

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0056572</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																						
Facility Name: <u>Aspen Rehab Health Care</u>		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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																																																						
Address: <u>1403 9th Avenue</u> <u>Silvis</u> <u>61282</u>																																																																																								
Number City Zip Code																																																																																								
County: <u>Rock Island</u>																																																																																								
Telephone Number: <u>(309) 796-2600</u> Fax # <u>(309) 796-2981</u>																																																																																								
HFS ID Number: _____		<table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Mark Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>10/1/2005</u></td><td colspan="2">(Telephone) <u>()</u> Fax # <u>()</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table></td><td colspan="2">ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2">201 S. Grand Avenue East</td></tr><tr><td colspan="2">Name: <u>Mike Kocher</u></td><td colspan="2">Springfield, IL 62763-0001</td></tr><tr><td colspan="2">Telephone Number: <u>(309)689-5850</u></td><td colspan="2">Phone # (217) 782-1630</td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mark Petersen</u>	(Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	Date of Initial License for Current Owners: <u>10/1/2005</u>		(Telephone) <u>()</u> Fax # <u>()</u>		Type of Ownership:		MAIL TO: BUREAU OF HEALTH FINANCE		<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table>		☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☒	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES		In the event there are further questions about this report, please contact:		201 S. Grand Avenue East		Name: <u>Mike Kocher</u>		Springfield, IL 62763-0001		Telephone Number: <u>(309)689-5850</u>		Phone # (217) 782-1630		Email Address: _____			
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Facility Name & ID Number Aspen Rehab Health Care

0056572 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	12,357	432		12,789	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,357	432		12,789	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.62%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☐ NO ☒ If YES, enter number of beds certified and days of care provided

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ 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.

Facility Name & ID Number Aspen Rehab Health Care # 0056572 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	101,577	10,424		112,001		112,001	3,405	115,406			1
2	Food Purchase		80,137		80,137		80,137	(906)	79,231			2
3	Housekeeping	76,244	15,649		91,893		91,893	66	91,959			3
4	Laundry	19,049	7,019		26,068		26,068		26,068			4
5	Heat and Other Utilities			46,825	46,825		46,825	232	47,057			5
6	Maintenance	36,081	5,598	28,818	70,497		70,497	2,045	72,542			6
7	Other (specify):*											7
8	TOTAL General Services	232,951	118,827	75,643	427,421		427,421	4,842	432,263			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	687,678	36,410	66,676	790,764		790,764	3,191	793,955			10
10a	Therapy		16		16		16		16			10a
11	Activities	17,425	604		18,029		18,029	(128)	17,901			11
12	Social Services	36,302			36,302		36,302		36,302			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	741,405	37,030	84,676	863,111		863,111	3,063	866,174			16
	C. General Administration											
17	Administrative	74,004		93,600	167,604		167,604	(74,662)	92,942			17
18	Directors Fees											18
19	Professional Services			5,716	5,716		5,716	13,899	19,615			19
20	Dues, Fees, Subscriptions & Promotions			3,487	3,487		3,487	1,743	5,230			20
21	Clerical & General Office Expenses	33,062	1,403	13,224	47,689		47,689	21,115	68,804			21
22	Employee Benefits & Payroll Taxes			122,752	122,752		122,752	5,796	128,548			22
23	Inservice Training & Education							35	35			23
24	Travel and Seminar							11	11			24
25	Other Admin. Staff Transportation			5,866	5,866		5,866	2,440	8,306			25
26	Insurance-Prop.Liab.Malpractice			27,481	27,481		27,481	372	27,853			26
27	Other (specify):*											27
28	TOTAL General Administration	107,066	1,403	272,126	380,595		380,595	(29,251)	351,344			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,081,422	157,260	432,445	1,671,127		1,671,127	(21,346)	1,649,781			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			26,786	26,786		26,786	50,915	77,701			30
31	Amortization of Pre-Op. & Org.			1,043	1,043		1,043	8,341	9,384			31
32	Interest			8,552	8,552		8,552	74,496	83,048			32
33	Real Estate Taxes			52,069	52,069		52,069	134	52,203			33
34	Rent-Facility & Grounds			183,052	183,052		183,052	(183,052)				34
35	Rent-Equipment & Vehicles			12,420	12,420		12,420	1,236	13,656			35
36	Other (specify):*											36
37	TOTAL Ownership			283,922	283,922		283,922	(47,930)	235,992			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,029	112,029		112,029		112,029			42
43	Other (specify):*			23,521	23,521		23,521	(23,521)				43
44	TOTAL Special Cost Centers			135,550	135,550		135,550	(23,521)	112,029			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,081,422	157,260	851,917	2,090,599		2,090,599	(92,797)	1,997,802			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	(906)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,683)	30		9
10	Interest and Other Investment Income	(23)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(108)	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	(11,313)	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	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(642)	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	414	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,261)		\$	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)	(64,536)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (64,536)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (92,797)		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	Disallowed Special Events	542	43	1
2	Offset Transportation Revenue	(128)	11	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	414		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%	\$ 3,405	\$ 3,405	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%	66	66	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	232	232	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,045	2,045	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%	3,191	3,191	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	93,600	Petersen Health Care Management, Inc.	100.00%	18,938	(74,662)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	11,186	11,186	12
13	V								13
14	Total			\$ 93,600			\$ 39,063	\$ * (54,537)	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%	\$ 1,743	\$ 1,743	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	21,115	21,115	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	5,796	5,796	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	35	35	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	11	11	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,440	2,440	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	372	372	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	3,447	3,447	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%	168	168	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	134	134	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,236	1,236	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			\$			\$ 36,497	\$ * 36,497	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 Business, LLC	100.00%	\$	\$	15
16	V	2	Food		Petersen Health Business, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Business, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Business, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Business, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Business, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Business, LLC	100.00%			22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%			23
24	V	17	Administrative		Petersen Health Business, LLC	100.00%			24
25	V	19	Professional Services		Petersen Health Business, LLC	100.00%	2,713	2,713	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%			26
27	V	21	Clerical and General Office		Petersen Health Business, LLC	100.00%			27
28	V	22	Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%			28
29	V	23	Inservice Training & Education		Petersen Health Business, LLC	100.00%			29
30	V	24	Travel and Seminar		Petersen Health Business, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%			32
33	V	30	Depreciation		Petersen Health Business, LLC	100.00%			33
34	V	31	Amortization		Petersen Health Business, LLC	100.00%			34
35	V	32	Interest		Petersen Health Business, LLC	100.00%	7,688	7,688	35
36	V	33	Real Estate Taxes		Petersen Health Business, LLC	100.00%			36
37	V	34	Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%			38
39	Total			\$			\$ 10,401	\$ * 10,401	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	\$	Aspen Land Company, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	Aspen Land Company, LLC	100.00%			16
17	V	21	Equipment		Aspen Land Company, LLC	100.00%			17
18	V	26	Insurance-Property		Aspen Land Company, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		Aspen Land Company, LLC	100.00%			19
20	V	30	Depreciation		Aspen Land Company, LLC	100.00%	51,151	51,151	20
21	V	31	Amortization		Aspen Land Company, LLC	100.00%	8,341	8,341	21
22	V	32	Interest		Aspen Land Company, LLC	100.00%	66,663	66,663	22
23	V	33	Real Estate Taxes		Aspen Land Company, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	183,052	Aspen Land Company, LLC	100.00%		(183,052)	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			\$ 183,052			\$ 126,155	\$ * (56,897)	39

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

Facility Name & ID Number

Aspen Rehab Health Care

0056572

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

Aspen Rehab Health Care

0056572

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

Aspen Rehab Health Care

0056572

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

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 Aspen Rehab Health Care # 0056572 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 Aspen Rehab Health Care# 0056572

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	12,789	\$ 3,405	1
2	2	Food	Resident Days	1,282,791	75	0	0	12,789	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	12,789	66	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	12,789	232	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	12,789	2,045	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	12,789	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	12,789	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	12,789	3,191	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	12,789	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	12,789	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	12,789	18,938	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	12,789	11,186	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	12,789	1,743	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	12,789	21,115	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	12,789	5,796	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	12,789	35	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	12,789	11	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	12,789	2,440	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	12,789	372	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	12,789	3,447	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	12,789	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	12,789	168	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	12,789	134	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	12,789	1,236	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 75,560	25

Facility Name & ID Number Aspen Rehab Health Care# 0056572

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 Business, 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	70,323	9	\$	\$	8,738	\$	1
2	2	Food	Resident Days	70,323	9			8,738		2
3	3	Housekeeping	Resident Days	70,323	9			8,738		3
4	4	Laundry	Resident Days	70,323	9			8,738		4
5	5	Utilities	Resident Days	70,323	9			8,738		5
6	6	Maintenance	Resident Days	70,323	9			8,738		6
7	7	Mgmt. Allocation of Benefits	Resident Days	70,323	9			8,738		7
8	10	Nursing and Medical Records	Resident Days	70,323	9			8,738		8
9	15	Mgmt. Allocation of Benefits	Resident Days	70,323	9			8,738		9
10	17	Administrative	Resident Days	70,323	9			8,738		10
11	19	Professional Services	Resident Days	70,323	9	21,833		8,738	2,713	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	70,323	9			8,738		12
13	21	Clerical and General Office	Resident Days	70,323	9			8,738		13
14	22	Employee Benefits & Payroll	Resident Days	70,323	9			8,738		14
15	23	Inservice Training & Education	Resident Days	70,323	9			8,738		15
16	24	Travel and Seminar	Resident Days	70,323	9			8,738		16
17	25	Other Admin. Staff Transport.	Resident Days	70,323	9			8,738		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	70,323	9			8,738		18
19	30	Depreciation	Resident Days	70,323	9			8,738		19
20	31	Amortization	Resident Days	70,323	9			8,738		20
21	32	Interest	Resident Days	70,323	9	61,870		8,738	7,688	21
22	33	Real Estate Taxes	Resident Days	70,323	9			8,738		22
23	34	Rent-Facility and Grounds	Resident Days	70,323	9			8,738		23
24	35	Rent-Equipment & Vehicles	Resident Days	70,323	9			8,738		24
25	TOTALS					\$ 83,703	\$		\$ 10,401	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	Bank Leumi		X	Mortgage	Varies	5/10/16	975,000	\$ Paid	5/9/41	Varies	\$ 8,552	1
2	Sector		X	Mortgage	Varies	4/1/20	499,721	499,721	3/31/23	Varies	66,663	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 1,474,721	\$ 499,721			\$ 75,215	9
	B. Non-Facility Related*											
10								Interest Income Offset			(23)	10
11								Home Office Allocation-PHCM			168	11
12								Home Office Allocation-PHB			7,688	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 7,833	14
15	TOTALS (line 9+line14)						\$ 1,474,721	\$ 499,721			\$ 83,048	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.			\$	53,530	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.)			\$	52,019	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,511)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	53,580	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.)			\$	134	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	52,203	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	51,385	8		
	2016	51,487	9		
	2017	51,461	10		
	2018	51,986	11		
	2019	52,019	12		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aspen Rehab Health Care COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0056572

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 09-32300073	Long-Term Care Facility	\$ 52,019.32	\$ 52,019.32
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 52,019.32	\$ 52,019.32

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:

17,656

B. General Construction Type:

Exterior

Brick

Frame

Wood

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:

25,023

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

3

3. Current Period Amortization:

9,384

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	261,360	2005	\$ 36,000	1
2					2
3	TOTALS	261,360		\$ 36,000	3

Facility Name & ID Number Aspen Rehab Health Care

0056572

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	63		2005	1970	\$ 959,500	\$	25	\$ 38,380	\$ 38,380	\$ 594,890	4
5			2005		15,000		15	1,000	1,000	15,500	5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalks		2006		7,180		15	479	479	6,466	9
10	Showers		2006		3,401		20	170	170	2,295	10
11	Subflooring		2006		5,450		20	273	273	3,685	11
12	Ceramic Tile		2008		5,450		15	364	364	4,186	12
13	Showers		2008		6,075		25	243	243	2,796	13
14	Carpet for Building		2008		27,539		7			27,539	14
15	Sprinkler Head Installation		2009		3,816		15	254	254	2,667	15
16	Door Alarm Keypad		2011		2,972		10	298	298	2,533	16
17	Soffit Replacement & Repair to Water Damaged Kitchen Walls		2011		2,500		7			2,500	17
18	Kitchen Floor Tile Replacement		2011		6,150		7			6,150	18
19	Roof Replacement on West 100 Wing		2011		26,475		25	1,059	1,059	9,002	19
20	Water Heater		2012		3,814		7	278	278	3,814	20
21	Air Compressor		2013		5,393		7	388	388	5,393	21
22	Sprinkler Dry Vacuum		2013		5,325		7	760	760	4,940	22
23	Sprinkler Head Replacement		2013		22,722		15	1,514	1,514	11,355	23
24	Kitchen & Shower Floor Tile Replacement		2013		14,451		15	964	964	7,230	24
25	Plumbing Repair-Resident Bathrooms		2013		8,035		7	573	573	8,035	25
26	Flooring Replacement-Kitchen, Bathroom, Shower Rooms		2013		42,610		15	2,840	2,840	21,300	26
27	Plumbing Repair-Resident Bathrooms		2014		6,544		7	935	935	6,078	27
28	Water Heater		2014		3,255		7	465	465	3,023	28
29	Water Softener		2014		4,206		7	600	600	3,900	29
30	Downspouts (10)		2014		3,830		15	255	255	1,658	30
31	Nurse Call Station System		2014		8,005		7	1,144	1,144	7,436	31
32	Resident Room Floor Replacement in 29 Roor		2014		\$ 26,385	\$	15	\$ 2,653	2,653	17,245	32
33	Concrete Slab for Garbage Dumpsters		2014		10,728		15	715	715	4,648	33
34	Sidewalk Replacement		2014		6,200		15	413	413	2,685	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aspen Rehab Health Care

0056572

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	Kitchen Floor Rebuild and Replacement	2014	24,666		15	1,644	\$ 1,644	\$ 10,686	37
38	Mold Remediation in Bathrooms and Shower Install	2014	6,382		7	912	912	5,928	38
39	Shower Room Floor Repair	2014	4,224		7	603	603	3,920	39
40	Front Awning	2014	4,300		15	287	287	1,866	40
41	Dining Room Floor Replacement	2014	24,954		15	1,664	1,664	10,816	41
42	Ductwork Repair	2014	3,175		7	454	454	2,951	42
43	Kitchen Flooring, Sinks in 2 Res Rooms, Pipe Rep. in Bathroom	2015	28,630		15	1,910	1,910	10,505	43
44	Generator Repair	2017	3,071		7	439	439	1,536	44
45	Flooring-Entry Area to Hallway	2017	4,963		7	709	709	2,642	45
46	Bathroom Remodel-Flooring, Tiling	2018	8,300		15	554	554	1,385	46
47	Competition of Hallway Flooring Project	2018	3,283		7	470	470	1,175	47
48	Water Heater	2020	5,500		7	393	393	393	48
49	Sprinkler Repair	2020	4,270		7	305	305	305	49
50	Water Heater	2020	11,300		7	807	807	807	50
51	Water Damage Restoration	2020	4,833		7	345	345	345	51
52									52
53									53
54									54
55									55
56									56
57	Land Improvements Booked			2,273			(2,273)		57
58	Building Booked			38,405			(38,405)		58
59	Building Improvement Booked			30,971			(30,971)		59
60									60
61	2020-Home Office Allocation-Building Improvements		6,466			155	155		61
62	2020-Home Office Allocation-Land Improvements		649			41	41		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,391,977	\$ 71,649		\$ 68,709	\$ (2,940)	\$ 844,209	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	\$57,132	\$6,288	\$5,741	\$(547)	5-10 yrs.	\$38,110	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	205,615					205,615	73
74	Home Office Allocation			3,251	3,251			74
75	TOTALS	\$262,747	\$6,288	\$8,992	\$2,704		\$243,725	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,690,724	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$77,937	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$77,701	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(236)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,087,934	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?
16. Rental Amount for movable equipment: \$13,656 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)
- ☒ YES☐ NO

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.

Aspen Rehab Health Care
0056572
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	\$	4,195
Dishwasher		375
Copier		7,850
Home Office Allocation		<u>1,236</u>
		<u><u>13,656</u></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.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)	hrs				16		16	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 16		\$ 16	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	\$ (8,223)	\$ (8,223)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27,059)	378,838	378,838	3
4	Supply Inventory (priced at Cost)	7,870	7,870	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,531	15,531	6
7	Other Prepaid Expenses	2,696	8,601	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 396,712	\$ 402,617	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		36,000	13
14	Buildings, at Historical Cost		980,966	14
15	Leasehold Improvements, at Historical Cost	20,403	411,011	15
16	Equipment, at Historical Cost		262,747	16
17	Accumulated Depreciation (book methods)	(1,603)	(1,087,934)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		15,640	20
21	Restricted Funds	12,257	50,553	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	579,344	755,780	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 610,401	\$ 1,424,763	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,007,113	\$ 1,827,380	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 271,259	\$ 271,259	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,778	43,778	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,580	53,580	32
33	Accrued Interest Payable		5,993	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	57,865	57,865	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 426,482	\$ 432,475	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		499,721	40
41	Bonds Payable			41
42	Deferred Compensation	40,935	40,935	42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans			43
44	Loan Payable-MCAD Adv. & SBA PPP	229,400	229,400	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 270,335	\$ 770,056	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 696,817	\$ 1,202,531	46
47	TOTAL EQUITY (page 18, line 24)	\$ 310,296	\$ 624,849	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,007,113	\$ 1,827,380	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (14,736)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(101,409)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (116,145)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	426,441	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)	\$ 426,441	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)	\$ 310,296	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aspen Rehab Health Care

0056572

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	\$ 2,580,670	1
2	Discounts and Allowances for all Levels	(710,741)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,869,929	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	9	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 9	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	906	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 906	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	128	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	646,045	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 646,173	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,517,040	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	427,421	31
32	Health Care	863,111	32
33	General Administration	380,595	33
	B. Capital Expense		
34	Ownership	283,922	34
	C. Ancillary Expense		
35	Special Cost Centers	23,521	35
36	Provider Participation Fee	112,029	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,090,599	40
41	Income before Income Taxes (line 30 minus line 40)**	426,441	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 426,441	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,800,575	44
45	Private Pay - Net Inpatient Revenue	69,354	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,869,929	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	2,210	2,238	\$ 65,631	\$ 29.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,633	1,808	58,080	32.12	3
4	Licensed Practical Nurses	7,492	7,628	189,430	24.83	4
5	CNAs & Orderlies	20,087	20,843	324,162	15.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,377	1,421	17,425	12.26	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	36,302	17.45	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,497	13.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,131	7,282	73,080	10.04	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	36,081	17.35	17
18	Housekeepers	6,973	7,190	76,244	10.60	18
19	Laundry	1,975	1,985	19,049	9.60	19
20	Administrator	2,044	2,080	74,004	35.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,997	2,096	33,062	15.77	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					31
32	Other Health Care(specify)					32
33	Other(specify) CPC	1,350	1,392	50,375	36.19	33
34	TOTAL (lines 1 - 33)	60,509	62,203	\$ 1,081,422 *	\$ 17.39	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		\$		35
36	Medical Director	Monthly	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,868	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	10	623	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	10	\$ 22,491		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	25	670	L10,C3	51
52	Certified Nurse Assistants/Aides	3,755	61,515	L10,C3	52
53	TOTAL (lines 50 - 52)	3,780	\$ 62,185		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Elizabeth Webster	Administrator	0	\$ 74,004
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 74,004
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 93,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 93,600
C. Professional Services			
Vendor/Payee	Type		Amount
Mediacom	Computer Services		\$ 1,687
Sector Bank	Title Lien Searches-July 2020		253
Ability Network	Computer Services		3,776
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 5,716
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 15,255
Unemployment Compensation Insurance			12,125
FICA Taxes			75,353
Employee Health Insurance			4,583
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			577
Home Office Allocation			5,796
Employee Retirement			63
Administrator Benefits			14,796
TOTAL (agree to Schedule V, line 22, col.8)			\$ 128,548
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,990
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 5)			
Patient Background Checks 23			675
Miscellaneous Licenses & Permits			822
Home Office Allocation			1,743
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 5,230
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			11
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 11

*** Attach copy of IMRF notifications**

****See instructions.**

Aspen Rehab Health Care

0056572

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)		5,716

Home Office Allocation

Baker Tilly Virchow Krause LLP	Legal	197
Duane Morris	Legal	275
Lexis Nexis	Legal	5
Livingston, Barger, Brant, Schroeder	Legal	10
Miller, Hall, Triggs	Legal	34
Miscellaneous	Legal	13
SB2	Legal	102
SmithAmundsen LLC	Legal	629
Sorling Northrup	Legal	179
Sector Bank	Legal	2,084
CliftonLarsonAllen	Accounting	782
Ginoli & Co.	Accounting	1,187
Ability Network	Computer Services	2,007
Allscripts	Computer Services	317
AOD Matrix Care	Computer Services	3,526
AT&T	Computer Services	4
ATS	Computer Services	192
CCH	Computer Services	11
Charter Communications	Computer Services	18
Citrix Systems	Computer Services	60
Comcast	Computer Services	21
ITSavvy	Computer Services	93
Kemper Technology	Computer Services	458
Miscellaneous	Computer Services	89
Pearl Technology	Computer Services	83
Stratus Networks	Computer Services	364
TR Professional	Computer Services	8
David Budde	Other Prof Fees	8
DJ Howard and Associates	Other Prof Fees	15
Getzler Henrich & Associates	Other Prof Fees	62
LRI Consulting Services	Other Prof Fees	60
McQuellon Consulting	Other Prof Fees	38
Miscellaneous	Other Prof Fees	74
Optimizer	Other Prof Fees	33
Registered Agent Solutions	Other Prof Fees	18
RSM McGladrey	Other Prof Fees	199
SB2	Other Prof Fees	254
Sedgwick CMS	Other Prof Fees	343
Tarver Program Consultants	Other Prof Fees	47

Total (agree to Schedule V, line 19, column 8)	<u><u>19,615</u></u>
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Aspen Rehab Health Care
0056572
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	850
Auto Repairs		2,107
Mileage-Travel		2,909
Home Office Allocation		<u>2,440</u>
		<u>8,306</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>7,862</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>112,029</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>906</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>128</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 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>No</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|--|