

		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: 0047399

Facility Name: Batavia Rehab Hlth Care Ctr

Address: 520 Fabyan Parkway Batavia 60510
Number City Zip Code

County: Kane

Telephone Number: (630) 879-5266 Fax # (630) 879-5214

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2005

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

Facility Name & ID Number Batavia Rehab Hlth Care Ctr

0047399 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 <u>N/A</u>					
	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	10,867	1,803		12,670	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,867	1,803		12,670	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.10%

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 10/1/2015

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

ACCRUAL ☒ 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 Batavia Rehab Hlth Care Ctr # 0047399 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	134,644	9,682		144,326		144,326	3,374	147,700			1
2	Food Purchase		103,032		103,032		103,032	(279)	102,753			2
3	Housekeeping	128,314	22,325		150,639		150,639	65	150,704			3
4	Laundry	25,349	4,021		29,370		29,370		29,370			4
5	Heat and Other Utilities			49,318	49,318		49,318	230	49,548			5
6	Maintenance	17,189	3,684	22,223	43,096		43,096	2,026	45,122			6
7	Other (specify):*											7
8	TOTAL General Services	305,496	142,744	71,541	519,781		519,781	5,416	525,197			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	835,566	40,969	32,129	908,664		908,664	4,821	913,485			10
10a	Therapy											10a
11	Activities	24,230	229		24,459		24,459	(38)	24,421			11
12	Social Services	31,246			31,246		31,246		31,246			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	891,042	41,198	39,329	971,569		971,569	4,783	976,352			16
	C. General Administration											
17	Administrative	66,504		107,600	174,104		174,104	(88,838)	85,266			17
18	Directors Fees											18
19	Professional Services			5,230	5,230		5,230	90,625	95,855			19
20	Dues, Fees, Subscriptions & Promotions			3,261	3,261		3,261	1,727	4,988			20
21	Clerical & General Office Expenses	31,387	367	8,749	40,503		40,503	20,890	61,393			21
22	Employee Benefits & Payroll Taxes			139,627	139,627		139,627	13,654	153,281			22
23	Inservice Training & Education							35	35			23
24	Travel and Seminar							11	11			24
25	Other Admin. Staff Transportation			384	384		384	2,417	2,801			25
26	Insurance-Prop.Liab.Malpractice			26,391	26,391		26,391	12,358	38,749			26
27	Other (specify):*											27
28	TOTAL General Administration	97,891	367	291,242	389,500		389,500	52,879	442,379			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,294,429	184,309	402,112	1,880,850		1,880,850	63,078	1,943,928			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			3,483	3,483		3,483	27,557	31,040			30
31	Amortization of Pre-Op. & Org.							5,111	5,111			31
32	Interest							20,296	20,296			32
33	Real Estate Taxes							51,018	51,018			33
34	Rent-Facility & Grounds			141,171	141,171		141,171	(141,171)				34
35	Rent-Equipment & Vehicles			4,648	4,648		4,648	6,783	11,431			35
36	Other (specify):*											36
37	TOTAL Ownership			149,302	149,302		149,302	(30,406)	118,896			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			109,188	109,188		109,188		109,188			42
43	Other (specify):*			36,161	36,161		36,161	(36,161)				43
44	TOTAL Special Cost Centers			145,349	145,349		145,349	(36,161)	109,188			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,294,429	184,309	696,763	2,175,501		2,175,501	(3,489)	2,172,012			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	(279)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,722)	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	4,441	30		9
10	Interest and Other Investment Income	(137)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(14,962)	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	(1,425)	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	(112)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (32,216)		\$	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)	28,727	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 28,727		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,489)		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	Offset Miscellaneous Office Supplies Revenue	\$ (28)	21	1
2	Offset Transportation Revenue	(38)	11	2
3	Offset Miscellaneous Nursing Supplies Revenue	(14)	10	3
4	Disallowed Special Events	(32)	43	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	(112)		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%	\$ 3,374	\$ 3,374	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%	65	65	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	230	230	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,026	2,026	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%	3,161	3,161	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	107,600	Petersen Health Care Management, Inc.	100.00%	18,762	(88,838)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	11,082	11,082	12
13	V								13
14	Total			\$ 107,600			\$ 38,700	\$ * (68,900)	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%	\$ 1,727	\$ 1,727	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	20,918	20,918	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	5,742	5,742	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%	2,417	2,417	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	368	368	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	3,415	3,415	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%	166	166	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	133	133	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,225	1,225	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			\$			\$ 36,157	\$ * 36,157	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 Operations, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	1,674	1,674	22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	72,988	72,988	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	7,912	7,912	28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	0		33
34	V	31	Amortization		Petersen Health Operations, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	5,637	5,637	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	5,558	5,558	38
39	Total			\$			\$ 93,769	\$ * 93,769	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	\$	Batavia Land, LLC	100.00%	\$		15
16	V	19	Professional Services	\$	Batavia Land, LLC	100.00%	6,555	6,555	16
17	V	21	Equipment		Batavia Land, LLC	100.00%			17
18	V	26	Insurance-Property		Batavia Land, LLC	100.00%	6,039	6,039	18
19	V	26	Insurance-Mortgage Insurance		Batavia Land, LLC	100.00%	5,951	5,951	19
20	V	30	Depreciation		Batavia Land, LLC	100.00%	19,701	19,701	20
21	V	31	Amortization		Batavia Land, LLC	100.00%	5,111	5,111	21
22	V	32	Interest	624	Batavia Land, LLC	100.00%	15,254	14,630	22
23	V	33	Real Estate Taxes		Batavia Land, LLC	100.00%	50,885	50,885	23
24	V	34	Rent-Income and Grounds	141,171	Batavia Land, LLC	100.00%		(141,171)	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			\$ 141,795			\$ 109,496	\$ * (32,299)	39

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

Facility Name & ID Number

Batavia Rehab Hlth Care Ctr

0047399

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

Batavia Rehab Hlth Care Ctr

0047399

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

Batavia Rehab Hlth Care Ctr

0047399

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 Batavia Rehab Hlth Care Ctr # 0047399 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 Batavia Rehab Hlth Care Ctr# 0047399

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 341,562	\$ 398,718	12,670	\$ 3,374	1
2	2	Food	Resident Days	75	0	0	12,670	0	2
3	3	Housekeeping	Resident Days	75	6,607	3,056	12,670	65	3
4	5	Utilities	Resident Days	75	23,320	0	12,670	230	4
5	6	Maintenance	Resident Days	75	205,132	187,746	12,670	2,026	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	12,670	0	6
7	9	Medical Director	Resident Days	75	0	0	12,670	0	7
8	10	Nursing and Medical Records	Resident Days	75	320,057	736,064	12,670	3,161	8
9	10A	Therapy	Resident Days	75	0	0	12,670	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	12,670	0	10
11	17	Administrative	Resident Days	75	1,899,565	7,673,667	12,670	18,762	11
12	19	Professional Services	Resident Days	75	1,122,028	0	12,670	11,082	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	174,863	0	12,670	1,727	13
14	21	Clerical and General Office	Resident Days	75	2,117,880	2,195,755	12,670	20,918	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	581,393	0	12,670	5,742	15
16	23	Inservice Training & Education	Resident Days	75	3,513	0	12,670	35	16
17	24	Travel and Seminar	Resident Days	75	1,094	0	12,670	11	17
18	25	Other Admin. Staff Transport.	Resident Days	75	244,700	0	12,670	2,417	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	37,297	0	12,670	368	19
20	30	Depreciation	Resident Days	75	345,756	0	12,670	3,415	20
21	31	Amortization	Resident Days	75	0	0	12,670	0	21
22	32	Interest	Resident Days	75	16,842	0	12,670	166	22
23	33	Real Estate Taxes	Resident Days	75	13,451	0	12,670	133	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	124,017	0	12,670	1,225	24
25	TOTALS				\$ 7,579,077	\$ 11,195,006		\$ 74,857	25

Facility Name & ID Number Batavia Rehab Hlth Care Ctr# 0047399

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 Operations, 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	163,986	9	\$	\$	12,670	\$	1
2	2	Food	Resident Days	163,986	9			12,670		2
3	3	Housekeeping	Resident Days	163,986	9			12,670		3
4	4	Laundry	Resident Days	163,986	9			12,670		4
5	5	Utilities	Resident Days	163,986	9			12,670		5
6	6	Maintenance	Resident Days	163,986	9			12,670		6
7	7	Mgmt. Allocation of Benefits	Resident Days	163,986	9			12,670		7
8	10	Nursing and Medical Records	Resident Days	163,986	9	21,660		12,670	1,674	8
9	15	Mgmt. Allocation of Benefits	Resident Days	163,986	9			12,670		9
10	17	Administrative	Resident Days	163,986	9			12,670		10
11	19	Professional Services	Resident Days	163,986	9	944,677		12,670	72,988	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	163,986	9			12,670		12
13	21	Clerical and General Office	Resident Days	163,986	9			12,670		13
14	22	Employee Benefits & Payroll	Resident Days	163,986	9	102,400		12,670	7,912	14
15	23	Inservice Training & Education	Resident Days	163,986	9			12,670		15
16	24	Travel and Seminar	Resident Days	163,986	9			12,670		16
17	25	Other Admin. Staff Transport.	Resident Days	163,986	9			12,670		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	163,986	9			12,670		18
19	30	Depreciation	Resident Days	163,986	9			12,670		19
20	31	Amortization	Resident Days	163,986	9			12,670		20
21	32	Interest	Resident Days	163,986	9	72,956		12,670	5,637	21
22	33	Real Estate Taxes	Resident Days	163,986	9			12,670		22
23	34	Rent-Facility and Grounds	Resident Days	163,986	9			12,670		23
24	35	Rent-Equipment & Vehicles	Resident Days	163,986	9	71,940		12,670	5,558	24
25	TOTALS					\$ 1,213,633	\$		\$ 93,769	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	Capital Finance Group		X	Mortgage	Varies	10/1/2014	\$ 1,123,000	\$ 897,056	12/31/24	Varies	\$ 15,254	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 1,123,000	\$ 897,056			\$ 15,254	9
	B. Non-Facility Related*											
10								Interest Income Offset			(761)	10
11								Home Office Allocation-PHO			166	11
12								Home Office Allocation-PHCM			5,637	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 5,042	14
15	TOTALS (line 9+line14)						\$ 1,123,000	\$ 897,056			\$ 20,296	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 5,951 Line # 26

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	52,260	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.)			\$	50,813	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,447)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	52,332	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.)		Home Office Allocation	\$	133	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	51,018	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	50,013	8	
		2016	49,477	9	
		2017	50,033	10	
		2018	50,733	11	
		2019	50,813	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Batavia Rehab Hlth Care Ctr COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047399

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. 12-14-103-006	Long-Term Care Facility	\$ 50,812.70	\$ 50,812.70
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 50,812.70	\$ 50,812.70

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,290 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: 112,446 2. Number of Years Over Which it is Being Amortized: 30 3. Current Period Amortization: 5,111 4. Dates Incurred: 2014 Refinancing

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	79,279	2005	\$ 110,500	1
2					2
3	TOTALS	79,279		\$ 110,500	3

Facility Name & ID Number Batavia Rehab Hlth Care Ctr

0047399

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	1972	\$ 104,000	\$	25	\$ 4,160	\$ 4,160	\$ 66,560	4
5				2012	22,390		25	896	896	7,616	5
6											6
7											7
8											8
	Improvement Type**										
9	Tile		2005		8,119		20	406	406	6,293	9
10	Sidewalks		2006		14,105		15	940	940	13,630	10
11	Roof		2006		18,900		10			18,900	11
12	Backflow		2007		6,490		10			6,490	12
13	Laundry Room Drywall and Replacement of Sub-Floor		2007		7,430		20	372	372	5,022	13
14	Sprinkler System		2007		3,792		15	252	252	3,402	14
15	Shower Room Repairs		2008		4,600		39	118	118	1,475	15
16	Roof Repair		2008		3,480		25	140	140	1,750	16
17	Furnace		2008		4,200		5			4,200	17
18	Water Heater-100 Gallon		2008		12,377		7			12,377	18
19	Carpeting		2008		34,139		15	2,276	2,276	28,450	19
20	Floor Tiling-Store Room & Lunch Room		2009		7,435		15	496	496	5,704	20
21	Sprinkler System Repair		2009		16,775		15	1,118	1,118	12,857	21
22	Floor Tiling-Kitchen		2009		20,746		15	1,383	1,383	15,905	22
23	Sprinkler System Repair		2010		4,048		7			4,048	23
24	Nurse Call Station Replacement-East Side of Building		2012		6,704		15	753	753	6,704	24
25	Roof Replacement		2013		41,915		25	1,764	1,764	13,230	25
26	Subflooring Replacement-Men & Women Bathroom & Showers		2013		11,767		15	1,029	1,029	11,767	26
27	Fire Sprinkler System Replacement		2013		5,487		7	391	391	5,487	27
28	Nurse Call Station Replacement-West Side of Building		2014		6,975		7	996	996	6,474	28
29	Subflooring Replacement-Men & Women Bathroom & Showers		2014		13,024		15	868	868	5,642	29
30	Air Conditioner-Roof Top Unit East Wing of Building		2015		12,370		15	826	826	4,543	30
31	Air Conditioner-Roof Top Unit West Wing of Building		2016		11,198		15	746	746	3,357	31
32	Dry Pipe Valve Repair		2016		3,985		7	570	570	2,565	32
33	Tile Replacement in Hallways		2016		3,150		10	316	316	1,422	33
34	Patio Door		2017		3,479		7	497	497	1,740	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 Batavia Rehab Hlth Care Ctr

0047399

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Boiler Repair	2018	\$ 4,251	\$	7	\$ 608	\$ 608	\$ 1,520	37
38 Drywall Repair	2019	3,591		7	514	514	771	38
39 Air Condtioner	2019	4,200		15	280	280	420	39
40 Roof Repair	2019	6,808		7	972	972	1,458	40
41 Sprinkler Repair	2020	5,720		7	409	409	409	41
42 Roof Repair	2020	2,500		7	179	179	179	42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57 Land Improvements Booked			940			(940)		57
58 Building Booked			896			(896)		58
59 Building Improvement Booked			18,381			(18,381)		59
60								60
61 2020-Home Office Allocation-Building Improvements		6,406			154	154		61
62 2020-Home Office Allocation-Land Improvements		643			41	41		62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 447,199	\$ 20,217		\$ 24,470	\$ 4,253	\$ 282,367	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	\$30,527	\$2,967	\$3,350	\$383	5-10 yrs.	\$20,739	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	52,559					52,559	73
74				3,220	3,220			74
75	TOTALS	\$83,086	\$2,967	\$6,570	\$3,603		\$73,298	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)	\$640,785	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$23,184	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$31,040	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$7,856	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$355,665	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: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 11,431 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.

Batavia Rehab Hlth Care Ctr
0047399
Period Beginning 1/1/2020
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Schedule 14A

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

Medical Equipment	\$	1,067
Dishwasher		701
Copier		2,880
Home Office Allocation		6,783
		<u>11,431</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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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		hrs							4
5	Physician Care	N/A	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			\$		\$	\$		\$	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	\$ 143,461	\$ 143,461	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 192,805)	1,810,515	1,810,515	3
4	Supply Inventory (priced at Cost)	8,400	8,400	4
5	Short-Term Investments			5
6	Prepaid Insurance	12,831	20,560	6
7	Other Prepaid Expenses		14,840	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,975,207	\$ 1,997,776	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		110,500	13
14	Buildings, at Historical Cost		132,796	14
15	Leasehold Improvements, at Historical Cost	26,226	314,403	15
16	Equipment, at Historical Cost	5,171	83,086	16
17	Accumulated Depreciation (book methods)	(9,035)	(355,665)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		112,446	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(31,945)	20
21	Restricted Funds		250,457	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	38,090	55,653	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 60,452	\$ 671,731	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,035,659	\$ 2,669,507	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 266,657	\$ 269,443	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,985	70,985	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		52,332	32
33	Accrued Interest Payable		2,878	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	72,797	72,797	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 410,439	\$ 468,435	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		897,056	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	130,000	130,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 130,000	\$ 1,027,056	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 540,439	\$ 1,495,491	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,495,220	\$ 1,174,016	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,035,659	\$ 2,669,507	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 495,215	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	450,952	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 946,167	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	549,053	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)	\$ 549,053	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)	\$ 1,495,220	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Batavia Rehab Hlth Care Ctr

0047399

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	\$ 2,744,737	1
2	Discounts and Allowances for all Levels	(593,231)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,151,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	279	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)	\$ 279	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	137	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 137	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	38	28
28a	<u>Miscellaneous and Illinois Cares Revenue</u>	572,594	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 572,632	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,724,554	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	519,781	31
32	Health Care	971,569	32
33	General Administration	389,500	33
	B. Capital Expense		
34	Ownership	149,302	34
	C. Ancillary Expense		
35	Special Cost Centers	36,161	35
36	Provider Participation Fee	109,188	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,175,501	40
41	Income before Income Taxes (line 30 minus line 40)**	549,053	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 549,053	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,662,767	44
45	Private Pay - Net Inpatient Revenue	396,215	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	92,524	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,151,506	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	\$ 72,010	\$ 34.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	480	5,087	169,396	33.30	3
4	Licensed Practical Nurses	8,658	8,826	254,950	28.89	4
5	CNAs & Orderlies	16,743	17,788	274,340	15.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,650	1,737	24,230	13.95	9
10	Activity Assistants					10
11	Social Service Workers	1,970	2,034	31,246	15.36	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	33,022	15.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,705	8,786	101,622	11.57	15
16	Dishwashers					16
17	Maintenance Workers	1,137	1,140	17,189	15.08	17
18	Housekeepers	9,155	9,534	128,314	13.46	18
19	Laundry	1,592	1,708	25,349	14.84	19
20	Administrator	2,080	2,080	66,504	31.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,923	2,023	31,387	15.52	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	1,756	1,854	64,870	34.99	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	60,009	66,757	\$ 1,294,429 *	\$ 19.39	34

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	7,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,804	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 11,004		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	280	\$ 9,513	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,107	18,812	L10,C3	52
53	TOTAL (lines 50 - 52)	1,387	\$ 28,325		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Batavia Rehab Hlth Care Ctr

#

0047399

Report Period Beginning:

1/1/2020

Page 21

Ending:

12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Joy Chanthavong		Administrator	0	\$ 66,504	Workers' Compensation Insurance		\$ 15,255	IDPH License Fee		\$ 1,990	
					Unemployment Compensation Insurance		10,966	Advertising: Employee Recruitment			
					FICA Taxes		92,233	Health Care Worker Background Check			
					Employee Health Insurance		3,134	(Indicate # of checks performed 7)		10	
					Employee Meals			Patient Background Checks		90	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		1,171	
					Home Office Allocation		13,654	Home Office Allocation		1,727	
					Employee Retirement		4,143				
					Administrator Benefits		13,896				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 66,504							
B. Administrative - Other											
Description				Amount							
Management Fees-See Page 6, Eliminated on P 3, C 7				\$ 107,600					Less: Public Relations Expense		()
									Non-allowable advertising		()
									Yellow page advertising		()
					TOTAL (agree to Schedule V, line 22, col.8)			\$ 153,281			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 107,600	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
C. Professional Services					Description		Line #	Amount	Description		Amount
Vendor/Payee	Type			Amount					Out-of-State Travel		\$
Comcast	Computer Services			\$ 1,300							
Fifth Third Bank	Legal Filing Fees-1/10/20			88							
Ability Network	Computer Services			3,842					In-State Travel		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 5,230	TOTAL			\$	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.

Batavia Rehab Hlth Care Ctr
0047399
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)		5,230
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	291
Duane Morris	Legal	21,050
Lexis Nexis	Legal	5
Livingston, Barger, Brant, Schroeder	Legal	8,805
Miller, Hall, Triggs	Legal	34
Miscellaneous	Legal	13
SB2	Legal	583
SmithAmundsen LLC	Legal	1,388
Sorling Northrup	Legal	333
Capital Finance Group	Legal	2,907
Illinois Secretary of Sate	Legal	93
McGuire Woods	Legal	3,863
CliftonLarsonAllen	Accounting	775
Ginoli & Co.	Accounting	9,087
Ability Network	Computer Services	1,989
Allscripts	Computer Services	314
AOD Matrix Care	Computer Services	3,493
AT&T	Computer Services	4
ATS	Computer Services	190
CCH	Computer Services	11
Charter Communications	Computer Services	18
Citrix Systems	Computer Services	59
Comcast	Computer Services	20
ITSavvy	Computer Services	92
Kemper Technology	Computer Services	454
Miscellaneous	Computer Services	88
Pearl Technology	Computer Services	82
Stratus Networks	Computer Services	361
TR Professional	Computer Services	8
Creative Health Capital	Other Prof Fees	3,125
Mohr and Kerr	Other Prof Fees	5,692
Planning and Zoning Resource Company	Other Prof Fees	800
David Budde	Other Prof Fees	8
DJ Howard and Associates	Other Prof Fees	749
Getzler Henrich & Associates	Other Prof Fees	805
LRI Consulting Services	Other Prof Fees	814
McQuellon Consulting	Other Prof Fees	502
Miscellaneous	Other Prof Fees	70
Optimizer	Other Prof Fees	32
Registered Agent Solutions	Other Prof Fees	18
RSM McGladrey	Other Prof Fees	197
SB2	Other Prof Fees	252
Sedgwick CMS	Other Prof Fees	21,104
Tarver Program Consultants	Other Prof Fees	47
Total (agree to Schedule V, line 19, column 8)		<u><u>95,855</u></u>

Batavia Rehab Hlth Care Ctr
0047399
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	384
Auto Repairs		-
Mileage-Travel		-
Home Office Allocation		<u>2,417</u>
		<u><u>2,801</u></u>

XX. GENERAL INFORMATION:

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

No

(2) Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

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

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

7 yrs.

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

\$ 8,333

Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 109,188

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 279

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

Yes

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ 38

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Ginoli and Company

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

No

Attach invoices and a summary of services for all architect and appraisal fees.

HFS 3745 (N-4-99)

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