

		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>0055822</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Charleston Rehab Health CC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>716 Eighteenth St</u> <u>Charleston</u> <u>61920</u>																									
Number City Zip Code																									
County: <u>Coles</u>																									
Telephone Number: <u>(217) 345-7054</u> Fax # <u>(217) 348-1264</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Mark Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Mark Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Mark Petersen</u>																								
	(Title) <u>Chief Executive Officer</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>11/28/2006</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 _____</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 _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ 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>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u>																									
Email Address: _____																									

Facility Name & ID Number Charleston Rehab Health CC

0055822 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	<u>93</u>	Skilled (SNF)	<u>93</u>	<u>33,945</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>46</u>	Intermediate (ICF)	<u>46</u>	<u>16,790</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>139</u>	TOTALS	<u>139</u>	<u>50,735</u>	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		<u>2,550</u>	<u>5,617</u>	<u>8,167</u>	8
9	SNF/PED					9
10	ICF	<u>15,283</u>			<u>15,283</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,283</u>	<u>2,550</u>	<u>5,617</u>	<u>23,450</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.22%

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 11/28/2006

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/28/2006 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 93 and days of care provided 5,617

Medicare Intermediary National Government Services

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 **Charleston Rehab Health CC** # **0055822** 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	189,614	24,514		214,128		214,128	6,244	220,372			1
2	Food Purchase		166,694		166,694		166,694	(3,346)	163,348			2
3	Housekeeping	79,545	24,124		103,669		103,669	121	103,790			3
4	Laundry	46,000	5,402		51,402		51,402		51,402			4
5	Heat and Other Utilities			109,096	109,096		109,096	426	109,522			5
6	Maintenance	43,491	17,826	25,207	86,524		86,524	3,750	90,274			6
7	Other (specify):*											7
8	TOTAL General Services	358,650	238,560	134,303	731,513		731,513	7,195	738,708			8
	B. Health Care and Programs											
9	Medical Director			18,400	18,400		18,400		18,400			9
10	Nursing and Medical Records	1,482,215	140,196	68,209	1,690,620		1,690,620	4,899	1,695,519			10
10a	Therapy			565,502	565,502		565,502		565,502			10a
11	Activities	56,079	179	4,906	61,164		61,164	(2,535)	58,629			11
12	Social Services	25,395	95		25,490		25,490		25,490			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,563,689	140,470	657,017	2,361,176		2,361,176	2,364	2,363,540			16
	C. General Administration											
17	Administrative	72,232		286,100	358,332		358,332	(251,375)	106,957			17
18	Directors Fees											18
19	Professional Services			14,020	14,020		14,020	20,511	34,531			19
20	Dues, Fees, Subscriptions & Promotions			3,093	3,093		3,093	3,197	6,290			20
21	Clerical & General Office Expenses	34,152	3,252	24,877	62,281		62,281	38,563	100,844			21
22	Employee Benefits & Payroll Taxes			230,450	230,450		230,450	10,628	241,078			22
23	Inservice Training & Education							64	64			23
24	Travel and Seminar							20	20			24
25	Other Admin. Staff Transportation			6,091	6,091		6,091	4,473	10,564			25
26	Insurance-Prop.Liab.Malpractice			65,776	65,776		65,776	2,663	68,439			26
27	Other (specify):*											27
28	TOTAL General Administration	106,384	3,252	630,407	740,043		740,043	(171,256)	568,787			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,028,723	382,282	1,421,727	3,832,732		3,832,732	(161,697)	3,671,035			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			8,633	8,633		8,633	109,385	118,018			30
31	Amortization of Pre-Op. & Org.							36,588	36,588			31
32	Interest			615	615		615	162,298	162,913			32
33	Real Estate Taxes							51,182	51,182			33
34	Rent-Facility & Grounds			280,882	280,882		280,882	(280,882)				34
35	Rent-Equipment & Vehicles			71,282	71,282		71,282	2,267	73,549			35
36	Other (specify):*											36
37	TOTAL Ownership			361,412	361,412		361,412	80,838	442,250			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		159,441		159,441		159,441		159,441			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,547	180,547		180,547		180,547			42
43	Other (specify):*		19	188,307	188,326		188,326	(188,326)				43
44	TOTAL Special Cost Centers		159,460	368,854	528,314		528,314	(188,326)	339,988			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,028,723	541,742	2,151,993	4,722,458		4,722,458	(269,185)	4,453,273			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,346)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,872)	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	(16,851)	30		9
10	Interest and Other Investment Income	(146)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(308)	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	(34,889)	43		18
19	Entertainment				19
20	Contributions	(1,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,000)	43		24
25	Fund Raising, Advertising and Promotional	(548)	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	(44,349)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (212,309)		\$	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	2	
		Amount	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)	(56,876)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (56,876)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (269,185)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (32,960)	43	1
2	X-Rays-Part A	(9,074)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(153)	21	3
4	Offset Transportation Revenue	(2,535)	11	4
5	Disallowed Special Events	1,325	43	5
6	Offset Miscellaneous Nursing Supplies Revenue	(952)	10	6
7				7
8				8
9				9
10				10
11				11
12				12
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(44,349)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 6,244	\$ 6,244	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%	121	121	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	426	426	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,750	3,750	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%	5,851	5,851	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	286,100	Petersen Health Care Management, Inc.	100.00%	34,725	(251,375)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	20,511	20,511	12
13	V								13
14	Total			\$ 286,100			\$ 71,628	\$ * (214,472)	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.

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,197	\$ 3,197	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	38,716	38,716	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	10,628	10,628	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	64	64	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	20	20	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,473	4,473	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	682	682	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	6,321	6,321	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%	308	308	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	246	246	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	2,267	2,267	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			\$			\$ 66,922	\$ * 66,922	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	\$	Charleston Land, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	Charleston Land, LLC	100.00%			16
17	V	21	Equipment		Charleston Land, LLC	100.00%			17
18	V	26	Insurance-Property		Charleston Land, LLC	100.00%	1,981	1,981	18
19	V	26	Insurance-Mortgage Insurance		Charleston Land, LLC	100.00%			19
20	V	30	Depreciation		Charleston Land, LLC	100.00%	119,915	119,915	20
21	V	31	Amortization		Charleston Land, LLC	100.00%	36,588	36,588	21
22	V	32	Interest		Charleston Land, LLC	100.00%	162,136	162,136	22
23	V	33	Real Estate Taxes		Charleston Land, LLC	100.00%	50,936	50,936	23
24	V	34	Rent-Income and Grounds	280,882	Charleston Land, LLC	100.00%		(280,882)	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			\$ 280,882			\$ 371,556	\$ * 90,674	39

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

Facility Name & ID Number

Charleston Rehab Health CC

0055822

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

Charleston Rehab Health CC

0055822

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

Charleston Rehab Health CC

0055822

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Charleston Rehab Health CC

0055822

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6			Betty's Garden	Kewanee				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Charleston Rehab Health CC # 0055822 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 Charleston Rehab Health CC# 0055822

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	1,282,791	75	\$ 341,562	\$ 398,718	23,450	\$ 6,244	1
2	2	Food	Resident Days	1,282,791	75	0	0	23,450	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	23,450	121	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	23,450	426	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	23,450	3,750	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	23,450	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	23,450	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	23,450	5,851	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	23,450	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	23,450	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	23,450	34,725	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	23,450	20,511	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	23,450	3,197	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	23,450	38,716	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	23,450	10,628	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	23,450	64	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	23,450	20	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	23,450	4,473	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	23,450	682	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	23,450	6,321	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	23,450	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	23,450	308	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	23,450	246	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	23,450	2,267	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 138,550	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	X-Caliber		X	Mortgage	Varies	12/1/19	2,230,458	\$ 2,230,458	11/30/2029	Varies	\$ 162,136	1
2	Dodge		X	Facility Van	Varies	6/29/20	39,027	36,053	6/28/25	Varies	615	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 2,269,485	\$ 2,266,511			\$ 162,751	9
	B. Non-Facility Related*											
10								Interest Income Offset			(146)	10
11								Home Office Allocation-PHCM			308	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 162	14
15	TOTALS (line 9+line14)						\$ 2,269,485	\$ 2,266,511			\$ 162,913	15

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

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

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

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

B. Real Estate Taxes

			Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2019 report.			\$	51,348	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.)			\$	50,384	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(964)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	51,900	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.				246	
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.			\$	51,182	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	<u>40,593</u>	8		
	2016	<u>40,714</u>	9		
	2017	<u>49,191</u>	10		
	2018	<u>49,846</u>	11		
	2019	<u>50,384</u>	12		
<u>Accrual based on prior year tax bill.</u>					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

NOTES:

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

FACILITY NAME Charleston Rehabilitation & Health Care Center COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0050658

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

B. Real Estate Tax Cost Allocations

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.)

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.

Page 10A

A. Square Feet:

35,515

B. General Construction Type:

Exterior Brick

Frame Concrete Block

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:

73,173

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

2

3. Current Period Amortization:

36,588

4. Dates Incurred:

2020

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	146,070	2006	\$ 111,120	1
2					2
3	TOTALS	146,070		\$ 111,120	3

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number **Charleston Rehab Health CC**

0055822

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	139		2006	1970	\$ 2,152,800	\$	30	\$ 71,760	\$ 71,760	\$ 1,019,565
5										
6										
7										
8										
	Improvement Type**									
9	Sewer Pipe		2006		4,602		15	307	307	4,144
10	Carpeting-Lobby		2007		8,855		10			8,855
11	Concrete Work		2010		5,438		15	362	362	3,439
12	Sprinkler System Replacement		2010		134,590		20	6,730	6,730	63,935
13	Roof Replacement on 200 Wing		2011		25,700		25	1,028	1,028	8,738
14	Roof Replacement on Building		2013		28,400		25	1,136	1,136	7,384
15	Nurse Call System		2013		5,527		7	790	790	5,135
16	Landscaping		2015		8,186		7	1,170	1,170	6,435
17	Tiling and Carpeting of Resident Rooms, Common Area, Offices		2015		164,225		15	10,948	10,948	60,214
18	Generator		2015		17,850		10	1,786	1,786	9,823
19	Air Conditioner-Main Area		2016		6,706		15	448	448	2,016
20	Air Conditioner-Rooftop		2017		4,592		15	306	306	1,071
21	Remodeling of Medicare Rooms		2017		2,934		7	420	420	1,470
22	Air Handler and Heat Pump		2019		9,127		15	608	608	912
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					5,460			(5,460)	
31	Building Booked					81,160			(81,160)	
32	Building Improvement Booked					25,025			(25,025)	
33										
34	2020-Home Office Allocation-Building Improvements				11,857			285	285	
35	2020-Home Office Allocation-Land Improvements				1,189			75	75	
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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,592,578	\$ 111,645		\$ 98,159	\$ (13,486)	\$ 1,203,136	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	\$ 87,757	\$ 8,700	\$ 9,796	\$ 1,096	5-10 yrs.	\$ 52,789	71
72	Current Year Purchases	2,781	398	199	(199)	7 yrs.	199	72
73	Fully Depreciated Assets	310,603					310,603	73
74	Home Office Allocation			5,961	5,961			74
75	TOTALS	\$ 401,141	\$ 9,098	\$ 15,956	\$ 6,858		\$ 363,591	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Facility	2007 Ford E150 Van	2007	\$ 29,385	\$	\$	\$		\$ 29,385
77	Facility	2019 Dodge Caravan	2020	39,027	7,805	3,903	(3,902)	5 yrs.	3,903
78									
79									
80	TOTALS			\$ 68,412	\$ 7,805	\$ 3,903	\$ (3,902)		\$ 33,288

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	3,173,251
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	128,548
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	118,018
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(10,530)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,600,015

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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? X YES NO
16. Rental Amount for movable equipment: \$ 73,549 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Charleston Rehab Health CC
0055822

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

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	66,006
Dishwasher		-
Copier		5,276
Home Office Allocation		2,267
		<u>73,549</u>

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

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

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

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	13,793	\$ 206,894	\$	13,793	\$ 206,894	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		8,059	120,886		8,059	120,886	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		15,848	237,722		15,848	237,722	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				159,441		159,441	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			\$	37,700	\$ 565,502	\$ 159,441	37,700	\$ 724,943	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	\$ 471,051	\$ 471,051	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,320)	2,043,610	2,043,610	3
4	Supply Inventory (priced at Cost)	10,803	10,803	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,639	29,620	6
7	Other Prepaid Expenses		28,287	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Ed. Loans, PPD Mgmt	122,771	122,771	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,675,874	\$ 2,706,142	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		111,120	13
14	Buildings, at Historical Cost		2,164,657	14
15	Leasehold Improvements, at Historical Cost		427,921	15
16	Equipment, at Historical Cost	71,193	469,553	16
17	Accumulated Depreciation (book methods)	(33,288)	(1,600,015)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		73,173	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(42,686)	20
21	Restricted Funds		216,146	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Escrow Accounts	1,651,665	1,623,378	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,689,570	\$ 3,443,247	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,365,444	\$ 6,149,389	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,063,165	\$ 1,063,165	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	104,264	104,264	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		51,900	32
33	Accrued Interest Payable		13,733	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	117,407	117,407	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,284,836	\$ 1,350,469	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	36,053	36,053	39
40	Mortgage Payable		2,230,458	40
41	Bonds Payable			41
42	Deferred Compensation	448,506	448,506	42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv & SBA PPP	553,400	553,400	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,037,959	\$ 3,268,417	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,322,795	\$ 4,618,886	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,042,649	\$ 1,530,503	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,365,444	\$ 6,149,389	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (866,823)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	1,593,677	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 726,854	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,315,795	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)	\$ 1,315,795	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)	\$ 2,042,649	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Charleston Rehab Health CC

0055822

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,973,956	1
2	Discounts and Allowances for all Levels	(791,650)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,182,306	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,195,567	6
7	Oxygen	6,760	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,202,327	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	3,346	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,483	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	21,495	20
21	Other Medical Services	46,112	21
22	Laundry	936	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 336,372	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	146	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 146	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	2,535	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	314,567	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 317,102	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,038,253	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	731,513	31
32	Health Care	2,361,176	32
33	General Administration	740,043	33
	B. Capital Expense		
34	Ownership	361,412	34
	C. Ancillary Expense		
35	Special Cost Centers	347,767	35
36	Provider Participation Fee	180,547	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,722,458	40
41	Income before Income Taxes (line 30 minus line 40)**	1,315,795	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,315,795	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,054,023	44
45	Private Pay - Net Inpatient Revenue	425,305	45
46	Medicare - Net Inpatient Revenue	1,684,556	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	18,422	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,182,306	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	2,376	2,376	\$ 79,788	\$ 33.58	1
2	Assistant Director of Nursing	480	480	13,361	27.84	2
3	Registered Nurses	4,427	4,577	153,353	33.51	3
4	Licensed Practical Nurses	13,999	14,498	404,200	27.88	4
5	CNAs & Orderlies	39,696	40,563	718,957	17.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	36,048	17.33	9
10	Activity Assistants					10
11	Social Service Workers	1,887	1,963	25,395	12.94	11
12	Dietician					12
13	Food Service Supervisor	2,095	2,095	33,977	16.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,130	14,342	155,637	10.85	15
16	Dishwashers					16
17	Maintenance Workers	2,395	2,421	43,491	17.96	17
18	Housekeepers	7,322	7,597	79,545	10.47	18
19	Laundry	4,297	4,493	46,000	10.24	19
20	Administrator	1,992	2,080	69,996	33.65	20
21	Assistant Administrator	100	100	2,236	22.36	21
22	Other Administrative					22
23	Office Manager	2,080	2,080	34,152	16.42	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	999	1,005	30,730	30.58	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	829	837	18,547	22.16	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	3,781	3,789	83,310	21.99	33
34	TOTAL (lines 1 - 33)	104,965	107,376	\$ 2,028,723 *	\$ 18.89	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	18,400	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant			L10, C3	38
39	Pharmacist Consultant	Monthly	7,335	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	24,044	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Online Medical</u>	Monthly	19,032	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 68,811		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	107	\$ 3,569	L10,C3	50
51	Licensed Practical Nurses	497	14,229	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	604	\$ 17,798		53

Charleston Rehab Health CC
0055822
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		Average Hourly Wage
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	
Care Plan Coordinator		2,292	2,292	27.61
Transportation		1,489	1,497	13.38
	TOTAL	3,781	3,789	83,310

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Valerie Tischler	Administrator	0	\$ 69,996
Brittney Steingraber	Asst. Admin.	0	2,236
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,232
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7		\$	286,100
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 286,100
C. Professional Services			
Vendor/Payee	Type		Amount
Mediacom	Computer Services	\$	1,530
Ability Network	Computer Services		8,162
Allscripts	Computer Services		1,829
CliftonLarsonAllen	Accounting Fees		2,499
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 14,020
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	34,182
Unemployment Compensation Insurance			18,853
FICA Taxes			147,169
Employee Health Insurance			4,299
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			11,626
Home Office Allocation			10,628
Employee Retirement			317
Administrator Benefits			14,004
TOTAL (agree to Schedule V, line 22, col.8)			\$ 241,078
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			
Health Care Worker Background Check (Indicate # of checks performed 18)			
Patient Background Checks	96		2,873
Miscellaneous Licenses & Permits			220
Miscellaneous Dues & Subscriptions			3,197
Home Office Allocation			
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 6,290
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			
Home Office Allocation			20
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	20

*** Attach copy of IMRF notifications**

****See instructions.**

Charleston Rehab Health CC

0055822

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)		14,020
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	361
Duane Morris	Legal	505
Lexis Nexis	Legal	10
Livingston, Barger, Brant, Schroeder	Legal	19
Miller, Hall, Triggs	Legal	62
Miscellaneous	Legal	23
SB2	Legal	186
SmithAmundsen LLC	Legal	1,154
Sorling Northrup	Legal	329
CliftonLarsonAllen	Accounting	1,434
Ginoli & Co.	Accounting	1,023
Ability Network	Computer Services	3,681
Allscripts	Computer Services	581
AOD Matrix Care	Computer Services	6,465
AT&T	Computer Services	7
ATS	Computer Services	352
CCH	Computer Services	21
Charter Communications	Computer Services	33
Citrix Systems	Computer Services	110
Comcast	Computer Services	38
ITSavvy	Computer Services	170
Kemper Technology	Computer Services	840
Miscellaneous	Computer Services	163
Pearl Technology	Computer Services	152
Stratus Networks	Computer Services	668
TR Professional	Computer Services	14
David Budde	Other Prof Fees	15
DJ Howard and Associates	Other Prof Fees	28
Getzler Henrich & Associates	Other Prof Fees	114
LRI Consulting Services	Other Prof Fees	111
McQuellon Consulting	Other Prof Fees	70
Miscellaneous	Other Prof Fees	131
Optimizer	Other Prof Fees	60
Registered Agent Solutions	Other Prof Fees	33
RSM McGladrey	Other Prof Fees	365
SB2	Other Prof Fees	467
Sedgwick CMS	Other Prof Fees	629
Tarver Program Consultants	Other Prof Fees	87
Total (agree to Schedule V, line 19, column 8)		<u>34,531</u>

Charleston Rehab Health CC
0055822

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

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	3,234
Auto Repairs		97
Mileage-Travel		294
Hotels-Travel		2,466
Home Office Allocation		4,473
		<u>10,564</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.

\$ 22,623

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.

\$ 180,547

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.

\$ 3,346

(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.

\$ 2,535

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.

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