

		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: 0047423 Facility Name: Cisne Rehab Health Care Ctr Address: 107 N Watkins Bx 370 Cisne 62823 County: Wayne Telephone Number: (618) 673-2177 Fax #: (618) 673-2309 HFS ID Number: Date of Initial License for Current Owners: 10/1/2005 Type of Ownership: VOLUNTARY, NON-PROFIT Charitable Corp. Trust IRS Exemption Code PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Mike Kocher Telephone Number: (309) 689-5850 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) Mark Petersen (Title) Chief Executive Officer Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) () Fax # () MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Cisne Rehab Health Care Ctr

0047423 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>11</u>	Skilled (SNF)	<u>11</u>	<u>4,015</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>24</u>	Intermediate (ICF)	<u>24</u>	<u>8,760</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>35</u>	TOTALS	<u>35</u>	<u>12,775</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>2,992</u>	<u>737</u>	<u>3,729</u>	8
9	SNF/PED					9
10	ICF	<u>6,254</u>			<u>6,254</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,254</u>	<u>2,992</u>	<u>737</u>	<u>9,983</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.14%

D. How many bed reserve days during this year were paid by the Department?

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☒ NO ☐

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

YES ☐ NO ☒

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

Date started 10/1/2005

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

YES ☒ Date 10/1/2005 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 11 and days of care provided 794

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Cisne Rehab Health Care Ctr # 0047423 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	84,626	6,647		91,273		91,273	2,658	93,931			1
2	Food Purchase		68,707		68,707		68,707	(726)	67,981			2
3	Housekeeping	40,675	8,991		49,666		49,666	51	49,717			3
4	Laundry	20,672	5,239		25,911		25,911		25,911			4
5	Heat and Other Utilities			25,934	25,934		25,934	181	26,115			5
6	Maintenance	28,512	5,265	19,855	53,632		53,632	1,596	55,228			6
7	Other (specify):*											7
8	TOTAL General Services	174,485	94,849	45,789	315,123		315,123	3,760	318,883			8
	B. Health Care and Programs											
9	Medical Director			8,600	8,600		8,600		8,600			9
10	Nursing and Medical Records	626,856	37,260	2,994	667,110		667,110	(1,170)	665,940			10
10a	Therapy			141,825	141,825		141,825		141,825			10a
11	Activities	28,754			28,754		28,754	(3,461)	25,293			11
12	Social Services	27,317			27,317		27,317		27,317			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	682,927	37,260	153,419	873,606		873,606	(4,631)	868,975			16
	C. General Administration											
17	Administrative	65,004		97,600	162,604		162,604	(82,817)	79,787			17
18	Directors Fees											18
19	Professional Services			7,625	7,625		7,625	72,796	80,421			19
20	Dues, Fees, Subscriptions & Promotions			631	631		631	1,361	1,992			20
21	Clerical & General Office Expenses		1,577	3,106	4,683		4,683	16,412	21,095			21
22	Employee Benefits & Payroll Taxes			102,376	102,376		102,376	10,759	113,135			22
23	Inservice Training & Education							27	27			23
24	Travel and Seminar							8	8			24
25	Other Admin. Staff Transportation			1,694	1,694		1,694	1,904	3,598			25
26	Insurance-Prop.Liab.Malpractice			14,783	14,783		14,783	10,495	25,278			26
27	Other (specify):*											27
28	TOTAL General Administration	65,004	1,577	227,815	294,396		294,396	30,945	325,341			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	922,416	133,686	427,023	1,483,125		1,483,125	30,074	1,513,199			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			1,527	1,527		1,527	24,743	26,270			30
31	Amortization of Pre-Op. & Org.							5,194	5,194			31
32	Interest							17,888	17,888			32
33	Real Estate Taxes							11,808	11,808			33
34	Rent-Facility & Grounds			109,629	109,629		109,629	(109,629)				34
35	Rent-Equipment & Vehicles			13,309	13,309		13,309	5,345	18,654			35
36	Other (specify):*											36
37	TOTAL Ownership			124,465	124,465		124,465	(44,651)	79,814			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		20,493		20,493		20,493		20,493			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,665	74,665		74,665		74,665			42
43	Other (specify):*		6	35,726	35,732		35,732	(35,732)				43
44	TOTAL Special Cost Centers		20,499	110,391	130,890		130,890	(35,732)	95,158			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	922,416	154,185	661,879	1,738,480		1,738,480	(50,309)	1,688,171			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(570)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,524)	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	(1,108)	30		9
10	Interest and Other Investment Income	(31)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	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	(12,725)	43		18
19	Entertainment				19
20	Contributions	(400)	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	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(581)	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	(15,125)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (46,108)		\$	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)	(4,201)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,201)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (50,309)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Special Events	\$ (138)	43	1
2	Offset Meals on Wheels Revenue	(156)	2	2
3	Offset Miscellaneous Office Supplies Revenue	(70)	21	3
4	Labs-Part A	(2,708)	43	4
5	X-Rays-Part A	(3,612)	43	5
6	Offset Transportation Revenue	(3,461)	11	6
7	Offset Miscellaneous Nursing Supplies Revenue	(4,980)	10	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
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(15,125)		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%	\$ 2,658	\$ 2,658	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%	51	51	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	181	181	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,596	1,596	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%	2,491	2,491	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	97,600	Petersen Health Care Management, Inc.	100.00%	14,783	(82,817)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	8,732	8,732	12
13	V								13
14	Total			\$ 97,600			\$ 30,492	\$ * (67,108)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 1,361	\$ 1,361	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	16,482	16,482	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	4,525	4,525	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	27	27	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	8	8	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,904	1,904	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	290	290	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	2,691	2,691	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%	131	131	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	105	105	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	965	965	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			\$			\$ 28,489	\$ * 28,489	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	1,319	1,319	22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	57,509	57,509	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	6,234	6,234	28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	0		33
34	V	31	Amortization		Petersen Health Operations, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	4,441	4,441	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	4,380	4,380	38
39	Total			\$			\$ 73,883	\$ * 73,883	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	\$	Cisne Land, LLC	100.00%	\$		15
16	V	19	Professional Services	\$	Cisne Land, LLC	100.00%	6,555	6,555	16
17	V	21	Equipment		Cisne Land, LLC	100.00%			17
18	V	26	Insurance-Property		Cisne Land, LLC	100.00%	4,478	4,478	18
19	V	26	Insurance-Mortgage Insurance		Cisne Land, LLC	100.00%	5,727	5,727	19
20	V	30	Depreciation		Cisne Land, LLC	100.00%	23,160	23,160	20
21	V	31	Amortization		Cisne Land, LLC	100.00%	5,194	5,194	21
22	V	32	Interest	580	Cisne Land, LLC	100.00%	13,927	13,347	22
23	V	33	Real Estate Taxes		Cisne Land, LLC	100.00%	11,703	11,703	23
24	V	34	Rent-Income and Grounds	109,629	Cisne Land, LLC	100.00%		(109,629)	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			\$ 110,209			\$ 70,744	\$ * (39,465)	39

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

Facility Name & ID Number

Cisne Rehab Health Care Ctr

0047423

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

Cisne Rehab Health Care Ctr

0047423

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

Cisne Rehab Health Care Ctr

0047423

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Cisne Rehab Health Care Ctr # 0047423 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 Cisne Rehab Health Care Ctr# 0047423

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	9,983	\$ 2,658	1
2	2	Food	Resident Days	1,282,791	75	0	0	9,983	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	9,983	51	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	9,983	181	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	9,983	1,596	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	9,983	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	9,983	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	9,983	2,491	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	9,983	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	9,983	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	9,983	14,783	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	9,983	8,732	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	9,983	1,361	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	9,983	16,482	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	9,983	4,525	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	9,983	27	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	9,983	8	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	9,983	1,904	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	9,983	290	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	9,983	2,691	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	9,983	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	9,983	131	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	9,983	105	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	9,983	965	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 58,981	25

Facility Name & ID Number Cisne Rehab Health Care Ctr# 0047423

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Operations, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	163,986	9	\$	\$	9,983	\$	1
2	2	Food	Resident Days	163,986	9			9,983		2
3	3	Housekeeping	Resident Days	163,986	9			9,983		3
4	4	Laundry	Resident Days	163,986	9			9,983		4
5	5	Utilities	Resident Days	163,986	9			9,983		5
6	6	Maintenance	Resident Days	163,986	9			9,983		6
7	7	Mgmt. Allocation of Benefits	Resident Days	163,986	9			9,983		7
8	10	Nursing and Medical Records	Resident Days	163,986	9	21,660		9,983	1,319	8
9	15	Mgmt. Allocation of Benefits	Resident Days	163,986	9			9,983		9
10	17	Administrative	Resident Days	163,986	9			9,983		10
11	19	Professional Services	Resident Days	163,986	9	944,677		9,983	57,509	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	163,986	9			9,983		12
13	21	Clerical and General Office	Resident Days	163,986	9			9,983		13
14	22	Employee Benefits & Payroll	Resident Days	163,986	9	102,400		9,983	6,234	14
15	23	Inservice Training & Education	Resident Days	163,986	9			9,983		15
16	24	Travel and Seminar	Resident Days	163,986	9			9,983		16
17	25	Other Admin. Staff Transport.	Resident Days	163,986	9			9,983		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	163,986	9			9,983		18
19	30	Depreciation	Resident Days	163,986	9			9,983		19
20	31	Amortization	Resident Days	163,986	9			9,983		20
21	32	Interest	Resident Days	163,986	9	72,956		9,983	4,441	21
22	33	Real Estate Taxes	Resident Days	163,986	9			9,983		22
23	34	Rent-Facility and Grounds	Resident Days	163,986	9			9,983		23
24	35	Rent-Equipment & Vehicles	Resident Days	163,986	9	71,940		9,983	4,380	24
25	TOTALS					\$ 1,213,633	\$		\$ 73,883	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Capital Finance Group		X	Mortgage	Varies	1/1/2015	\$ 1,118,500	\$ 859,937	12/31/2024	Varies	\$ 13,927	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 1,118,500	\$ 859,937			\$ 13,927	9
	B. Non-Facility Related*											
10								Interest Income Offset			(611)	10
11								Home Office Allocation-PHCM			131	11
12								Home Office Allocation-PHO			4,441	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 3,961	14
15	TOTALS (line 9+line14)						\$ 1,118,500	\$ 859,937			\$ 17,888	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 5,727 Line # 26

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$13,032	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.)			\$12,183	2
3. Under or (over) accrual (line 2 minus line 1).			\$(849)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$12,552	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. Home Office Allocation			105	
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.			\$11,808	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		201513,4208		
		201613,2889		
		201713,15510		
		201812,72911		
		201912,18312		
Accrual based on prior year tax bill.				

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

NOTES:

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

FACILITY NAME Cisne Rehabilitation & Health Care Center COUNTY Wayne

FACILITY IDPH LICENSE NUMBER 0047423

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,413

B. General Construction Type: Exterior Brick Veneer

Frame Wood

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 103,883

2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 5,194

4. Dates Incurred: 2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	75,359		2005		\$ 9,000	
2							
3	TOTALS	75,359				\$ 9,000	

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	35		2005	1970	\$ 186,500	\$	25	\$ 7,060	\$ 7,060	\$ 115,099
5										
6										
7										
8										
	Improvement Type**									
9	Waterline		2005		1,634		15	54	54	1,634
10	Sewer Line		2007		3,500		20	175	175	2,363
11	Condenser Unit		2009		5,018		7			5,018
12	Sprinkler System Repair		2011		3,799		7			3,799
13	Sewer Line Repair		2013		4,926		7	350	350	4,926
14	Canopy Replacement		2014		3,093		15	206	206	1,339
15	Landscaping		2014		18,811		15	1,254	1,254	8,151
16	Nursing Call Station		2016		5,261		7	752	752	3,384
17	Parking Lot Resurfacing		2016		38,210		15	2,548	2,548	11,466
18	Back Patio Repair		2016		4,406		7	630	630	2,835
19	Sidewalk Ramp		2016		3,000		15	200	200	900
20	HVAC System		2017		8,517		15	568	568	1,988
21	Roof Replacement		2019		39,811		15	2,654	2,654	3,981
22	Water Heater		2020		4,000		7	286	286	286
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					1,318			(1,318)	
31	Building Booked					7,090			(7,090)	
32	Building Improvement Booked					9,667			(9,667)	
33										
34	2020-Home Office Allocation-Building Improvements				5,048			121	121	
35	2020-Home Office Allocation-Land Improvements				506			32	32	
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Cisne Rehab Health Care Ctr

0047423

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 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
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64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 336,040	\$ 18,075		\$ 16,890	\$ (1,185)	\$ 167,169	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	\$52,352	\$6,612	\$6,842	\$230	5-10 yrs.	\$27,001	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	52,213					52,213	73
74				2,538	2,538			74
75	TOTALS	\$104,565	\$6,612	\$9,380	\$2,768		\$79,214	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	2010 Ford Van	2010	\$28,001	\$		\$	5 yrs.	\$28,001	76
77	Facility	2010 Ford Van Repair	2016	3,426				3 yrs.	3,426	77
78										78
79										79
80	TOTALS			\$31,427	\$	\$	\$		\$31,427	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)	\$481,032	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$24,687	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$26,270	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$1,583	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$277,810	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

15. Is Movable equipment rental included in building rental? X YES NO
16. Rental Amount for movable equipment: \$ 18,654 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.

Cisne Rehab Health Care Ctr
0047423

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	\$	10,748
Dishwasher		(202)
Copier		2,763
Home Office Allocation		5,345
		<u>18,654</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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

\$

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,796	\$ 56,941	\$	3,796	\$ 56,941	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		780	11,701		780	11,701	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,879	73,183		4,879	73,183	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				20,493		20,493	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	9,455	\$ 141,825	\$ 20,493	9,455	\$ 162,318	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	\$ 102,314	\$ 102,314	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27,973)	1,043,854	1,043,854	3
4	Supply Inventory (priced at Cost)	4,944	4,944	4
5	Short-Term Investments			5
6	Prepaid Insurance	7,411	14,166	6
7	Other Prepaid Expenses		11,459	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,158,523	\$ 1,176,737	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		9,000	13
14	Buildings, at Historical Cost		191,548	14
15	Leasehold Improvements, at Historical Cost	4,000	144,492	15
16	Equipment, at Historical Cost	38,113	135,992	16
17	Accumulated Depreciation (book methods)	(33,913)	(277,810)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		103,883	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(32,463)	20
21	Restricted Funds		199,584	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	21,390	39,198	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 29,590	\$ 513,424	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,188,113	\$ 1,690,161	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 385,771	\$ 385,771	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,106	52,106	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		12,552	32
33	Accrued Interest Payable		2,759	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	48,160	48,160	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 486,037	\$ 501,348	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		859,937	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)	\$	\$ 859,937	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 486,037	\$ 1,361,285	46
47	TOTAL EQUITY(page 18, line 24)	\$ 702,076	\$ 328,876	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,188,113	\$ 1,690,161	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (379,512)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	381,897	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,385	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	699,691	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)	\$ 699,691	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)	\$ 702,076	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Cisne Rehab Health Care Ctr

0047423

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	\$ 1,830,713	1
2	Discounts and Allowances for all Levels	(198,477)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,632,236	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	252,366	6
7	Oxygen	179	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 252,545	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	726	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	38,897	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,669	20
21	Other Medical Services	8,192	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 55,484	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	31	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	3,461	28
28a	<u>Miscellaneous Revenue</u>	494,414	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 497,875	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,438,171	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	315,123	31
32	Health Care	873,606	32
33	General Administration	294,396	33
	B. Capital Expense		
34	Ownership	124,465	34
	C. Ancillary Expense		
35	Special Cost Centers	56,225	35
36	Provider Participation Fee	74,665	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,738,480	40
41	Income before Income Taxes (line 30 minus line 40)**	699,691	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 699,691	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 978,724	44
45	Private Pay - Net Inpatient Revenue	429,405	45
46	Medicare - Net Inpatient Revenue	204,765	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	19,342	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,632,236	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	2,152	2,244	\$ 67,646	\$ 30.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,464	4,671	128,363	27.48	3
4	Licensed Practical Nurses	4,540	4,743	96,933	20.44	4
5	CNAs & Orderlies	21,689	22,306	289,807	12.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,703	1,743	24,364	13.98	9
10	Activity Assistants					10
11	Social Service Workers	1,798	1,893	27,317	14.43	11
12	Dietician					12
13	Food Service Supervisor	1,870	1,880	23,733	12.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,229	5,452	60,893	11.17	15
16	Dishwashers					16
17	Maintenance Workers	1,625	1,659	28,512	17.19	17
18	Housekeepers	3,459	3,607	40,675	11.28	18
19	Laundry	1,542	1,868	20,672	11.07	19
20	Administrator	1,992	2,080	65,004	31.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	2,068	2,071	48,497	23.42	33
34	TOTAL (lines 1 - 33)	54,131	56,217	\$ 922,416 *	\$ 16.41	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	8,600	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,994	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 11,594		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Cisne Rehab Health Care Ctr
0047423
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		1,668	1,671	26.40
Transportation		400	400	10.98
	TOTAL	2,068	2,071	48,497

STATE OF ILLINOIS

Facility Name & ID Number

Cisne Rehab Health Care Ctr

0047423

Report Period Beginning:

1/1/2020

Page 21

Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
Melissa Talbert		Administrator	0	\$ 65,004	Workers' Compensation Insurance		\$ 8,475	IDPH License Fee		\$		
					Unemployment Compensation Insurance		11,064	Advertising: Employee Recruitment		(202)		
					FICA Taxes		64,877	Health Care Worker Background Check				
					Employee Health Insurance		4,175	(Indicate # of checks performed 10)				
					Employee Meals			Patient Background Checks		10 300		
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		533		
					Employee Relations		200	Miscellaneous Dues & Subscriptions				
					Home Office Allocation		589	Home Office Allocation		1,361		
					Employee Retirement		10,759					
					Administrator Benefits		12,996					
								Less: Public Relations Expense		()		
								Non-allowable advertising		()		
								Yellow page advertising		()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 65,004	TOTAL (agree to Schedule V, line 22, col.8)				\$ 113,135	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,992
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description				Amount	Description		Line #	Amount	Description		Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7				\$ 97,600					Out-of-State Travel		\$	
									In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 97,600								
C. Professional Services												
Vendor/Payee		Type		Amount								
Ability Network		Computer Services		\$ 6,928								
Wabash Telephone Co-Op		Computer Services		672								
Illinois Secretary of State		Legal Fees-9/23/20		25								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 7,625	TOTAL				\$	Seminar Expense		
									Home Office Allocation		8	
									Entertainment Expense		()	
									(agree to Sch. V, line 24, col. 8)			
									TOTAL		\$ 8	

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Cisne Rehab Health Care Ctr
0047423
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)		7,625
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	229
Duane Morris	Legal	16,586
Lexis Nexis	Legal	4
Livingston, Barger, Brant, Schroeder	Legal	6,938
Miller, Hall, Triggs	Legal	27
Miscellaneous	Legal	10
SB2	Legal	459
SmithAmundsen LLC	Legal	1,093
Sorling Northrup	Legal	262
Capital Finance Group	Legal	2,355
Illinois Secretary of Sate	Legal	73
McGuire Woods	Legal	3,044
CliftonLarsonAllen	Accounting	610
Ginoli & Co.	Accounting	8,486
Ability Network	Computer Services	1,567
Allscripts	Computer Services	247
AOD Matrix Care	Computer Services	2,752
AT&T	Computer Services	3
ATS	Computer Services	150
CCH	Computer Services	9
Charter Communications	Computer Services	14
Citrix Systems	Computer Services	47
Comcast	Computer Services	16
ITSavvy	Computer Services	72
Kemper Technology	Computer Services	358
Miscellaneous	Computer Services	69
Pearl Technology	Computer Services	65
Stratus Networks	Computer Services	284
TR Professional	Computer Services	6
Creative Health Capital	Other Prof Fees	2,462
Mohr and Kerr	Other Prof Fees	4,485
Planning and Zoning Resource Company	Other Prof Fees	630
David Budde	Other Prof Fees	6
DJ Howard and Associates	Other Prof Fees	590
Getzler Henrich & Associates	Other Prof Fees	634
LRI Consulting Services	Other Prof Fees	641
McQuellon Consulting	Other Prof Fees	395
Miscellaneous	Other Prof Fees	59
Optimizer	Other Prof Fees	25
Registered Agent Solutions	Other Prof Fees	14
RSM McGladrey	Other Prof Fees	155
SB2	Other Prof Fees	199
Sedgwick CMS	Other Prof Fees	16,629
Tarver Program Consultants	Other Prof Fees	37
Total (agree to Schedule V, line 19, column 8)		<u>80,421</u>

Cisne Rehab Health Care Ctr
0047423

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

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$ 1,696
Auto Repairs	(2)
Mileage-Travel	-
Home Office Allocation	<u>1,904</u>
	<u><u>3,598</u></u>

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. No

(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?
What was the average life used for new equipment added during this period? Yes
7 yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,405 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. \$ 74,665
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. \$ 570

(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. \$ 3,461
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.