

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0056580

Facility Name: Arcola Health Care Center

Address: 422 E 4th South St Arcola 61910
Number City Zip Code

County: Douglas

Telephone Number: (217) 268-3022 Fax # (217) 268-4180

HFS ID Number:

Date of Initial License for Current Owners: 11/09/93

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Mark Petersen
(Title) Chief Executive Officer

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

#	0056580	Report Period Beginning:	1/1/2020	Ending:	12/31/2020
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D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

N/A

Meals on Wheels

F. Does the facility maintain a daily midnight census?

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

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

Date started 11/9/1993

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/9/1993

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 50 and days of care provided

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*
X	

MODIFIEDCASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/2020 **Fiscal Year:** 12/31/2020

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

	1 Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,091	1,677	1,564	7,332	8
9	SNF/PED					9
10	ICF	18,250			18,250	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,341	1,677	1,564	25,582	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **70.09 %**

Facility Name & ID Number Arcola Health Care Center # 0056580 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	198,315	28,277	450	227,042		227,042	6,812	233,854			1
2	Food Purchase		197,215		197,215		197,215	(6,827)	190,388			2
3	Housekeeping	158,685	35,093		193,778		193,778	132	193,910			3
4	Laundry	21,695	7,888		29,583		29,583		29,583			4
5	Heat and Other Utilities			77,392	77,392		77,392	465	77,857			5
6	Maintenance	50,668	10,795	19,688	81,151		81,151	4,091	85,242			6
7	Other (specify):*											7
8	TOTAL General Services	429,363	279,268	97,530	806,161		806,161	4,673	810,834			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	1,436,114	115,289	89,769	1,641,172		1,641,172	(173)	1,640,999			10
10a	Therapy			242,509	242,509		242,509		242,509			10a
11	Activities	82,946	891		83,837		83,837	(715)	83,122			11
12	Social Services	53,681			53,681		53,681		53,681			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,572,741	116,180	368,278	2,057,199		2,057,199	(888)	2,056,311			16
	C. General Administration											
17	Administrative	124,004		219,800	343,804		343,804	(181,918)	161,886			17
18	Directors Fees											18
19	Professional Services			11,094	11,094		11,094	25,195	36,289			19
20	Dues, Fees, Subscriptions & Promotions			2,953	2,953		2,953	3,487	6,440			20
21	Clerical & General Office Expenses	28,027	4,870	19,615	52,512		52,512	42,068	94,580			21
22	Employee Benefits & Payroll Taxes			224,646	224,646		224,646	11,594	236,240			22
23	Inservice Training & Education							70	70			23
24	Travel and Seminar							22	22			24
25	Other Admin. Staff Transportation			8,712	8,712		8,712	4,880	13,592			25
26	Insurance-Prop.Liab.Malpractice			50,239	50,239		50,239	744	50,983			26
27	Other (specify):*											27
28	TOTAL General Administration	152,031	4,870	537,059	693,960		693,960	(93,858)	600,102			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,154,135	400,318	1,002,867	3,557,320		3,557,320	(90,073)	3,467,247			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 Arcola Health Care Center #0056580 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			21,068	21,068		21,068	37,173	58,241			30
31	Amortization of Pre-Op. & Org.			8,129	8,129		8,129	65,030	73,159			31
32	Interest			69,145	69,145		69,145	243,713	312,858			32
33	Real Estate Taxes			35,125	35,125		35,125	268	35,393			33
34	Rent-Facility & Grounds			394,012	394,012		394,012	(394,012)				34
35	Rent-Equipment & Vehicles			24,149	24,149		24,149	2,473	26,622			35
36	Other (specify):*											36
37	TOTAL Ownership			551,628	551,628		551,628	(45,355)	506,273			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,928		48,928		48,928		48,928			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			200,409	200,409		200,409		200,409			42
43	Other (specify):*		315	63,584	63,899		63,899	(63,899)				43
44	TOTAL Special Cost Centers		49,243	263,993	313,236		313,236	(63,899)	249,337			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,154,135	449,561	1,818,488	4,422,184		4,422,184	(199,327)	4,222,857			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,858)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,706)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,213)	30		9
10	Interest and Other Investment Income	(24)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(439)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(18,332)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	43		24
25	Fund Raising, Advertising and Promotional	(315)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(38,515)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,402)		\$	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)	(116,925)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (116,925)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (199,327)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (23,436)	43	1
2	X-Rays-Part A	(4,103)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(6,556)	10	3
4	Offset Miscellaneous Office Supplies Revenue	(168)	21	4
5	Resident Flowers	(121)	43	5
6	Offset Transportation Revenue	(715)	11	6
7	Disallowed Special Events	21	43	7
8	Disallowed Vending Machine Expense	(1,468)	43	8
9	To offset Meals On Wheels Revenue	(1,969)	2	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
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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	(38,515)		49

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
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 6,812	\$ 6,812	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	132	132	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	465	465	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	4,091	4,091	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	6,383	6,383	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	219,800	Petersen Health Care Management, Inc.	100.00%	37,882	(181,918)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	22,376	22,376	12
13	V								13
14	Total			\$ 219,800			\$ 78,141	\$ * (141,659)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,487	\$ 3,487	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	42,236	42,236	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	11,594	11,594	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	70	70	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	22	22	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,880	4,880	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	744	744	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	6,895	6,895	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	336	336	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	268	268	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	2,473	2,473	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			\$			\$ 73,005	\$ * 73,005	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Quality, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Quality, LLC.	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Quality, LLC.	100.00%	0		17
18	V	4	Laundry		Petersen Health Quality, LLC.	100.00%	0		18
19	V	5	Utilities		Petersen Health Quality, LLC.	100.00%	0		19
20	V	6	Maintenance		Petersen Health Quality, LLC.	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Quality, LLC.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Quality, LLC.	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Quality, LLC.	100.00%	0		23
24	V	17	Administrative		Petersen Health Quality, LLC.	100.00%	0		24
25	V	19	Professional Services		Petersen Health Quality, LLC.	100.00%	2,819	2,819	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Quality, LLC.	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Quality, LLC.	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Quality, LLC.	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Quality, LLC.	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Quality, LLC.	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Quality, LLC.	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Quality, LLC.	100.00%	0		32
33	V	30	Depreciation		Petersen Health Quality, LLC.	100.00%	427	427	33
34	V	31	Amortization		Petersen Health Quality, LLC.	100.00%	0		34
35	V	32	Interest		Petersen Health Quality, LLC.	100.00%	346	346	35
36	V	33	Real Estate Taxes		Petersen Health Quality, LLC.	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Quality, LLC.	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Quality, LLC.	100.00%	0		38
39	Total			\$			\$ 3,592	\$ * 3,592	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	\$	Arcola Land Company, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	Arcola Land Company, LLC	100.00%			16
17	V	21	Equipment		Arcola Land Company, LLC	100.00%			17
18	V	26	Insurance-Property		Arcola Land Company, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		Arcola Land Company, LLC	100.00%			19
20	V	30	Depreciation		Arcola Land Company, LLC	100.00%	34,064	34,064	20
21	V	31	Amortization		Arcola Land Company, LLC	100.00%	65,030	65,030	21
22	V	32	Interest		Arcola Land Company, LLC	100.00%	243,055	243,055	22
23	V	33	Real Estate Taxes		Arcola Land Company, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	394,012	Arcola Land Company, LLC	100.00%		(394,012)	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			\$ 394,012			\$ 342,149	\$ * (51,863)	39

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

Facility Name & ID Number

Arcola Health Care Center

0056580

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Arcola Health Care Center

0056580

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Arcola Health Care Center

0056580

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Arcola Health Care Center

0056580

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6			Betty's Garden	Kewanee				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 Arcola Health Care Center # 0056580 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 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	N/A										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 Arcola Health Care Center# 0056580

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	25,582	\$ 6,812	1
2	2	Food	Resident Days	1,282,791	75	0	0	25,582	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	25,582	132	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	25,582	465	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	25,582	4,091	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	25,582	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	25,582	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	25,582	6,383	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	25,582	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	25,582	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	25,582	37,882	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	25,582	22,376	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	25,582	3,487	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	25,582	42,236	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	25,582	11,594	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	25,582	70	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	25,582	22	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	25,582	4,880	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	25,582	744	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	25,582	6,895	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	25,582	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	25,582	336	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	25,582	268	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	25,582	2,473	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 151,146	25

Facility Name & ID Number Arcola Health Care Center# 0056580

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Quality, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	47,439	5	\$	\$	15,335	\$	1
2	2	Food	Resident Days	47,439	5			15,335		2
3	3	Housekeeping	Resident Days	47,439	5			15,335		3
4	4	Laundry	Resident Days	47,439	5			15,335		4
5	5	Utilities	Resident Days	47,439	5			15,335		5
6	6	Maintenance	Resident Days	47,439	5			15,335		6
7	7	Mgmt. Allocation of Benefits	Resident Days	47,439	5			15,335		7
8	10	Nursing and Medical Records	Resident Days	47,439	5			15,335		8
9	15	Mgmt. Allocation of Benefits	Resident Days	47,439	5			15,335		9
10	17	Administrative	Resident Days	47,439	5			15,335		10
11	19	Professional Services	Resident Days	47,439	5	8,721		15,335	2,819	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	47,439	5			15,335		12
13	21	Clerical and General Office	Resident Days	47,439	5			15,335		13
14	22	Employee Benefits & Payroll	Resident Days	47,439	5			15,335		14
15	23	Inservice Training & Education	Resident Days	47,439	5			15,335		15
16	24	Travel and Seminar	Resident Days	47,439	5			15,335		16
17	25	Other Admin. Staff Transport.	Resident Days	47,439	5			15,335		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	47,439	5			15,335		18
19	30	Depreciation	Resident Days	47,439	5	1,320		15,335	427	19
20	31	Amortization	Resident Days	47,439	5			15,335		20
21	32	Interest	Resident Days	47,439	5	1,070		15,335	346	21
22	33	Real Estate Taxes	Resident Days	47,439	5			15,335		22
23	34	Rent-Facility and Grounds	Resident Days	47,439	5			15,335		23
24	35	Rent-Equipment & Vehicles	Resident Days	47,439	5			15,335		24
25	TOTALS					\$ 11,111	\$		\$ 3,592	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Gemino		X	Mortgage	Varies	3/27/15	\$ 1,729,794	\$ Paid		Varies	\$	1	
2	Sector		X	Mortgage	Varies	4/1/20	3,896,133	3,896,133	3/31/23	Varies	311,585	2	
3	Dodge		X	Auto Van	Varies	6/29/20	39,027	36,053	6/28/25	Varies	615	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 5,664,954	\$ 3,932,186			\$ 312,200	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(24)	10	
11								Home Office Allocation-PHCM			336	11	
12								Home Office Allocation-PHQ			346	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 658	14	
15	TOTALS (line 9+line14)						\$ 5,664,954	\$ 3,932,186			\$ 312,858	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																		
1. Real Estate Tax accrual used on 2019 report.			\$	25,920	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.)			\$	30,073	2															
3. Under or (over) accrual (line 2 minus line 1).			\$	4,153	3															
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	30,972	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.)			\$	268	6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	35,393	7															
Real Estate Tax History:																				
Real Estate Tax Bill for Calendar Year:		2015 2016 2017 2018 2019	20,165 31,107 24,944 25,162 30,073	8 9 10 11 12	<table><tr><td></td><td>FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2019</td><td>\$</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td></tr></table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2019	\$	14	PLUS APPEAL COST FROM LINE 5	\$	15	LESS REFUND FROM LINE 6	\$	16	AMOUNT TO USE FOR RATE CALCULATION	\$
	FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2019	\$																		
14	PLUS APPEAL COST FROM LINE 5	\$																		
15	LESS REFUND FROM LINE 6	\$																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$																		

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.

FACILITY NAME Arcola Health Care Center COUNTY Douglas
FACILITY IDPH LICENSE NUMBER 0053074
CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER
TELEPHONE (309)689-5850 FAX #: (309)691-8622

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.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

22,000

B. General Construction Type:

Exterior Brick

Frame Steel

Number of Stories

1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (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?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

195,091

2. Number of Years Over Which it is Being Amortized:

3

3. Current Period Amortization:

73,159

4. Dates Incurred:

2020

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	159,865	1993	\$ 44,078	1
2					2
3	TOTALS	159,865		\$ 44,078	3

Facility Name & ID Number Arcola Health Care Center

0056580

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100		1995	1975	\$ 859,153	\$	35	\$ 24,547	\$ 24,547	\$ 625,948	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fully Depreciated Assets 1993-1998			1993	102,724		20			102,724	9
10	Wood Flooring			1999	1,174		20	59	59	1,149	10
11	Asphalt Lot			1999	4,680		20	234	234	4,563	11
12	Tile			1999	6,477		20	324	324	6,316	12
13	Vinyl Siding			1999	5,600		25	224	224	4,368	13
14	Door Alarms			2000	1,593		20	80	80	1,479	14
15	Water Heater			2000	5,075		20	254	254	4,699	15
16	Sidewalk			2000	876		20	44	44	814	16
17	Carpeting			2000	670		20	34	34	628	17
18	Scarf Swags/Valances			2001	6,043		20	302	302	5,134	18
19	Scarf Holders			2001	1,083		20	54	54	918	19
20	Fence			2001	2,000		20	100	100	1,700	20
21	Replacement Wall			2001	686		20	34	34	579	21
22	Security System			2002	\$ 5,959	\$	20	\$ 298	298	4,917	22
23	Sprinkler System			2002	4,946		20	247	247	4,078	23
24	Sign			2002	1,248		20			1,248	24
25	Medicare Wing Expansion			2003	100,808		20	5,040	5,040	78,121	25
26	Architect Fees			2003	1,343		20	67	67	1,343	26
27	Patio			2003	5,858		20	293	293	4,688	27
28	Medicare Wing Expansion			2003	2,500		20	125	125	1,938	28
29	Medicare Wing Expansion			2003	750		20	38	38	587	29
30	Medicare Wing Expansion			2003	1,500		20	75	75	1,163	30
31	Medicare Wing Expansion			2003	500		20	25	25	438	31
32	Furnace			2004	2,195		20	110	110	1,595	32
33	Roofing			2005	2,500		20	125	125	1,689	33
34	Asphalt West Lot			2006	21,480		20	1,074	1,074	13,425	34
35	Door Alarm			2007	2,117		10			2,117	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Arcola Health Care Center

0056580

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	
37	Furnace/Air Conditioner	2007	3,985		10		\$	3,985	37
38	Blinds	2007	4,431		10			4,431	38
39	Windows	2007	19,021		20	951	951	10,937	39
40	Water Heater	2008	6,500		7			6,500	40
41	Boiler	2008	3,425		20	172	172	2,248	41
42	6 New Sprinklers	2008	5,990		25	240	240	2,520	42
43	Fire Alarm Repair	2008	2,899		7			2,899	43
44	Kitchen Exhaust Fan	2010	8,000		10	800	800	3,200	44
45	Roof Replacement on North Building	2011	58,091		25	2,324	2,324	17,430	45
46	Nurse Call System	2014	7,296		7	1,042	1,042	5,731	46
47	Air Conditioner	2014	4,456		15	297	297	1,634	47
48	Dumpster Pad	2014	3,200		15	213	213	1,172	48
49	Parking Lot Sealcoat	2014	6,588		7	941	941	5,175	49
50	Nursing Station	2014	13,609		15	907	907	4,989	50
51	Sprinkler System Repair	2014	12,142		15	809	809	4,450	51
52	Bathroom Repair	2014	2,500		7	357	357	1,964	52
53	Bathroom Repair	2015	2,500		7	358	358	1,611	53
54	Repair from Fire Damage	2017	5,011		7	716	716	1,790	54
55	Sprinkler Repair	2018	4,656		7	665	665	998	55
56	Flooring for Hallway	2020	6,400		7	457	457	457	56
57									57
58									58
59									59
60									60
61									61
62									62
63	Land Improvements Booked			1,486			(1,486)		63
64	Building Booked			23,372			(23,372)		64
65	Building Improvement Booked			15,181			(15,181)		65
66									66
67	2020-Home Office Allocation-Building Improvements		12,935			310	310		67
68	2020-Home Office Allocation-Land Improvements		1,297			82	82		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,346,470	\$ 40,039		\$ 45,448	\$ 5,409	\$ 962,487	70

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

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	\$ 82,908	\$ 11,191	\$ 9,348	\$ (1,843)	5-10 yrs.	\$ 50,159	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	99,617					99,617	73
74								74
75	TOTALS	\$ 182,525	\$ 11,191	\$ 9,348	\$ (1,843)		\$ 149,776	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2005 Ford Van	2004	33,217	\$	\$	\$		\$ 33,217	76
77	Facility	2019 Dodge Caravan	2020	39,027	3,902	3,902		5	3,902	77
78										78
79										79
80	TOTALS			\$ 72,244	\$ 3,902	\$ 3,902	\$		\$ 37,119	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)	\$ 1,645,317	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,132	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,698	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,566	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,149,382	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	N/A				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.

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: *

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: \$ 26,622 Description: See Attached Schedule 14A
(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.

Arcola Health Care Center
0056580
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs
 B. Equipment
 16. Description of rental amount for movable equipment

Medical Equipment	\$	19,292
Dishwasher		701
Copier		4,156
Home Office Allocation		<u>2,473</u>
		<u>26,622</u>

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

☒ 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)	\$			

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	7,340	\$ 110,100	\$	7,340	\$ 110,100	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,450	21,746		1,450	21,746	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,370	110,547		7,370	110,547	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				48,928		48,928	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	10A(3)			8	116		8	116	12
13	Other (specify):									13
14	TOTAL			\$	16,168	\$ 242,509	\$ 48,928	16,168	\$ 291,437	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (15,674)	\$ (15,674)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 58,430)	1,850,864	1,850,864	3
4	Supply Inventory (priced at Cost)	12,222	12,222	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,498	28,498	6
7	Other Prepaid Expenses		12,710	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,875,910	\$ 1,888,620	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		44,078	13
14	Buildings, at Historical Cost		872,088	14
15	Leasehold Improvements, at Historical Cost		467,982	15
16	Equipment, at Historical Cost	72,244	254,769	16
17	Accumulated Depreciation (book methods)	(37,119)	(1,148,925)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		121,932	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	151,582	450,165	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	413,791	627,065	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 600,498	\$ 1,689,154	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,476,408	\$ 3,577,774	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 832,830	\$ 832,830	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,999	122,999	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,972	30,972	32
33	Accrued Interest Payable		52,946	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	122,143	122,143	36
37	Accrued Management Fees	36,281	36,281	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,145,225	\$ 1,198,171	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	36,053	36,053	39
40	Mortgage Payable		3,896,133	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	445,700	445,700	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 481,753	\$ 4,377,886	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,626,978	\$ 5,576,057	46
47	TOTAL EQUITY(page 18, line 24)	\$ 849,430	\$ (1,998,283)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,476,408	\$ 3,577,774	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,214,098)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	1,286,657	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,559	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	776,871	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 776,871	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)	\$ 849,430	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Arcola Health Care Center

0056580

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,691,828	1
2	Discounts and Allowances for all Levels	(751,977)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,939,851	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	326,691	6
7	Oxygen	496	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 327,187	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,927	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	89,526	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,127	20
21	Other Medical Services	11,540	21
22	Laundry	200	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 121,320	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	715	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	809,958	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 810,673	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,199,055	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	806,161	31
32	Health Care	2,057,199	32
33	General Administration	693,960	33
	B. Capital Expense		
34	Ownership	551,628	34
	C. Ancillary Expense		
35	Special Cost Centers	112,827	35
36	Provider Participation Fee	200,409	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,422,184	40
41	Income before Income Taxes (line 30 minus line 40)**	776,871	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 776,871	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,130,443	44
45	Private Pay - Net Inpatient Revenue	258,645	45
46	Medicare - Net Inpatient Revenue	539,040	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	11,723	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,939,851	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 70,000	\$ 33.65	1
2	Assistant Director of Nursing	1,579	1,748	46,417	26.55	2
3	Registered Nurses	7,413	7,648	235,192	30.75	3
4	Licensed Practical Nurses	14,789	15,425	340,479	22.07	4
5	CNAs & Orderlies	36,991	38,212	560,893	14.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,725	1,814	31,794	17.53	9
10	Activity Assistants	1,040	1,040	15,377	14.79	10
11	Social Service Workers	4,027	4,027	53,681	13.33	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	38,298	18.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,344	12,762	160,017	12.54	15
16	Dishwashers					16
17	Maintenance Workers	3,727	3,783	50,668	13.39	17
18	Housekeepers	13,898	14,464	158,685	10.97	18
19	Laundry	1,887	2,007	21,695	10.81	19
20	Administrator	2,016	2,080	74,004	35.58	20
21	Assistant Administrator	1,970	2,010	50,000	24.88	21
22	Other Administrative					22
23	Office Manager	1,942	2,047	28,027	13.69	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	698	698	19,655	28.16	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	7,975	8,192	199,253	24.32	33
34	TOTAL (lines 1 - 33)	118,181	122,117	\$ 2,154,135 *	\$ 17.64	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	9	\$ 450	L1, C3	35
36	Medical Director	Monthly	36,000	L9,C3	36
37	Medical Records Consultant			L9,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,844	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	87	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Telehealth</u>	Monthly	27,329	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	11	\$ 71,710		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,718	\$ 54,509	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,718	\$ 54,509		53

Arcola Health Care Center
0056580
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period Total	Average
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Salaries, Wages	Hourly Wage
Care Plan Coordinator	3,346	3,463	98,797	28.53
Transportation	1,997	2,009	35,775	17.81
Psych Dir	1,638	1,662	41,431	24.93
Psych Assistant	994	1,058	23,250	21.98
TOTAL	7,975	8,192	199,253	

Arcola Health Care Center
0056580

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

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		11,094

Home Office Allocation

Baker Tilly Virchow Krause LLP	Legal	394
Duane Morris	Legal	551
Lexis Nexis	Legal	11
Livingston, Barger, Brant, Schroeder	Legal	21
Miller, Hall, Triggs	Legal	68
Miscellaneous	Legal	25
SB2	Legal	203
SmithAmundsen LLC	Legal	1,259
Sorling Northrup	Legal	359
Thompson Burton	Legal	194
CliftonLarsonAllen	Accounting	3,168
Ginoli & Co.	Accounting	2,137
Ability Network	Computer Services	4,016
Allscripts	Computer Services	634
AOD Matrix Care	Computer Services	7,052
AT&T	Computer Services	8
ATS	Computer Services	384
CCH	Computer Services	22
Charter Communications	Computer Services	36
Citrix Systems	Computer Services	120
Comcast	Computer Services	41
ITSavvy	Computer Services	186
Kemper Technology	Computer Services	916
Miscellaneous	Computer Services	178
Pearl Technology	Computer Services	166
Stratus Networks	Computer Services	728
TR Professional	Computer Services	16
David Budde	Other Prof Fees	16
DJ Howard and Associates	Other Prof Fees	31
Getzler Henrich & Associates	Other Prof Fees	124
LRI Consulting Services	Other Prof Fees	121
McQuellon Consulting	Other Prof Fees	76
Miscellaneous	Other Prof Fees	145
Optimizer	Other Prof Fees	65
Registered Agent Solutions	Other Prof Fees	36
RSM McGladrey	Other Prof Fees	398
SB2	Other Prof Fees	509
Sedgwick CMS	Other Prof Fees	686
Tarver Program Consultants	Other Prof Fees	95

Total (agree to Schedule V, line 19, column 8)	<u><u>36,289</u></u>
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Arcola Health Care Center
0056580
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	3,043
Auto Repairs		5,252
Mileage-Travel		417
Home Office Allocation		<u>4,880</u>
		<u><u>13,592</u></u>

XX. GENERAL INFORMATION:

- | | |
|---|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u>
If YES, give association name and amount. _____</p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>7 yrs.</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>20,883</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>200,409</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>4,858</u></p> <p>(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>Yes</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>715</u>
 c. What percent of all travel expense relates to transportation of nurses and patients? <u>100</u>
 d. Have vehicle usage logs been maintained? <u>Yes</u>
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u>
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u>
 g. Does the facility transport residents to and from day training? <u>No</u>
 Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____ </p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u>
Firm Name: <u>Ginoli and Company</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>N/A</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
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