

		FOR BHF USE			

LL2

### Supportive Living Facility

**2020**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE & FAMILY SERVICES**  
**COST REPORT FOR**  
**SUPPORTIVE LIVING FACILITIES**  
**(FISCAL YEAR 2020)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p><b>I. Facility ID Number:</b> <u>1000017</u></p> <p><b>Facility Name:</b> <u>Robbins SL</u></p> <hr/> <p><b>Address:</b> <u>13820 Utica Avenue</u> <u>Robbins</u> <u>60472</u>        Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(708) 389-7140</u> Fax # _____</p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>9/30/2002</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steven N. Lavenda</u> <b>Telephone Number:</b> <u>(847) - 282- 6300</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input checked="" type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:30%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>5/3/2020</td> </tr> <tr> <td></td> <td colspan="2">(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Marcum LLP</u> <u>Nine Parkway North, Suite 200 Deerfield, IL 60015</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u></td> <td>Fax <u>(847) 282-6301</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE        IL DEPT OF HEALTHCARE AND FAMILY SERVICES        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		<b>Paid Preparer</b>	(Signed) _____	5/3/2020		(Date) _____			(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u>			(Firm Name & Address) <u>Marcum LLP</u> <u>Nine Parkway North, Suite 200 Deerfield, IL 60015</u>			(Telephone) <u>(847) 282-6300</u>	Fax <u>(847) 282-6301</u>
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Facility Name Robbins SLReport Period Beginning: 1/1/2020 Ending: 12/31/2020**III. STATISTICAL DATA****A. Certified units; enter number of units and unit days**Date of change in certified units N/A

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	103	Single Unit Apartment	103	37,698	1
2	25	Double Unit Apartment	25	9,150	2
3		Other			3
4	128	TOTALS	128	46,848	4

**B. Census-For the entire report period.**

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	42,233			42,233	5
6	Double Unit					6
7	Other					7
8	TOTALS	42,233			42,233	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.15%

**D. Indicate the number of paid bed-hold days the SLF had during this year**

None Also, indicate the number of unpaid bed-hold days the SLF had during this year. None (Do not include bed-hold days in Section B.)

**E. Does page 3 include expenses for services or investments not directly related to SLF services?**YES  NO **F. Does the BALANCE SHEET reflect any non-SLF assets?**YES  NO **G. List all services provided by your facility for non-residents.**

(E.g., day care, "meals on wheels", outpatient therapy)

None**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

**I. Is your fiscal year identical to your tax year?**  YES  NOTax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

**J. Does the facility have any Illinois Housing Development Authority Loans outstanding?**

No If yes, did the facility make all of the required payments of interest and principal? N/A

If no, explain. \_\_\_\_\_

**K. Does the facility have any loans from the Federal Home Loan Bank outstanding?**

No If yes, did the facility make all of the required payments of interest and principal? N/A

If no, explain. \_\_\_\_\_

**L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding?**

No If yes, did the facility make all of the required payments of interest and principal? N/A

If no, explain. \_\_\_\_\_

Facility Name: Robbins SL

Report Period Beginning:

1/1/2020

Ending: 12/31/2020

## IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	198,401	253,550	137,029	588,980		588,980	1
2	Housekeeping, Laundry and Maintenance	198,261	49,315	150,258	397,834	9,372	407,206	2
3	Heat and Other Utilities			153,269	153,269	1,962	155,231	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>396,662</b>	<b>302,865</b>	<b>440,556</b>	<b>1,140,083</b>	<b>11,334</b>	<b>1,151,417</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	412,361	5,199	73,078	490,638		490,638	6
7	Activities and Social Services	42,231	456	4,327	47,014		47,014	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>454,592</b>	<b>5,655</b>	<b>77,405</b>	<b>537,652</b>		<b>537,652</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	281,064	10,012	344,322	635,398	(155,396)	480,002	10
11	Marketing Materials, Promotions and Advertising	65,874	7,429	11,070	84,373	1,576	85,949	11
12	Employee Benefits and Payroll Taxes			160,988	160,988		160,988	12
13	Insurance-Property, Liability and Malpractice			45,172	45,172	155,834	201,006	13
14	Other (specify):					7,441	7,441	14
15	<b>TOTAL General Administration</b>	<b>346,938</b>	<b>17,441</b>	<b>561,552</b>	<b>925,931</b>	<b>9,456</b>	<b>935,387</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,198,192</b>	<b>325,961</b>	<b>1,079,513</b>	<b>2,603,666</b>	<b>20,789</b>	<b>2,624,455</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			59,565	59,565	298,698	358,263	17
18	Interest					689,146	689,146	18
19	Real Estate Taxes			223,272	223,272		223,272	19
20	Rent -- Facility and Grounds			1,337,226	1,337,226	(1,326,608)	10,618	20
21	Rent -- Equipment			11,447	11,447		11,447	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>1,631,510</b>	<b>1,631,510</b>	<b>(338,763)</b>	<b>1,292,747</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,198,192</b>	<b>325,961</b>	<b>2,711,023</b>	<b>4,235,176</b>	<b>(317,974)</b>	<b>3,917,202</b>	<b>24</b>

Robbins SL

Report Period Beginning: 1/1/2020  
 Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Non-Straight Line Depreciation	(146,262)	17
2	Misc Revenue	(40)	10
3	Interest Income	(8,452)	18
4	Bad Debts	(2,424)	10
5	Bank Charges	(3,192)	10
6	Cable Service	(9,769)	02
7	Use Tax	(83)	10
8	Meals & Entertainment	(119)	10
9	Capitalized R&M	(27,633)	02
10			10
11	BUILDING COMPANY		11
12	Interest Income	(277)	18
13	Interest Expense	697,855	18
14	Depreciation	444,960	17
15	Rent	(1,337,236)	20
16	Asset Management Fee	46,129	02
17	Insurance	153,694	13
18			18
19	MANAGEMENT OFFICE ALLOCATION		19
20	Housekeeping/Maint/Laundry	645	02
21	Utilities	1,962	03
22	Administrative and General	124,785	10
23	Advertising and Marketing	1,576	11
24	Insurance	2,140	13
25	Admin Emp Benefits & Payroll Taxes	7,441	14
26	Building Rental	10,618	20
27	Management Fees	(274,323)	10
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
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88			88
89			89
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92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(317,674)	101

Facility Name: Robbins SL

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2.56	\$ 28.13	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	10.91	11.56	3
4	Activity Director & Assistants	0.97	20.95	4
5	Social Service Workers			5
6	Head Cook	1.92	10.37	6
7	Cook Helpers/Assistants	5.70	13.25	7
8	Dishwashers			8
9	Maintenance Workers	1.73	21.96	9
10	Housekeepers	4.99	11.47	10
11	Laundry			11
12	Managers			12
13	Other Administrative	0.97	38.98	13
14	Clerical	6.05	16.10	14
15	Marketing	1.03	30.84	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>36.83</b>	<b>\$</b>	<b>17</b>

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1	N/A			\$	1
2					2
3					3
4					4
5					5
				<b>Total</b>	<b>6</b>
				\$	

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>3</b>
\$		

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	City
Rockford SLF	Rockford, IL
Coles SLF	Chicago, IL
Jackson Park SLF	Chicago, IL
Grand Regency of Peoria	Peoria, IL

OTHER RELATED BUSINESS ENTITIES

Name	City	Type of Business
Robbins SLF Realty	Robbins, IL	Building Co
Grand Lifestyles	Skokie, IL	Management Co
Grand at Twin Lakes	Palatine, IL	Ind. Living

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES  NO

Name of related entity: N/A If yes, what is the value of those services? \$ N/A

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES  NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Robbins SL

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VIII. OWNERSHIP COSTS

A. Purchase price of land 567,500 Year land was acquired 2016

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. \*Total units on this schedule must agree with page 2.

	1 Units*	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	
1	128		2016	2002	\$ 4,548,527	\$ 504,525	35	\$ 129,958	\$ (374,567)	\$ 649,790	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Total From Supplemental Page 5's				334,543		20	16,729	16,729	39,807	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 4,883,070	\$ 504,525		\$ 146,687	\$ (357,838)	\$ 689,597	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 2,115,768	\$	\$ 211,576	211,576		\$ 951,635	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	\$ 2,115,768	\$	\$ 211,576	211,576		\$ 951,635	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name & ID Number Robbins SL

#

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Repaired Roof	2017	4,750		20	238	238	951	1
2	Installed New Hoses	2017	2,500		20	125	125	500	2
3	Installed Scald Protectors	2017	3,096		20	155	155	619	3
4	Installed New Furnace	2017	5,771		20	289	289	1,155	4
5	Installed New Surveillance System	2017	5,172		20	259	259	1,035	5
6	Installed A/C System	2017	3,500		20	175	175	700	6
7	1St-4Th Floor-Office/Corridor Tiling/Paint/Lighting	2018	164,441		20	8,222	8,222	24,666	7
8	Roof Repair	2018	3,000		20	150	150	450	8
9	Repaired Pavement And Sewer	2019	26,050		20	1,303	1,303	2,606	9
10	Ptac Heat Pump	2019	2,703		20	135	135	270	10
11	Repairs Of Roof	2019	7,100		20	355	355	710	11
12	Installed Fire Alarm	2019	9,639		20	482	482	823	12
13	Repaired Sewer In Basement	2019	3,412		20	171	171	342	13
14	Installed Security Cameras	2019	3,385		20	169	169	338	14
15	Repaired Elevator	2019	2,826		20	141	141	282	15
16	Wall Face Sign	2020	19,421		20	971	971	971	16
17	Roof Repair	2020	9,500		20	475	475	475	17
18	1St-4Th Floor-Office/Corridor Tiling/Paint/Lighting	2020	30,644		20	1,532	1,532	1,532	18
19	Heater Repair	2020	3,908		20	195	195	195	19
20	Elevator Repair	2020	3,250		20	163	163	163	20
21	2 Furnaces Repair	2020	4,730		20	237	237	237	21
22	Repair Walk-In Freezer	2020	15,745		20	787	787	787	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 334,543	\$		\$ 16,729	\$ 16,729	\$ 39,807	34

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

Facility Name & ID Number Robbins SL

#

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	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
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28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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



Facility Name & ID Number Robbins SL

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
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29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	34

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

Facility Name: Robbins SL

Report Period Beginning: 1/1/2020

Ending: 2/31/2020

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

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?  YES  NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6	Allocated from Grand Lifestyles			/ /	10,618			6
7	<b>TOTAL</b>				\$ 10,618			7

8. Is movable equipment rental included in building rental?  YES  NO

9. Rental amount for movable equipment \$ 11,447

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

**X. INTEREST EXPENSE**

	1	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	<b>A. Directly Facility Related</b>									
	<b>Long-Term</b>									
1	MB Financial		X	Mortgage	/ /	\$	17,634,604	/ /		\$ 697,855
2					/ /			/ /		
3					/ /			/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$	17,634,604			\$ 697,855
	<b>B. Non-Facility Related</b>									
8	Interest Income		X		/ /			/ /		-8,452
9	Building Co. - Interest Income		X		/ /			/ /		-257
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	17,634,604			\$ 689,146

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

\*\* If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Robbins SL

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,465,948	\$ 1,721,862	1
2	Cash-Patient Deposits	7,900	7,900	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	679,808	675,687	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	181,085	213,860	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		1,928,395	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,334,741	\$ 4,547,704	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		567,500	13
14	Buildings, at Historical Cost	9,741	5,065,798	14
15	Leasehold Improvements, at Historical Cost	49,825	49,825	15
16	Equipment, at Historical Cost	426,080	2,120,053	16
17	Accumulated Depreciation (book methods)	(485,645)	(2,674,784)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	243,055	7,987,018	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 243,056	\$ 13,115,410	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,577,797	\$ 17,663,114	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 75,637	\$ 88,259	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		276,085	29
30	Accrued Salaries Payable	87,859	87,859	30
31	Accrued Taxes Payable	189,469	446,753	31
32	Accrued Interest Payable		57,753	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36		96,053	344,024	36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 449,018	\$ 1,300,733	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable		17,358,519	39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43		1,374,844	1,374,844	43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 1,374,844	\$ 18,733,363	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 1,823,862	\$ 20,034,096	45
46	<b>TOTAL EQUITY</b>	\$ 753,935	\$ (2,370,982)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 2,577,797	\$ 17,663,114	47

\*(See instructions.)

Facility Name: Robbins SL

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

## XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 5,491,542	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 5,491,542</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	8,452	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 8,452</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15		246,940	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 246,940</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 5,746,934</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	1,140,083	19
20	Health Care/ Personal Care	537,652	20
21	General Administration	925,931	21
<b>B. Capital Expense</b>			
22	Ownership	1,631,510	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 4,235,176</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 1,511,758</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 1,511,758</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 4,407,300	32
33	Private Pay - Net Inpatient Revenue	1,084,242	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 5,491,542</b>	<b>37</b>