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: 0049759

Facility Name: West Suburban Nsg Rehab Ctr

Address: 311 Edgewater Drive (Number) Bloomingdale (City) 60108 (Zip Code)

County: Dupage

Telephone Number: 708-449-1900 **Fax #** 708-449-1500

HFS ID Number:

Date of Initial License for Current Owners: 11/1/07

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: Aaron Mauer **Telephone Number:** 773-747-4506
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Paresh Vipani
(Title) CFO

Paid Preparer

(Signed) _____ 3/5/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

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

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	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	259	Skilled (SNF)	259	94,535	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	259	TOTALS	259	94,535	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	52,732	1,278	12,346	66,356	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,732	1,278	12,346	66,356	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.19%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/1/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 259 and days of care provided 8,429

Medicare Intermediary Wisconsin Physician 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.

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				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	589,225	40,669	12,000	641,894		641,894	(40)	641,854			1
2	Food Purchase		422,569		422,569		422,569		422,569			2
3	Housekeeping	516,115	68,661		584,776		584,776		584,776			3
4	Laundry	152,262	20,955		173,217		173,217		173,217			4
5	Heat and Other Utilities			337,288	337,288		337,288	889	338,177			5
6	Maintenance	109,749	40,908	107,083	257,740		257,740	1,589	259,329			6
7	Other (specify):*											7
8	TOTAL General Services	1,367,351	593,762	456,371	2,417,484		2,417,484	2,438	2,419,922			8
	B. Health Care and Programs											
9	Medical Director			77,500	77,500		77,500		77,500			9
10	Nursing and Medical Records	5,185,779	361,175	487,015	6,033,969		6,033,969	(241,091)	5,792,878			10
10a	Therapy			1,247,195	1,247,195		1,247,195	(27)	1,247,168			10a
11	Activities	251,606	34,424		286,030		286,030	(1,171)	284,859			11
12	Social Services	125,349		4,778	130,127		130,127		130,127			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			19,503	19,503		19,503	(470)	19,033			15
16	TOTAL Health Care and Programs	5,562,734	395,599	1,835,991	7,794,324		7,794,324	(242,759)	7,551,565			16
	C. General Administration											
17	Administrative	123,228		13,388	136,616		136,616	76,151	212,767			17
18	Directors Fees											18
19	Professional Services			977,259	977,259		977,259	(8,140)	969,119			19
20	Dues, Fees, Subscriptions & Promotions			7,260	7,260		7,260	199	7,459			20
21	Clerical & General Office Expenses	186,359	70,799	675,155	932,313		932,313	29,498	961,811			21
22	Employee Benefits & Payroll Taxes			1,109,626	1,109,626		1,109,626	55,796	1,165,422			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,946	7,946		7,946		7,946			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,264,123	1,264,123		1,264,123	74,170	1,338,293			26
27	Other (specify):*											27
28	TOTAL General Administration	309,587	70,799	4,054,757	4,435,143		4,435,143	227,673	4,662,816			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,239,672	1,060,160	6,347,119	14,646,951		14,646,951	(12,647)	14,634,304			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number West Suburban Nsg Rehab Ctr #0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			97,021	97,021		97,021	141,874	238,895			30
31	Amortization of Pre-Op. & Org.			14,041	14,041		14,041	392,555	406,596			31
32	Interest			5,158	5,158		5,158	333,289	338,447			32
33	Real Estate Taxes							157,391	157,391			33
34	Rent-Facility & Grounds			1,961,604	1,961,604		1,961,604	(1,954,851)	6,753			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			2,147	2,147		2,147	(2,147)				36
37	**TOTAL Ownership**			2,079,971	2,079,971		2,079,971	(931,889)	1,148,082			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			20,390	20,390		20,390		20,390			38
39	Ancillary Service Centers		414,484		414,484		414,484	(6,702)	407,782			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			489,682	489,682		489,682		489,682			42
43	Other (specify):*			325,274	325,274		325,274	(325,274)				43
44	**TOTAL Special Cost Centers**		414,484	835,346	1,249,830		1,249,830	(331,976)	917,854			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,239,672	1,474,644	9,262,436	17,976,752		17,976,752	(1,276,512)	16,700,240			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 West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(44,625)	30		9
10	Interest and Other Investment Income	(131,607)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(40)	1		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	(650)	21		18
19	Entertainment				19
20	Contributions	(2,590)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(325,274)	43		24
25	Fund Raising, Advertising and Promotional	(23,793)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,147)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(12,833)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (543,559)		$	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)			34
35	Other- Attach Schedule	(718,478)	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (718,478)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,262,037)		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

West Suburban Nsg Rehab Ctr

ID# 0049759

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profit	$ (223)	10	1
2	RP Profit	(470)	15	2
3	RP Profit	(6,702)	39	3
4	Misc Income - Vendor Rebate	(1,905)	5	4
5	Misc Income - Med Records	(2,336)	10	5
6	Misc Income - Therapy Refund	(27)	10a	6
7	Misc Income - Activity	(1,171)	11	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**	(12,833)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(40)	0	0	0	0	0	0	0	0	0	0	(40)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,905)	2,794	0	0	0	0	0	0	0	0	0	889	5
6	Maintenance	0	1,589	0	0	0	0	0	0	0	0	0	1,589	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,945)	4,383	0	0	0	0	0	0	0	0	0	2,438	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,559)	(238,532)	0	0	0	0	0	0	0	0	0	(241,091)	10
10a	Therapy	(27)	0	0	0	0	0	0	0	0	0	0	(27)	10a
11	Activities	(1,171)	0	0	0	0	0	0	0	0	0	0	(1,171)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(470)	0	0	0	0	0	0	0	0	0	0	(470)	15
16	**TOTAL Health Care and Programs**	(4,226)	(238,532)	0	0	0	0	0	0	0	0	0	(242,759)	16
	C. General Administration													
17	Administrative	0	76,151	0	0	0	0	0	0	0	0	0	76,151	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(43,952)	35,812	0	0	0	0	0	0	0	0	(8,140)	19
20	Fees, Subscriptions & Promotions	0	199	0	0	0	0	0	0	0	0	0	199	20
21	Clerical & General Office Expenses	(27,033)	56,531	0	0	0	0	0	0	0	0	0	29,498	21
22	Employee Benefits & Payroll Taxes	0	55,796	0	0	0	0	0	0	0	0	0	55,796	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,962	71,208	0	0	0	0	0	0	0	0	74,170	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(27,033)	147,686	107,020	0	0	0	0	0	0	0	0	227,673	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,204)	(86,463)	107,020	0	0	0	0	0	0	0	0	(12,647)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(44,625)	89	186,410	0	0	0	0	0	0	0	0	141,874	30
31	Amortization of Pre-Op. & Org.	0	0	392,555	0	0	0	0	0	0	0	0	392,555	31
32	Interest	(131,607)	7,438	457,458	0	0	0	0	0	0	0	0	333,289	32
33	Real Estate Taxes	0	0	157,391	0	0	0	0	0	0	0	0	157,391	33
34	Rent-Facility & Grounds	0	6,753	(1,961,604)	0	0	0	0	0	0	0	0	(1,954,851)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(2,147)	0	0	0	0	0	0	0	0	0	0	(2,147)	36
37	TOTAL Ownership	(178,379)	14,280	(767,790)	0	0	0	0	0	0	0	0	(931,889)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(6,702)	0	0	0	0	0	0	0	0	0	0	(6,702)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(325,274)	0	0	0	0	0	0	0	0	0	0	(325,274)	43
44	TOTAL Special Cost Centers	(331,976)	0	0	0	0	0	0	0	0	0	0	(331,976)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(543,559)	(72,183)	(660,770)	0	0	0	0	0	0	0	0	(1,276,512)	45

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	37.5	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
GELP	37.5	Belhaven Nursing & Rehab Center	Chicago	Southpoint Realty		Realty Co.
Y & B Investments	20	Citi View Multicare Center	Cicero	United Rx		Pharmacy Co.
A&F Realty, LLC	5	Continental Nursing & Rehab Center	Chicago			
		Forest View Nursing & Rehab Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	5	Heat and Other Utilities	$	Infinity Healthcare Management of IL LLC		$ 2,794	$ 2,794	1
2	V	6	Maintenance	1	Infinity Healthcare Management of IL LLC		1,590	1,589	2
3	V	10	Nursing and Medical Records	320,114	Infinity Healthcare Management of IL LLC		81,582	(238,532)	3
4	V	17	Administrative	1,182	Infinity Healthcare Management of IL LLC		77,333	76,151	4
5	V	19	Professional Services	874,904	Infinity Healthcare Management of IL LLC		830,952	(43,952)	5
6	V	20	Dues, Fees, Subscriptions & Promotions		Infinity Healthcare Management of IL LLC		199	199	6
7	V	21	Clerical & General Office Expenses	228,761	Infinity Healthcare Management of IL LLC		285,292	56,531	7
8	V	22	Employee Benefits & Payroll Taxes	9	Infinity Healthcare Management of IL LLC		55,805	55,796	8
9	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		2,962	2,962	9
10	V	30	Depreciation		Infinity Healthcare Management of IL LLC		89	89	10
11	V	32	Interest		Infinity Healthcare Management of IL LLC		7,438	7,438	11
12	V	34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		6,753	6,753	12
13	V								13
14	Total			$ 1,424,971			$ 1,352,788	$ * (72,183)	14

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

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 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	34	Rent	$ 1,961,604	West Suburban Nursing Realty		$	$ (1,961,604)	15
16	V	31	Amortization		West Suburban Nursing Realty		392,555	392,555	16
17	V	30	Depreciation		West Suburban Nursing Realty		186,410	186,410	17
18	V	19	Professional Services		West Suburban Nursing Realty		35,812	35,812	18
19	V	26	Insurance		West Suburban Nursing Realty		71,208	71,208	19
20	V	32	Interest		West Suburban Nursing Realty		457,458	457,458	20
21	V	33	Real Estate Taxes		West Suburban Nursing Realty		157,391	157,391	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			$ 1,961,604			$ 1,300,834	$ * (660,770)	39

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

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Ctr	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streater				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				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 West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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 West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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 Loan		X	Mortgage	$64,538.00	11/16/13	$ 14,450,000	$ 12,550,419	7/1/44	3.4000	$ 416,179	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Credit Suisse		X	Working Capital	None	8/31/14	26,000,000	Various	3/14/22	4.5000	5,158	6
7												7
8												8
9	TOTAL Facility Related				$64,538.00		$ 40,450,000	$ 12,550,419			$ 421,337	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 40,450,000	$ 12,550,419			$ 421,337	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 71,208 Line # 26

* 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 West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.**	$ 121,353	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.)		$ 146,096	2
3. Under or (over) accrual (line 2 minus line 1).		$ 24,743	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 132,648	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.		$ 157,391	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	171,536	8
2016	174,838	9
2017	167,070	10
2018	141,646	11
2019	146,096	12

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME West Suburban Nsg Rehab Ctr COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0049759

CONTACT PERSON REGARDING THIS REPORT Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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.	02-23-124-022	Long Term Property	$ 146,096.26	$ 146,096.26
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 146,096.26	$ 146,096.26

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 West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,047 B. General Construction Type: Exterior Masonry Frame _____ Number of Stories 2

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

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

D. Does the Operating Entity? [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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 194,364 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 12,958 4. Dates Incurred: 2007

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			2007	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	259		2007		$ 7,270,000	$ 186,410	39	$ 186,410	$	$ 2,454,399	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PTAC Unit			2008	2,145		5			2,145	9
10	Ceiling Tile, Floor Tile, and Wall Tile			2008	5,720	147	39	147		1,908	10
11	Ceramic Cove Base			2008	160	4	39	4		53	11
12	Ceiling Tile			2008	255	7	39	7		87	12
13	A/C Unit Roof Top			2008	4,440	114	39	114		1,481	13
14	Plumbing			2008	7,400	190	39	190		2,467	14
15	Mortar, Metal Trim, Drywall			2008	399	10	39	10		132	15
16	Mortar, Metal Trim, Drywall			2008	214	5	39	5		69	16
17	Mortar, Metal Trim, Drywall			2008	50	1	39	1		16	17
18	Remodel (1st Floor Shower Room)			2008	3,000	77	39	77		1,000	18
19	3 A/C Unit Roof Top			2008	2,426	62	39	62		807	19
20	Service Parts for Nurse Call Systems			2008	672	17	39	17		223	20
21	Standby Generator Replacement			2008	900	23	39	23		300	21
22	Roofing Work			2008	1,500	38	39	38		498	22
23	Roofing Work			2008	32,500	833	39	833		10,832	23
24	Generator - 1st Installment			2008	18,013	462	39	462		6,005	24
25	Permit for Generator Work			2008	409	10	39	10		134	25
26	Generator - 2nd Installment			2008	18,013	462	39	462		6,005	26
27	Service Call and Testing for New Generator			2008	697	18	39	18		233	27
28	Adjustment to g/l			2008	(5,700)	(146)	39	(146)		(1,899)	28
29	Air Conditioner			2009	644	17	39	17		200	29
30	New Carpet			2009	1,164	30	39	30		359	30
31	Dining Room Heater Unit			2009	7,970	204	39	204		2,451	31
32	New Roof			2009	29,150	747	39	747		8,972	32
33	New Roof			2009	2,130	55	39	55		657	33
34	New Concrete for Entrance			2009	4,760	122	39	122		1,464	34
35	Dining Room Heater Unit			2010	22,295	572	39	572		6,289	35
36	Shower Room Flooring			2010	6,819	175	39	175		1,924	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 West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Shower Room Wall Tiles	2010	$ 9,803	$ 251	39	$ 251	$	$ 2,764	37
38	Corridor Wall Coverings, Stationar y Panels, Vin yl Tiles	2010	75,237	1,929	39	1,929		21,220	38
39	Shower Room Floor Tiles	2010	136	3	39	3		36	39
40	Carrier 4 Ton Unit w/ Curb Ada pter & Other Misc. Materials	2010	6,004	154	39	154		1,694	40
41	Draft Inducer Motor Assembl y	2010	594	15	39	15		166	41
42	Shower Remodel - Valves, Faucets, Dr ywall	2010	3,800	97	39	97		1,070	42
43	PVC Pi pes, Cou plings, & Other Materials	2010	663	17	39	17		187	43
44	Shower Room Supplies - Fittings, Corners, Valves	2010	506	13	39	13		143	44
45	Shower Room Remodeling	2010	3,600	92	39	92		1,015	45
46	Shower Room Remodeling - Facuets, Valves, Paint Pre p	2010	3,800	97	39	97		1,070	46
47	Sink Installation	2010	250	6	39	6		69	47
48	Re placement Shower Faucet	2010	200	5	39	5		56	48
49	Re placement Bricks	2010	1,950	50	39	50		550	49
50	Sheet Metal & Brick Re pairs	2010	950	24	39	24		267	50
51	Patch to Wall Flashings	2010	350	9	39	9		99	51
52	Patch to Wall Flashings, Resealed Eams on Granulated Roof	2010	850	22	39	22		241	52
53	Concrete Sidewalk Re pairs	2010	6,850	176	39	176		1,933	53
54	Parking Lot Lease Dues	2010	12	0	39	0		3	54
55	Blackto p Removal/Resurfacing	2010	7,500	192	39	192		2,115	55
56	John Brewer - Blackto p Removal/Resurfacing	2010	4,140	106	39	106		1,167	56
57	John Brewer - Blackto p Removal/Resurfacing	2010	3,200	82	39	82		902	57
58	Paint	2010	64	2	39	2		19	58
59	Surveying	2010	1,250	32	39	32		352	59
60	Ductwork Re pairs in Ceiling	2010	3,964	102	39	102		1,119	60
61	Professional Engineering Services for a Parking Lot	2010	10,440	268	39	268		2,945	61
62	Elevator Valve Re placement	2011	8,250	212	39	212		2,117	62
63	Wet Pi pe Fire S prinkler S ystem	2011	1,200	31	39	31		309	63
64	HUD Ins pection	2011	845	22	39	22		218	64
65	Storm Water Management Application	2011	2,500	64	39	64		640	65
66	Planning, Parking Lot	2011	336	9	39	9		87	66
67	Planning, Parking Lot	2011	192	5	39	5		50	67
68	Planning, Parking Lot	2011	288	7	39	7		73	68
69	Roof Repairs	2011	3,500	90	39	90		898	69
70	TOTAL (lines 4 thru 69)		$ 7,601,369	$ 194,852		$ 194,852	$	$ 2,554,805	70

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

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,601,369	$ 194,852		$ 194,852	$	$ 2,554,805	1
2	Replace Sinks & Valves	2011	2,420	62	39	62		620	2
3	New Automatic Door Motor	2011	1,457	37	39	37		372	3
4	Parking Lot, Design/Develo pment	2011	6,900	177	39	177		1,770	4
5	Elevator Shaft S prinkler Heads	2011	3,855	99	39	99		989	5
6	Re pair Electric Work, Permit	2011	550	14	39	14		140	6
7	Exhaust Fan/ Fire Alarm Rela y	2011	730	19	39	19		188	7
8	Re pair Electric Work, Permit	2011	550	14	39	14		140	8
9	Steel Doors/ Door Rim/ Door Lite	2011	1,269	33	39	33		327	9
10	Lighting Retrofit on all floors/nurses stations/offices	2011	11,033	283	39	283		2,830	10
11	Door Trim	2011	1,089	28	39	28		280	11
12	Flooring, Dial ysis Hallwa y & Storage	2011	1,900	49	39	49		488	12
13	Corridor Doors	2011	2,126	55	39	55		547	13
14	Windows on 1st floor atrium	2011	5,800	149	39	149		1,488	14
15	Windows and Frames on 1st floor atrium	2011	7,991	205	39	205		2,050	15
16	100 gallon tank Water Heater	2012	4,533	116	39	116		1,045	16
17	Replaced compressor	2012	2,347	60	39	60		541	17
18	Rebuild metal framing over plumbing	2012	2,865	73	39	73		659	18
19	New floor & walls in Alzheimers Unit	2012	11,323	290	39	290		2,612	19
20	New floors & walls on 1st & 2nd floor nurses stations	2012	40,000	1,026	39	1,026		9,232	20
21	New floors, walls & borders in Alzheimers Unit/nurses station	2012	54,323	1,393	39	1,393		12,537	21
22	Renovate patient treatment floor in Dial ysis unit	2012	14,811	380	39	380		3,419	22
23	Install shunt tri p	2012	2,600	67	39	67		601	23
24	Re place elevator disconnect	2012	2,880	74	39	74		666	24
25	Eidco Cor poration	2012	2,880	74	39	74		666	25
26	Eidco Cor poration	2012	(158,123)	(4,054)	39	(4,054)		(36,493)	26
27	Emergenc y electrical s yste m	2012	2,448	63	39	63		566	27
28	Furnish (2) 54" x 7" printed and laminated lexanfaces	2012	1,290	33	39	33		297	28
29	Finish 2 nursing stations	2012	19,800	508	39	508		4,570	29
30	2 fluorescent fixtures	2012	760	19	39	19		173	30
31	custom cabinetr y payout - Nurses station 2nd floor	2012	30,500	782	39	782		7,038	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,684,276	$ 196,977		$ 196,977	$	$ 2,575,164	34

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

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,684,276	$ 196,977		$ 196,977	$	$ 2,575,164	1
2	New flooring, walls, paint, ceiling tiles, cove base & wall								2
3	coverings at 1st floor nurses stations and corridors,								3
4	2nd floor nurses stations and corridors, 2nd floor therapy								4
5	room and passenger elevators 1 & 2	2012	410,486	10,525	39	10,525		84,201	5
6	Elevator Lift	2013	1,123	29	39	29		232	6
7	Carpet / Flooring day room	2013	2,890	74	39	74		592	7
8	sanding / painting - day room	2013	1,932	50	39	50		398	8
9	HVAC carrier system	2013	8,698	223	39	223		1,784	9
10	relocate s prinkler heads - 1st & 2nd floors	2013	1,014	26	39	26		208	10
11	relocate s prinkler heads - 1st & 2nd floors	2013	1,074	28	39	28		222	11
12	relocate s prinkler heads - 1st & 2nd floors	2013	2,502	64	39	64		512	12
13	Light Fixtures 1st floor	2013	440	11	39	11		90	13
14	Cabinets in PT room	2013	4,500	115	39	115		922	14
15	Cabinets in PT room	2013	6,240	160	39	160		1,280	15
16	Windows / Doors in PT room	2013	4,000	103	39	103		822	16
17	Car pet in PT room	2013	9,743	250	39	250		2,000	17
18	Crash bars - nurse station	2013	5,000	128	39	128		1,024	18
19	PT room 2nd fllor ceiling / door	2013	16,890	433	39	433		3,464	19
20	Window Trims	2013	2,500	64	39	64		512	20
21	2nd floor PT room windows	2013	16,000	410	39	410		3,281	21
22	PT room Paint windows/doors	2013	1,600	41	39	41		328	22
23	Door exit device	2013	2,610	67	39	67		536	23
24	Outlets - 2nd floor dining	2013	1,200	31	39	31		248	24
25	Celing grids / floor dining room	2013	1,122	29	39	29		232	25
26	Closets / dresers / call rooms	2013	9,000	231	39	231		1,848	26
27	Kitchen door, hinge, fire exit installed	2014	5,513	141	39	141		988	27
28	Wall flashings, re pair roof	2014	4,460	114	39	114		799	28
29	Furnish and install elevator door restrictors	2014	2,980	76	39	76		533	29
30	Furnish and install elevator o perator, clutch, etc	2014	5,800	149	39	149		1,042	30
31	Re pair and paint walls throughout facilit y	2014	9,976	256	39	256		1,792	31
32	Install new safet y close door	2014	2,233	57	39	57		400	32
33	Install 4 new heat detectors, rewired zone	2014	5,696	146	39	146		1,022	33
34	TOTAL (lines 1 thru 33)		$ 8,231,498	$ 211,009		$ 211,009	$	$ 2,686,473	34

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

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,231,498	$ 211,009		$ 211,009	$	$ 2,686,473	1
2	New beds for the facility	2014	41,000	1,051	39	1,051		7,358	2
3	Aluminum Car Sill	2015	2,674	69	39	69		413	3
4	Repair Grease Trap Chamber	2015	6,500	167	39	167		1,001	4
5	Re placed a Section of Roof Due to a Leak	2015	10,025	257	39	257		1,542	5
6	Re placed 7 downs pouts	2015	4,900	126	39	126		755	6
7	Custom Overhead Light - Part 3	2015	4,374	112	39	112		728	7
8	Re placed 14 downs pouts	2015	4,900	126	39	126		699	8
9	Replaces Gutters	2015	5,900	151	39	151		907	9
10	Re placed a Section of Roof Due to a Leak	2015	10,025	257	39	257		1,542	10
11	Relocation of Existing Generator	2015	10,750	276	39	276		1,655	11
12	Closed Circuit TV S ystem Part 1	2015	8,919	229	39	229		1,373	12
13	Karndean Vangough Flooring	2015	3,400	87	39	87		522	13
14	New Doors for Oxygen Room and Shower Room	2015	6,709	172	39	172		1,032	14
15	New Doors for Treatment Room, Oxygen Room, and Stairwell	2015	3,505	90	39	90		540	15
16	Closed Circuit TV S ystem Part 2	2015	2,208	57	39	57		341	16
17	Re pave Parking Lot	2016	51,044	1,309	39	1,309		6,545	17
18	Dining Room Chandeliers	2016	2,818	72	39	72		361	18
19	1st Floor Rewiring	2016	5,600	144	39	144		719	19
20	Cafeteria New Floor	2016	3,754	96	39	96		481	20
21	Cafeteria New Floor	2016	3,170	81	39	81		406	21
22	Pit Ladder	2016	3,900	100	39	100		500	22
23	Cafeteria New Floor	2016	1,332	34	39	34		170	23
24	Cafeteria New Floor	2016	3,755	96	39	96		481	24
25	Concrete & Sewer Work in Kitchen	2016	5,000	128	39	128		640	25
26									26
27									27
28	New Heat Exchanger Assembl y	2017	2,875	74	39	74		257	28
29	Solid State Starter for North Elevator	2017	2,450	63	39	63		220	29
30	Patch for Wall Flashing	2017	3,924	101	39	101		352	30
31	Install New Dr y Wall on 1st Floor Exit Corridor for Safet y Viola	2017	4,346	111	39	111		389	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,451,255	$ 216,644		$ 216,644	$	$ 2,718,403	34

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

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,451,255	$ 216,644		$ 216,644	$	$ 2,718,403	1
2	New Air Conditioners	2018	2,385	61	39	61		153	2
3	Dishwasher Exhaust Fan	2018	2,750	71	39	71		176	3
4	Repair 1st Floor Nurses Call System	2018	5,284	135	39	135		339	4
5	New Air Conditioners	2018	2,421	62	39	62		155	5
6	Picnic tables & trash can	2018	3,901	87	39	100	13	224	6
7									7
8	Replace Exterior Light Bulbs on Building Pole	2019	5,390	138	39	138		714	8
9	New Wiring for IT	2019	8,890	228	39	228		456	9
10	Change Head on Fire Alarm Conrol Panel	2019	3,133	80	39	80		154	10
11	Install Ceiling Mounted Heater in 1st Floor Shower Room; Replac	2019	7,025	180	39	180		345	11
12	New Control & Motorgear Box for Patio Door	2019	1,741	45	39	45		82	12
13	2nd Floor Wanderer System	2019	2,896	74	39	74		136	13
14	Replace Bathroom Heaters	2019	2,000	51	39	51		94	14
15	Wander Guard System	2019	2,671	68	39	68		126	15
16	New Flooring for 1st floor Public Restroom	2019	2,800	72	39	72		126	16
17	Plumbing Fixtures for 1st Floor Public Restroom	2019	4,206	108	39	108		189	17
18	Install Plumbing Fixters & Insulation in Public Restroom	2019	1,700	44	39	44		73	18
19	Lift Concrete Near Parking Lot & Building Sidewalk	2019	4,900	126	39	126		209	19
20	New Building Roof (first billing)	2019	50,073	1,284	39	1,284		2,033	20
21	New Building Roof (second billing)	2019	50,073	1,284	39	1,284		2,033	21
22	New Building Roof (third billing)	2019	50,073	1,284	39	1,284		2,033	22
23	New Building Roof (fourth billing)	2019	50,073	1,284	39	1,284		2,033	23
24	New Building Roof (fifth billing)	2019	50,023	1,283	39	1,283		2,031	24
25	New Building Roof (sixth billing)	2019	75,110	1,926	39	1,926		3,049	25
26	New Evaporator Coil for 400 Wing Nurse's Station AC System	2019	2,650	68	39	68		108	26
27	Provide Hydraulic Calculations & Install Placard on Sprinkler Sy	2019	7,500	192	39	192		288	27
28	Parts & Labor to Repair Katolight Generator	2019	1,909	49	39	49		73	28
29	New Building Roof (seventh billing)	2019	50,073	1,284	39	1,284		1,926	29
30	Relocate Rooftop Refrigeration Units	2019	7,347	188	39	188		267	30
31	Replace Evaporator Coil on Walk-In Cooler	2019	2,985	77	39	77		108	31
32	New Flooring for Main Office, Conference Room & Front Desk Ar	2019	2,850	73	39	73		104	32
33	Relocate Rooftop Refrigeration Units and Run New Freon Lines &	2019	8,754	224	39	224		318	33
34	TOTAL (lines 1 thru 33)		$ 8,924,843	$ 228,774		$ 228,787	$ 13	$ 2,738,558	34

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

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,924,843	$ 228,774		$ 228,787	$ 13	$ 2,738,558	1
2	Repair Leak in Freon Lines from Rooftop Refrigeration Relocation	2019	3,630	93	39	93		132	2
3	Remove & Reinstall Tiles & Dry Wall for 3 Showers on 2nd Floor	2019	4,885	125	39	125		177	3
4	Disconnect Rooftop RTUs	2019	2,703	69	39	69		98	4
5	2nd Floor Nurse Station Split System Installation	2019	2,200	56	39	56		80	5
6	Replace 1st Floor Nurse Station AC Condensor	2019	4,250	109	39	109		154	6
7	Disconnect 3 New Roof Top Heating Units	2019	8,570	220	39	220		311	7
8	Reconnect the 3 New Roof Top Heating Units	2019	4,879	125	39	125		177	8
9	Set the Last RTU on the Lower Roof with Crane, Rewire the Unit	2019	6,091	156	39	156		221	9
10	Conncet Power to the RTU Serving 1st Floor & 2nd Floor Nursing Stations	2019	2,879	74	39	74		105	10
11	Install Extension Ducts for RTU Serving 1st Floor Nursing Station	2019	1,654	42	39	42		57	11
12	Finish Ductwork Installation for RTU Serving 1st Floor Nursing Station	2019	2,779	71	39	71		95	12
13	Mill & Resurface 3 Sections of Parking Lot	2019	10,048	258	39	258		344	13
14	Install Concrete Dumpster Pad (down payment total price $3,398.00)	2019	1,699	44	39	44		58	14
15	Remove RTU Serving Dialysis for Roofers to Clean Area	2019	3,278	84	39	84		112	15
16	Finish Ductwork Installation for RTU Serving Dialysis Room	2019	3,367	86	39	86		115	16
17	Completion of Removal & Reinstall Tiles & Dry Wall for 3 Showers on 2nd Floor	2019	2,570	66	39	66		88	17
18	Put Dialysis RTU Back in Operations	2019	3,224	83	39	83		110	18
19	Remove RTU Serving Therapy for Roofers to Finish Flashing Roof	2019	2,190	56	39	56		75	19
20	Reconnect the RTU Serving Therapy	2019	2,585	66	39	66		88	20
21	Flooring Tile for Reception Area, BOM Office, Admissioins Office, Conference Rc	2019	2,850	73	39	73		97	21
22	Gas Line Re-Connection of the 3 RTUs, Modify Ductwork for Therapy RTU	2019	5,447	140	39	140		186	22
23	Finish Connecting Main Gas Line on South End RTU #2	2019	2,039	52	39	52		70	23
24	Install New Flooring for Main Office, Conference Room & Front Desk Area	2019	7,200	185	39	185		231	24
25	Remove Existing Floor Tiles, Install New Toilet, Install New Wall & Porcelain Tile	2019	3,800	97	39	97		114	25
26	Dumpster Enclosure Repair	2019	3,688	95	39	95		110	26
27	Remove Damaged Tile & Install New Tile in 400 Hallway Dining Room	2019	4,600	118	39	118		138	27
28	Remove Floor Tiles, New Toilet, New Wall & Porcelain Tile in 400 Hallway Rest R	2019	2,800	72	39	72		84	28
29	Remove Floor Tiles, New Toilet, New Wall & Porcelain Tile in 400 Hallway Nursir	2019	4,300	110	39	110		119	29
30	Remove Existing Floor Tiles, Install New Tile Flooring in Dialysis Room. Install F	2019	8,500	218	39	218		236	30
31	Remove Existing Floor Tiles, Install New Vinyl Planking in 600 Dining Room	2019	5,400	138	39	138		150	31
32	Remove Existing Floor & Wall Tiles, Install New Tiles in 600 Dining Room Bathrc	2019	2,800	72	39	72		78	32
33	Remove & Replace Tiles, Replace Dry Wall in 1st Floor Shower Room	2019	4,210	108	39	108		117	33
34	TOTAL (lines 1 thru 33)		$ 9,055,955	$ 232,136		$ 232,149	$ 13	$ 2,742,885	34

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

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 9,055,955	$ 232,136		$ 232,149	$ 13	$ 2,742,885	1
2	Remove Carpet Flooring & Base, Install Vinyl Plank Tile in 400 Hall Way Nurse's Station Office	2019	5,600	144	39	144		156	2
3	Remove Moldy Ceiling & Framing, Install New Celing in 1st Floor Shower Room	2019	1,290	33	39	33		36	3
4	Replace Damaged Floor Tiles, Replace Wall Panels, Install Granite Countertops, Sink, Cabinets-2nd Fl Green Dining Rm	2019	11,800	303	39	303		328	4
5	Replace Damaged Floor Tiles, Replace Wall Panels, Install French Double Doors in 2nd floor Dementia Dining Rm	2019	12,600	323	39	323		350	5
6	ReplaceDamaged Floor Tiles, Remove Wall Paper, Patch, Sand & Paint Walls, Ceiling & Base-1st fl Main Dining Rm	2019	25,000	641	39	641		694	6
7									7
8	New Chain Link Fence	2020	4,630	119	39	119		119	8
9	Remote Panel Annunciator, Wire Junction Boxes	2020	6,518	167	39	167		167	9
10	Install New Thermo-Temp Mixing Valve. Install Existing Cold Water RP2 Back Flow to Mixing Valve	2020	7,468	191	39	176	(16)	191	10
11	Surveillance Camera System for Nurse's Station	2020	7,032	180	39	135	(45)	180	11
12	New Call Lights for Rooms 301, 302, 303, 304, 305, 306, 307, 308, 310, 311 and 312	2020	13,905	357	39	267	(89)	357	12
13	New Water Heater for Kitchen #1	2020	12,850	329	39	220	(110)	329	13
14	New Water Heater for Kitchen/Dialysis Rooms	2020	8,750	224	39	131	(93)	224	14
15	New Roof Top Unit HVAC for Kitchen	2020	10,675	274	39	160	(114)	274	15
16	Hydrojet and Prepare Deteriorated Cast Iron Sewer lines Under Building	2020	21,850	560	39	187	(374)	560	16
17	Underground Sewer Pipe Repairs (Phase 1)	2020	17,365	445	39	148	(297)	445	17
18	Underground Sewer Pipe Repairs (Phase 2)	2020	10,336	265	39	88	(177)	265	18
19	Underground Sewer Pipe Repairs (Phase 3)	2020	8,566	220	39	73	(146)	220	19
20	Rebuilt Kitchen Grease Trap Pit	2020	2,650	68	39	23	(45)	68	20
21	Underground Sewer Pipe Repairs (Phase 4)	2020	5,455	140	39	47	(93)	140	21
22	New Wall Mounted Exterior Fixtures & Exterior Lights Throughout Building	2020	2,725	70	39	6	(64)	70	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)		$ 9,253,021	$ 237,189		$ 235,538	$ (1,651)	$ 2,748,059	34

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

Facility Name & ID Number West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	32,586	32,586	3,259	(29,327)	5		72
73	Fully Depreciated Assets	1,118,912	13,745	98	(13,647)	5	1,118,912	73
74								74
75	TOTALS	$ 1,151,498	$ 46,331	$ 3,357	$ (42,974)		$ 1,118,912	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,804,519	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 283,520	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 238,895	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (44,625)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,866,971	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 West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								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: $ Description:
(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 West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	7,148	$ 504,935	$	7,148	$ 504,935	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,013	163,362		2,013	163,362	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		9,568	578,897		9,568	578,897	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				277,878		277,878	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					13,493		13,493	12
13	Other (specify): Lab	39-2					123,113		123,113	13
14	TOTAL			$	18,729	$ 1,247,195	$ 414,484	18,729	$ 1,661,679	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 West Suburban Nsg Rehab Ctr # 0049759 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (129,330)	$ (128,236)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,134,575	5,134,575	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	399,027	399,027	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		127,263	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,404,272	$ 5,532,629	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		7,270,000	14
15	Leasehold Improvements, at Historical Cost	1,982,836	1,982,836	15
16	Equipment, at Historical Cost	621,495	621,495	16
17	Accumulated Depreciation (book methods)	(925,469)	(3,379,867)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	93,266	5,981,582	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(30,381)	(5,190,539)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		231,030	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,741,747	$ 7,916,537	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,146,019	$ 13,449,166	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,408,012	$ 1,548,108	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,518	11,518	28
29	Short-Term Notes Payable	1,695,600	2,048,813	29
30	Accrued Salaries Payable	221,948	221,948	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,718	23,718	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,360,796	$ 3,854,105	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,197,206	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,197,206	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,360,796	$ 16,051,311	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,785,223	$ (2,602,145)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,146,019	$ 13,449,166	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,908,302	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,908,302	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,876,924	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) **Rounding Error**	(3)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,876,921	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)**	$ 3,785,223	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	$ 17,361,086	1
2	Discounts and Allowances for all Levels	(40,444)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,320,642	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	460,458	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 460,458	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,853,542	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	33,681	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	47,970	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,935,193	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	131,607	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 131,607	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Income	5,776	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,776	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,853,676	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,417,484	31
32	Health Care	7,794,324	32
33	General Administration	4,435,143	33
	B. Capital Expense		
34	Ownership	2,079,971	34
	C. Ancillary Expense		
35	Special Cost Centers	1,249,830	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,976,752	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,876,924	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,876,924	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,554,488	44
45	Private Pay - Net Inpatient Revenue	362,791	45
46	Medicare - Net Inpatient Revenue	5,234,459	46
47	Other-(specify) NET PATIENT REVENUE	1,168,904	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,320,642	49

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

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

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

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

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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	944	1,049	$ 50,764	$ 48.39	1
2	Assistant Director of Nursing	7,134	8,214	303,803	36.99	2
3	Registered Nurses	18,626	24,929	1,064,244	42.69	3
4	Licensed Practical Nurses	38,027	48,809	1,823,617	37.36	4
5	CNAs & Orderlies	70,982	86,444	1,782,210	20.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,085	13,404	251,606	18.77	10
11	Social Service Workers	4,830	5,351	125,349	23.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,208	35,660	589,225	16.52	15
16	Dishwashers					16
17	Maintenance Workers	3,717	4,241	109,749	25.88	17
18	Housekeepers	20,830	24,364	402,943	16.54	18
19	Laundry	9,593	10,969	152,262	13.88	19
20	Administrator	2,016	2,158	123,228	57.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,967	8,884	186,359	20.98	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	5,109	10,153	274,314	27.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	231,068	284,629	$ 7,239,673 *	$ 25.44	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	250	$ 12,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,106	59,086	10-3	38
39	Pharmacist Consultant	390	19,503	15-3	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	42	2,714	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,788	$ 93,302		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-2	50
51	Licensed Practical Nurses			10-2	51
52	Certified Nurse Assistants/Aides	10,762	427,929	10-2	52
53	TOTAL (lines 50 - 52)	10,762	$ 427,929		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dominguez, Margaux	Administrators	0	$ 39,045
Granrath, Rebecca A	Administrators	0	84,183
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 123,228

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
Infinity Funding / Sedgwick	Legal	$ 18,189
Infinity Healthcare Management of Il	Legal	392
Klauke Law Group LLC	Legal	26
McGuire Woods - 10/12/20	Legal	2,099
See attached schedule		956,552
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 977,259

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 138,816
Unemployment Compensation Insurance	30,692
FICA Taxes	596,069
Employee Health Insurance	323,720
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Unifoms	3,573
Pension	50,057
Employee backround checks	1,169
Other employee benefits	21,326
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,165,422

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,824
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
The Joint Commisions	3,100
Management and network services	750
Dupage county health dept	863
Bloomingdale chamber of commerce	600
Other Licenses and dues	322
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,459

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel Reimbursement	1,846
Seminar Expense	
Education and Seminars	6,100
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,946

* Attach copy of IMRF notifications

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
Empire Risk Management Services, I	Professional Fees	12,000
GGM Associates, INC.	Professional Fees	2,700
Global Fiscal Midwest LLC	Professional Fees	6,383
Infinity H Funding	Professional Fees	5,773
Infinity Healthcare Management of II	Professional Fees	1,556
A/P Accruals - MTS CONSULTING,	Professional Fees	48
Professional Search Network Recruit	Professional Fees	16,500
PROSPECT RESOURCES	Professional Fees	1,200
USA Risk Management Inc	Professional Fees	1,529
Reclass - Premier Destine Inc - 10/25/	COVID-19 PROFESSIONAL FEES	704
People Powered LLC	COVID-19 PROFESSIONAL FEES	2,000
Infinity Healthcare Management of II	MANAGEMENT FEES	899,806
Transworld	Collection Costs	53
GGM Associates, INC.	Accounting fees	3,300
Johnson and Goldburg	Accounting fees	3,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		**$ 956,552**

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XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,541** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **489,682**
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. $ **0** Has any meal income been offset against related costs? **N/A** 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? **0%**
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.