthony's Property Partners, LLC										27
28	Complete Facility Rehabilitation and Renovation			2012	6,510,694		40	162,767	162,767	406,918	28
29	Complete Facility Rehabilitation and Renovation			2013	1,200,533		40	30,013	30,013	60,026	29
30	Chiller			2016	127,850		20	6,393	6,393	12,786	30
31											31
32											32
33											33
34	Depreciation - St Anthony's Nursing & Reehab Center					2,969			(2,969)		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,106,557	$ 2,969		$ 272,939	$ 269,970	$ 1,489,883	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,119,583	$ 4,692	$ 111,958	$ 107,266	10 yrs	$ 978,873	71
72	Current Year Purchases	9,648	703	482	(221)	10 yrs	482	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,129,231	$ 5,395	$ 112,440	$ 107,045		$ 979,355	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	Facility	Ford Windstar	2005	$ 1,506	$	$	$	7	$ 1,506	76
77	Facility	Snow Plow Truck	2010	5,500				7	5,500	77
78	Facility	Ford E 350 Bus	2014	15,623				5	15,623	78
79										79
80	TOTALS			$ 22,629	$	$	$		$ 22,629	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)	$ 11,413,417	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,364	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 385,379	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 377,015	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,491,867	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				22,572			5
6								6
7	TOTAL				$ 22,572 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: $ 5,646 Description: Copier
(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	Allocated from Management Co			2,171	19
20					20
21	TOTAL		$	$ 2,171	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

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

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

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	7,229	$ 326,077	$	7,229	$ 326,077	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,080	73,062		1,080	73,062	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		8,552	456,779		8,552	456,779	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				80,592		80,592	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	16,861	$ 855,918	$ 80,592	16,861	$ 936,510	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 472,052	$ 472,583	1
2	Cash-Patient Deposits	243	243	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 962,868)	1,622,324	1,622,324	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	46,624	195,371	7
8	Accounts Receivable (owners or related parties)	720,390	205,715	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,861,633	$ 2,496,236	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		155,000	13
14	Buildings, at Historical Cost		2,050,000	14
15	Leasehold Improvements, at Historical Cost	158,607	8,056,557	15
16	Equipment, at Historical Cost	455,966	1,151,860	16
17	Accumulated Depreciation (book methods)	(430,037)	(2,491,867)	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 (spe Loan Fees		141,810	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 184,536	$ 9,063,360	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,046,169	$ 11,559,596	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 9,160,618	$ 7,951,670	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,342	98,342	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		131,725	32
33	Accrued Interest Payable		1,626,123	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	304,512	304,512	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,563,472	$ 10,112,372	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,279,239	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Party	169,386	169,386	43
44	PPP Loan	788,000	788,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 957,386	$ 12,236,625	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,520,858	$ 22,348,997	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,474,689)	$ (10,789,401)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,046,169	$ 11,559,596	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,925,040)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,925,040)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	450,351	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)**	$ 450,351	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)**	$ (7,474,689)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,279,104	1
2	Discounts and Allowances for all Levels	558,271	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,837,375	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	336,280	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 336,280	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,312,795	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,312,795	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Income**	156	28
28a	**Prior Period Adjustments**	759,084	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 759,240	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,245,690	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,316,428	31
32	Health Care	3,270,360	32
33	General Administration	1,742,757	33
	B. Capital Expense		
34	Ownership	1,085,942	34
	C. Ancillary Expense		
35	Special Cost Centers	1,131,384	35
36	Provider Participation Fee	248,468	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,795,339	40
41	**Income before Income Taxes (line 30 minus line 40)****	450,351	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 450,351	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,959,371	44
45	Private Pay - Net Inpatient Revenue	179,959	45
46	Medicare - Net Inpatient Revenue	2,278,278	46
47	Other-(specify) Insurance	419,767	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,837,375	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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,814	1,830	$ 61,770	$ 33.75	1
2	Assistant Director of Nursing	2,862	3,008	89,294	29.69	2
3	Registered Nurses	6,334	6,787	193,381	28.49	3
4	Licensed Practical Nurses	29,303	31,087	853,794	27.46	4
5	CNAs & Orderlies	94,509	99,509	1,552,487	15.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,832	4,237	46,946	11.08	10
11	Social Service Workers	2,079	2,158	35,075	16.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,266	23,797	259,497	10.90	15
16	Dishwashers					16
17	Maintenance Workers	10,323	10,973	154,767	14.10	17
18	Housekeepers	16,828	17,967	188,689	10.50	18
19	Laundry	3,921	4,494	45,891	10.21	19
20	Administrator	2,048	2,160	101,506	46.99	20
21	Assistant Administrator					21
22	Other Administrative	2,092	2,160	44,331	20.52	22
23	Office Manager					23
24	Clerical	6,781	7,330	142,273	19.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,637	1,816	26,150	14.40	31
32	Other Health Care(specify)					32
33	Other(specify) MDS Coordinator	2,792	2,943	84,649	28.76	33
34	TOTAL (lines 1 - 33)	210,421	222,256	$ 3,880,500 *	$ 17.46	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 14,099	L1, C3	35
36	Medical Director	Monthly	22,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,451	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	25	1,915	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	25	$ 45,265		49

C. CONTRACT NURSES

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

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

** See instructions.

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel May	Administrator	0	$ 101,506
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,506

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 356,364
TOTAL (agree to Schedule V, line 17, col. 3)	$ 356,364
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Cohn Reznick	Accounting Services	3,600
Templin Healthcare Accounting	Accounting Services	4,843
Point Click Care	Data Processing	24,873
IPR Tech Group	Data Processing	25,008
Proliant	Data Processing	16,141
InPath Security, LLC	Data Processing	1,595
Personnel Planners Inc	Unemployment Consultant	1,500
Ability Network	Data Processing	5,733
MTS Consulting	Tax Consultant	(914)
See Attached Schedule	Legal Fees	38,310
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 120,689

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,758
Unemployment Compensation Insurance	31,246
FICA Taxes	283,679
Employee Health Insurance	24,251
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	3,749
TOTAL (agree to Schedule V, line 22, col.8)	$ 407,683

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	9,203
Health Care Worker Background Check	
(Indicate # of checks performed 114)	1,142
Patient Background Checks 248	2,480
Miscellaneous Licenses & Permits	1,070
Health Care Council of Illinois	15,990
Miscellaneous Dues & Subsrcriptions	718
Allocated from RE Entity	75
Allocated from Management Co.	8,680
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,348

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	67
Seminar Expense	
Allocated from Management Co.	12,646
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,713

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Anthonys Nsg Rehab Ctr # 0047126 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **15,990 Health Care Council of Illinois**

(3) Did the nursing home make political contributions or payments to a politica
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?

(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. $ **39,387** 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 fo
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 Departmen
during this cost report period. $ **248,468**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **0**

(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 fo
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% Line 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **Yes**
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:

(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