

		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>0035766</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Beardstown Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/19</u> to <u>9/30/20</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>300 East Eighth St</u> <u>Beardstown</u> <u>62618</u>																									
Number City Zip Code																									
County: <u>Cass</u>																									
Telephone Number: <u>(217)323-5554</u> Fax # <u>(217)323-3331</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Lisa Winnette</u></td></tr><tr><td>(Title) <u>Director of Operations</u></td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>Larry Templin</u> and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Templin Healthcare Accounting Services, LLP</u> & Address) <u>P.O. Box 326, Plainfield, IL 60544-0326</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Lisa Winnette</u>	(Title) <u>Director of Operations</u>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name <u>Larry Templin</u> and Title) <u>Partner</u>	(Firm Name <u>Templin Healthcare Accounting Services, LLP</u> & Address) <u>P.O. Box 326, Plainfield, IL 60544-0326</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()												
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	(Telephone) <u>(630) 361-2868</u> Fax # ()																								
Date of Initial License for Current Owners: <u>12/07/89</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 (c) 3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501 (c) 3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Beardstown Terrace

0035766 Report Period Beginning: 10/1/19 Ending: 9/30/20

III. STATISTICAL DATA

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

	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		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,460	31		5,491	13
14	TOTALS	5,460	31		5,491	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.77%

D. How many bed reserve days during this year were paid by the Department? 66 (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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 12/07/89

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 03/27/90 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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 9/30/2020 Fiscal Year: 9/30/2020
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Beardstown Terrace** # **0035766** Report Period Beginning: **10/1/19** Ending: **9/30/20**
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	37,982	3,824	1,398	43,204		43,204		43,204			1
2	Food Purchase		55,357		55,357		55,357		55,357			2
3	Housekeeping	21,931	3,771		25,702		25,702		25,702			3
4	Laundry		5,065		5,065		5,065		5,065			4
5	Heat and Other Utilities			13,997	13,997		13,997	72	14,069			5
6	Maintenance	10,764	9,290	8,679	28,733		28,733	10	28,743			6
7	Other (specify):*											7
8	TOTAL General Services	70,677	77,307	24,074	172,058		172,058	82	172,140			8
	B. Health Care and Programs											
9	Medical Director			7,700	7,700		7,700		7,700			9
10	Nursing and Medical Records	210,980	19,216	8,648	238,844		238,844	8	238,852			10
10a	Therapy											10a
11	Activities		1,123	928	2,051		2,051		2,051			11
12	Social Services											12
13	CNA Training	6,839			6,839		6,839		6,839			13
14	Program Transportation			2,952	2,952		2,952		2,952			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	217,819	20,339	20,228	258,386		258,386	8	258,394			16
	C. General Administration											
17	Administrative	17,786			17,786		17,786		17,786			17
18	Directors Fees							452	452			18
19	Professional Services			64,220	64,220		64,220	452	64,672			19
20	Dues, Fees, Subscriptions & Promotions			7,016	7,016		7,016	(233)	6,783			20
21	Clerical & General Office Expenses	25,648	3,922	6,865	36,435		36,435	7	36,442			21
22	Employee Benefits & Payroll Taxes			63,771	63,771		63,771		63,771			22
23	Inservice Training & Education			3,052	3,052		3,052		3,052			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			971	971		971		971			25
26	Insurance-Prop.Liab.Malpractice			5,157	5,157		5,157	1,242	6,399			26
27	Other (specify):*											27
28	TOTAL General Administration	43,434	3,922	151,052	198,408		198,408	1,920	200,328			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	331,930	101,568	195,354	628,852		628,852	2,010	630,862			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			20,845	20,845		20,845	80	20,925			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							12	12			35
36	Other (specify):*											36
37	TOTAL Ownership			20,845	20,845		20,845	92	20,937			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			43,819	43,819		43,819		43,819			42
43	Other (specify):* Disallowed Costs			3	3		3	(3)				43
44	TOTAL Special Cost Centers			43,822	43,822		43,822	(3)	43,819			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	331,930	101,568	260,021	693,519		693,519	2,099	695,618			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
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	80	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(267)	20		17
18	Fines and Penalties				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	(3)	43		24
25	Fund Raising, Advertising and Promotional				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (190)		\$	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)	2,289		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,289		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 2,099		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		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
None	N/A	Community Living Options, Inc. (CLO)		See Page 6 Supplemental		
		Unlimited Development, Inc. (CLO is sole member)				
		See Page 6 Supplemental for specific homes				

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	5	Utilities	\$	Community Living Options, Inc.	100.00%	\$ 72	\$	72 1
2	V	6	Maintenance		Community Living Options, Inc.	100.00%	10	10	2
3	V	10	Nursing Supplies-PPE		Community Living Options, Inc.	100.00%	8	8	3
4	V	18	Director Fees		Community Living Options, Inc.	100.00%	452	452	4
5	V	19	Professional Fees		Community Living Options, Inc.	100.00%	452	452	5
6	V	20	Dues, Licenses and Subs		Community Living Options, Inc.	100.00%	34	34	6
7	V	21	Clerical & General Office		Community Living Options, Inc.	100.00%	7	7	7
8	V	26	Property/ Liability Insurance		Community Living Options, Inc.	100.00%	1,242	1,242	8
9	V	35	Equipment Rental		Community Living Options, Inc.	100.00%	12	12	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 2,289	\$ *	2,289 14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Beardstown Terrace

0035766

Report Period Beginning:

10/1/19

Ending:

9/30/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Community Living Options, Inc.	100%			Allen Court	Clinton	CILA	1
2	Community Living Options, Inc.	100%	Beardstown Terrace	Beardstown				2
3	Community Living Options, Inc.	100%	Bellefontaine Place	Waterloo				3
4	Community Living Options, Inc.	100%	Braun's Terrace	Greenville				4
5	Community Living Options, Inc.	100%	Carthage Terrace	Carthage				5
6	Community Living Options, Inc.	100%	Curtiss Court	Springfield				6
7	Community Living Options, Inc.	100%	Davies Square	Pekin				7
8	Community Living Options, Inc.	100%	Douglas Terrace	Jacksonville				8
9	Community Living Options, Inc.	100%	Edwardsville Terrace	Edwardsville				9
10	Community Living Options, Inc.	100%	Effingham Terrace	Effingham				10
11	Community Living Options, Inc.	100%			Eisenhower Terrace	Jacksonville	CILA	11
12	Community Living Options, Inc.	100%	Freeburg Terrace	Freeburg				12
13	Community Living Options, Inc.	100%	Froehlich House	Galesburg				13
14	Community Living Options, Inc.	100%	Gaines Mill Place	Springfield				14
15	Community Living Options, Inc.	100%	Glenwood Terrace	Springfield				15
16	Community Living Options, Inc.	100%			Hawthorne Terrace	Galesburg	CILA	16
17	Community Living Options, Inc.	100%	Highview Terrace	Paris				17
18	Community Living Options, Inc.	100%	Jacksonville Group Homes:					18
19	Community Living Options, Inc.	100%	Anna Terrace	Jacksonville				19
20	Community Living Options, Inc.	100%	Campbell Court	Jacksonville				20
21	Community Living Options, Inc.	100%	LaFayette Terrace	Jacksonville				21
22	Community Living Options, Inc.	100%	Kepley House	Pittsfield				22
23	Community Living Options, Inc.	100%	Lawrence Place	Lincoln				23
24	Community Living Options, Inc.	100%	Lincoln Terrace	Lincoln				24
25	Community Living Options, Inc.	100%	Maple Terrace	Quincy				25
26	Community Living Options, Inc.	100%	Plonka Terrace	Galesburg				26
27	Community Living Options, Inc.	100%	Quincy Terrace	Quincy				27
28	Community Living Options, Inc.	100%	Schultz House	Danville				28
29	Community Living Options, Inc.	100%	Stevens House	Galesburg				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Beardstown Terrace

0035766

Report Period Beginning:

10/1/19

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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	Community Living Options, Inc.	100%	Tanner Place	Paris				1
2	Community Living Options, Inc.	100%	Taylor House	Springfield				2
3	Community Living Options, Inc.	100%	Thelma Terrace	Wood River				3
4	Community Living Options, Inc.	100%	Trulson House	Galesburg				4
5	Community Living Options, Inc.	100%	Vahle Terrace	Jerseyville				5
6	Community Living Options, Inc.	100%	Walsh Terrace	Galesburg				6
7	Community Living Options, Inc.	100%	Wetherell Place	Effingham				7
8	Community Living Options, Inc.	100%	Woodriver Group Homes:					8
9	Community Living Options, Inc.	100%	Aberdeen Terrace	Alton				9
10	Community Living Options, Inc.	100%	Linton Terrace	Wood River				10
11	Community Living Options, Inc.	100%	Madison Terrace	Wood River				11
12	Community Living Options, Inc.	100%	Pershing Terrace	Wood River				12
13	Community Living Options, Inc.	100%			Audrey Court-CILA	Clinton	CILA	13
14	Unlimited Development, Inc. (UDI)	100%	Parkway Manor	Marion				14
15	Unlimited Development, Inc. (UDI)	100%			Parkway Estates	Marion	Retirement living ce	15
16	Unlimited Development, Inc. (UDI)	100%	Maryville Manor	Maryville				16
17	Unlimited Development, Inc. (UDI)	100%	Shelbyville Manor	Shelbyville				17
18	Unlimited Development, Inc. (UDI)	100%	Leroy Manor	Leroy				18
19	Unlimited Development, Inc. (UDI)	100%	Manor Court of Carbondale	Carbondale				19
20	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Car	Carbondale	Retirement living ce	20
21	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				21
22	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	22
23	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gal	Galesburg	Assisted Living Faci	23
24	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				24
25	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	25
26	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				26
27	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				27
28	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	28
29	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	Unlimited Development, Inc. (UDI)	100%	River Hills Manor	Keokuk, IA				1
2	Unlimited Development, Inc. (UDI)	100%			River Hills Estates	Keokuk, IA	Retirement living ce	2
3	Unlimited Development, Inc. (UDI)	100%			River Hills Inn	Keokuk, IA	Assisted living facili	3
4	Unlimited Development, Inc. (UDI)	100%			Centralia East McCorn	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	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

SEE ACCOUNTANTS' PREPARATION REPORT

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	See Attached Schedule 7A								\$ 452	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 452		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 9/30/20

(309) 343-2857

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							\$					\$	1
2	N/A												2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$				\$		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$		15

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

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

** 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.		\$	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.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	N/A	8	
		2016	N/A	9	
		2017	N/A	10	
		2018	N/A	11	
		2019	N/A	12	
The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.				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.

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME Beardstown Terrace COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0035766

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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.

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.)

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: 4,200

B. General Construction Type: Exterior BrickFrame 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).

None

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:

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

3. Current Period Amortization:

4. Dates Incurred:

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	28,750	1990	\$ 22,692	1
2					2
3	TOTALS	28,750		\$ 22,692	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		1990	1989	\$ 412,308	\$ 5,903	30	\$ 5,983	\$ 80	\$ 412,308
5										
6										
7										
8										
	Improvement Type**									
9	Garage, Parking Lot, Sidewalks, and Landscaping			1989	30,000		15			30,000
10	Air Conditioner Compressor and Carpet			2001	15,164		5-15yrs			15,164
11	Furnaces			2005	6,448	322	15	322		6,448
12	Kitchen Cabinets			2006	4,646	310	15	310		4,517
13	Roof Replacement			2007	9,061		10			9,061
14	Parking Lot Repairs			2008	8,830		8			8,830
15	Air Conditioner Unit			2014	5,925		5			5,925
16	High Efficiency Gas Furnace			2015	3,749	252	15	252		1,418
17	Men's Bathroom Remodel - New Tile/Shower/Toilet/Grab bars			2016	7,230	603	12	603		2,561
18	4 Ton AC Unit			2016	4,833	967	5	967		4,108
19	Painting - Facility Walls/Ceilings/Door Jambs			2018	18,000	3,600	5	3,600		10,200
20	Back Corner Bathroom Remodel - Tile/Shower/Vanity/Fixtures			2018	15,250	1,270	12	1,270		2,859
21	Replace Light Fixtures - Entire Building			2018	8,612	861	10	861		1,650
22	Convert Facility Sprinkler System to a Wet System			2018	18,927	1,892	10	1,892		3,785
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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
SEE ACCOUNTANTS' PREPARATION REPORT

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

SEE ACCOUNTANTS' PREPARATION REPORT

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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	\$ 111,121	\$ 4,722	\$ 4,722	\$	3-20 yrs	\$ 60,397	71
72	Current Year Purchases	3,666	143	143		15 yrs	143	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 114,787	\$ 4,865	\$ 4,865	\$		\$ 60,540	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	Patient Care	1989 Ford Van	1993	\$ 7,313	\$	\$	\$	4	\$ 7,313	76
77	Patient Care	2012 Ford E350	2012	51,645				4	51,645	77
78										78
79										79
80	TOTALS			\$ 58,958	\$	\$	\$		\$ 58,958	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)	\$ 765,420	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,845	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,925	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 80	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 638,332	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' PREPARATION REPORT

** 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- Facility Owned
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
- N/A
- N/A
9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms: N/A
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 12
- Description: Allocated from home office
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

☒

☐

☐

138

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)		6,839		6,839
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,839	\$	\$ 6,839
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,839			

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(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.

SEE ACCOUNTANTS' PREPARATION REPORT

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		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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,266)	87,409	87,409	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	100	100	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	2,314,108	2,314,108	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,401,617	\$ 2,401,617	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	22,692	13
14	Buildings, at Historical Cost	569,611	568,983	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	173,745	173,745	16
17	Accumulated Depreciation (book methods)	(638,956)	(638,332)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 114,400	\$ 127,088	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,516,017	\$ 2,528,705	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 297	\$ 297	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,240	8,240	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,537	\$ 8,537	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,537	\$ 8,537	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,507,480	\$ 2,520,168	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,516,017	\$ 2,528,705	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,378,218	1
2	Restatements (describe):		2
3	Prior Period Adjustments	(996)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,377,222	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	130,258	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)	\$ 130,258	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)	\$ 2,507,480	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Beardstown Terrace

0035766

Report Period Beginning: 10/1/19

Ending:

9/30/20

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	\$ 790,303	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 790,303	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	25,985	10
11	CNA Training Reimbursements	6,839	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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)	\$ 32,824	23
	D. Non-Operating Revenue		
24	Contributions	650	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 650	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 823,777	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	172,058	31
32	Health Care	258,386	32
33	General Administration	198,408	33
	B. Capital Expense		
34	Ownership	20,845	34
	C. Ancillary Expense		
35	Special Cost Centers	3	35
36	Provider Participation Fee	43,819	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 693,519	40
41	Income before Income Taxes (line 30 minus line 40)**	130,258	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 130,258	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 712,141	44
45	Private Pay - Net Inpatient Revenue	78,162	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)	\$ 790,303	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	70	70	1,499	21.41	4
5	CNAs & Orderlies	10,883	11,514	178,931	15.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,658	2,842	37,982	13.36	15
16	Dishwashers					16
17	Maintenance Workers	677	821	10,764	13.11	17
18	Housekeepers	2,000	2,080	21,931	10.54	18
19	Laundry					19
20	Administrator	600	600	16,420	27.37	20
21	Assistant Administrator	100	100	1,366	13.66	21
22	Other Administrative	0	0			22
23	Office Manager					23
24	Clerical	1,973	2,113	25,648	12.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,479	3,587	37,389	10.42	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)					33
34	TOTAL (lines 1 - 33)	22,440	23,727	\$ 331,930 *	\$ 13.99	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	Monthly	\$ 1,398	L1, C3	35
36	Medical Director	Monthly	7,700	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	(414)	L10, C3	38
39	Pharmacist Consultant	Monthly	1,056	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) Dental	Monthly	6,231	L10, C3	46
47	Psychological Consultant	Monthly	1,775	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 17,746		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Courtney Anderson	Administrator	None	\$ 4,424
Courtney Hanlin	Administrator	None	11,996
Alexandrea Hines	Asst Admin	None	1,366
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 17,786
B. Administrative - Other			
Description			Amount
N/A			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
LTC Support Services, LLC	Support Services		\$ 26,844
RFMS, Inc.	Administrative Services		34,062
RSM US LLP	Accounting Services		2,213
Templin Healthcare Accounting	Accounting Services		1,101
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 64,220
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 5,325
Unemployment Compensation Insurance			4,802
FICA Taxes			24,777
Employee Health Insurance			25,110
Employee Meals			1,581
Illinois Municipal Retirement Fund (IMRF)* 401k			1,146
Other Employee Benefits			1,030
TOTAL (agree to Schedule V, line 22, col.8)			\$ 63,771
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			\$
Advertising: Employee Recruitment			5,594
Health Care Worker Background Check (Indicate # of checks performed 15)			150
Patient Background Checks			
Subscriptions			249
IHCA Dues			973
Licenses & Fees			50
Indirect costs			34
Less: Public Relations Expense			(267)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 6,783
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			0
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name & ID Number <u>Beardstown Terrace</u>	STATE OF ILLINOIS # <u>0035766</u>	Report Period Beginning: <u>10/1/19</u>	Ending: <u>9/30/20</u>
XX. GENERAL INFORMATION:			
(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u>	(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>		
(2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. <u>973 IHCA</u>	(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.		
(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u>	(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>1,581</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ <u>N/A</u>		
(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? _____	(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation.		
(5) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? <u>15 yrs</u>	b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>		
(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>885</u> Line <u>10</u>	c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Line 14</u>		
(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.	d. Have vehicle usage logs been maintained? <u>Yes</u>		
(8) Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease. <u>N/A</u>	e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u>		
(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>		
(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.	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. \$ <u>N/A</u>		
(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>43,819</u> This amount is to be recorded on line 42 of Schedule V.	(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u> Firm Name: <u>RSM US LLP</u>		
(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.	(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u>		
(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees.			

SEE ACCOUNTANTS' PREPARATION REPORT