

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: <u>0056499</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Decatur Rehab Health Care Ct</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>136 S Dipper Lane</u> <u>Decatur</u> <u>62522</u>			
Number City Zip Code			
County: <u>Macon</u>			
Telephone Number: <u>(217) 428-7767</u> Fax # <u>(217) 428-2555</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>10/1/2005</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ CORPORATION	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Mike Kocher</u>		Telephone Number: <u>(309)689-5850</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Mark Petersen</u>	
		(Title) <u>Chief Executive Officer</u>	
		Paid Preparer	
		(Signed) _____ (Date) _____	
		(Print Name and Title) _____	
		(Firm Name & Address) _____	
		(Telephone) <u>()</u> Fax # <u>()</u>	
		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	

#	0056499	Report Period Beginning:	1/1/2020	Ending:	12/31/2020
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D. How many bed reserve days during this year were paid by the Department?

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

N/A

None

Yes

YES ☒ NO ☐

YES ☐ **NO** ☒

Date started 10/1/2005

YES ☒ Date 10/1/2005 NO ☐

YES ☐ NO ☒ If YES, enter number

of beds certified and days of care provided

Medicare Intermediary **N/A****MODIFIED**

ACCRUAL	X
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CASH*

CASH* ☐

YES ☒ NO ☐

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

	1 Level of Care	2	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,274	1,068		15,342	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,274	1,068		15,342	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)	72.47%
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Facility Name & ID Number Decatur Rehab Health Care Ct # 0056499 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	147,000	14,601		161,601		161,601	4,085	165,686			1
2	Food Purchase		110,094		110,094		110,094	(2,537)	107,557			2
3	Housekeeping	134,147	26,737		160,884		160,884	79	160,963			3
4	Laundry	4,523	5,306		9,829		9,829		9,829			4
5	Heat and Other Utilities			45,634	45,634		45,634	279	45,913			5
6	Maintenance	40,681	10,999	26,605	78,285		78,285	2,753	81,038			6
7	Other (specify):*											7
8	TOTAL General Services	326,351	167,737	72,239	566,327		566,327	4,659	570,986			8
	B. Health Care and Programs											
9	Medical Director			16,200	16,200		16,200		16,200			9
10	Nursing and Medical Records	834,830	65,037	8,089	907,956		907,956	3,067	911,023			10
10a	Therapy			(21,232)	(21,232)		(21,232)		(21,232)			10a
11	Activities	54,397	2,059	(1,018)	55,438		55,438	(1,626)	53,812			11
12	Social Services	25,743	99		25,842		25,842		25,842			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	914,970	67,195	2,039	984,204		984,204	1,441	985,645			16
	C. General Administration											
17	Administrative	75,000		115,100	190,100		190,100	(92,381)	97,719			17
18	Directors Fees											18
19	Professional Services			7,600	7,600		7,600	13,959	21,559			19
20	Dues, Fees, Subscriptions & Promotions			5,056	5,056		5,056	1,796	6,852			20
21	Clerical & General Office Expenses	35,536	2,455	13,466	51,457		51,457	25,217	76,674			21
22	Employee Benefits & Payroll Taxes			149,999	149,999		149,999	6,953	156,952			22
23	Inservice Training & Education			1	1		1	42	43			23
24	Travel and Seminar							13	13			24
25	Other Admin. Staff Transportation			2,794	2,794		2,794	2,927	5,721			25
26	Insurance-Prop.Liab.Malpractice			26,949	26,949		26,949	446	27,395			26
27	Other (specify):*											27
28	TOTAL General Administration	110,536	2,455	320,965	433,956		433,956	(41,028)	392,928			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,351,857	237,387	395,243	1,984,487		1,984,487	(34,928)	1,949,559			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			145	145		145	30,098	30,243			30
31	Amortization of Pre-Op. & Org.							24,333	24,333			31
32	Interest							95,026	95,026			32
33	Real Estate Taxes			25,583	25,583		25,583	161	25,744			33
34	Rent-Facility & Grounds			128,558	128,558		128,558	(128,558)				34
35	Rent-Equipment & Vehicles			10,480	10,480		10,480	1,483	11,963			35
36	Other (specify):*											36
37	TOTAL Ownership			164,766	164,766		164,766	22,543	187,309			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		(787)		(787)		(787)		(787)			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,721	124,721		124,721		124,721			42
43	Other (specify):*		225	21,166	21,391		21,391	(21,391)				43
44	TOTAL Special Cost Centers		(562)	145,887	145,325		145,325	(21,391)	123,934			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,351,857	236,825	705,896	2,294,578		2,294,578	(33,776)	2,260,802			45

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

	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	(2,537)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,488)	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	(1,921)	30		9
10	Interest and Other Investment Income	(20)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(271)	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	(8,197)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,665)	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	(4,564)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,663)		\$	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)	(5,113)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (5,113)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (33,776)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Transportation Revenue	\$ (1,626)	11	1
2	Disallowed Special Events	(705)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(112)	21	3
4	Labs-Part A	(2,810)	43	4
5	Disallowed Chamber of Commerce Dues	(295)	20	5
6	X-Rays-Part A	1,745	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(761)	21	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
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31				31
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	(4,564)		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%	\$ 4,085	\$ 4,085	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%	79	79	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	279	279	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,453	2,453	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	3,828	3,828	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	115,100	Petersen Health Care Management, Inc.	100.00%	22,719	(92,381)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	13,419	13,419	12
13	V								13
14	Total			\$ 115,100			\$ 46,862	\$ * (68,238)	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%	\$ 2,091	\$ 2,091	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	25,329	25,329	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	6,953	6,953	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	42	42	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	13	13	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,927	2,927	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	446	446	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	4,135	4,135	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%	201	201	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	161	161	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,483	1,483	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			\$			\$ 43,781	\$ * 43,781	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	4	5	6	7	8
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Wellness, LLC	100.00%	\$	15
16	V	2 Food		Petersen Health Wellness, LLC	100.00%		16
17	V	3 Housekeeping		Petersen Health Wellness, LLC	100.00%		17
18	V	4 Laundry		Petersen Health Wellness, LLC	100.00%		18
19	V	5 Utilities		Petersen Health Wellness, LLC	100.00%		19
20	V	6 Maintenance		Petersen Health Wellness, LLC	100.00%		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%		21
22	V	10 Nursing and Medical Records		Petersen Health Wellness, LLC	100.00%		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%		23
24	V	17 Administrative		Petersen Health Wellness, LLC	100.00%		24
25	V	19 Professional Services		Petersen Health Wellness, LLC	100.00%	540	540 25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%		26
27	V	21 Clerical and General Office		Petersen Health Wellness, LLC	100.00%		27
28	V	22 Employee Benefits & Payroll		Petersen Health Wellness, LLC	100.00%		28
29	V	23 Inservice Training & Education		Petersen Health Wellness, LLC	100.00%		29
30	V	24 Travel and Seminar		Petersen Health Wellness, LLC	100.00%		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Wellness, LLC	100.00%		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Wellness, LLC	100.00%		32
33	V	30 Depreciation		Petersen Health Wellness, LLC	100.00%		33
34	V	31 Amortization		Petersen Health Wellness, LLC	100.00%		34
35	V	32 Interest		Petersen Health Wellness, LLC	100.00%	150	150 35
36	V	33 Real Estate Taxes		Petersen Health Wellness, LLC	100.00%		36
37	V	34 Rent-Facility and Grounds		Petersen Health Wellness, LLC	100.00%		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Wellness, LLC	100.00%		38
39	Total		\$			\$ 690	\$ * 690 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	\$	Decatur Land, LLC	100.00%	\$ 300	\$ 300	15
16	V	19	Professional Services	\$	Decatur Land, LLC	100.00%			16
17	V	21	Equipment		Decatur Land, LLC	100.00%			17
18	V	26	Insurance-Property		Decatur Land, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		Decatur Land, LLC	100.00%			19
20	V	30	Depreciation		Decatur Land, LLC	100.00%	27,884	27,884	20
21	V	31	Amortization		Decatur Land, LLC	100.00%	24,333	24,333	21
22	V	32	Interest		Decatur Land, LLC	100.00%	94,695	94,695	22
23	V	33	Real Estate Taxes		Decatur Land, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	128,558	Decatur Land, LLC	100.00%		(128,558)	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			\$ 128,558			\$ 147,212	\$ * 18,654	39

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

Facility Name & ID Number

Decatur Rehab Health Care Ct

0056499

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, L	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, I	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enterp	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 System	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 LI	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care M	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 Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	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 Proper	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LLC	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

Decatur Rehab Health Care Ct

0056499

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

Decatur Rehab Health Care Ct

0056499

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 Decatur Rehab Health Care Ct # 0056499 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 Decatur Rehab Health Care Ct# 0056499

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	15,342	\$ 4,085	1
2	2	Food	Resident Days	1,282,791	75	0	0	15,342	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	15,342	79	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	15,342	279	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	15,342	2,453	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	15,342	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	15,342	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	15,342	3,828	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	15,342	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	15,342	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	15,342	22,719	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	15,342	13,419	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	15,342	2,091	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	15,342	25,329	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,282,791	75	581,393	0	15,342	6,953	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	15,342	42	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	15,342	13	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	15,342	2,927	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	15,342	446	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	15,342	4,135	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	15,342	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	15,342	201	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	15,342	161	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	15,342	1,483	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 90,643	25

Facility Name & ID Number Decatur Rehab Health Care Ct# 0056499

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 Wellness, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	65,205	8	\$	\$	9,091	\$	1
2	2	Food	Resident Days	65,205	8			9,091		2
3	3	Housekeeping	Resident Days	65,205	8			9,091		3
4	4	Laundry	Resident Days	65,205	8			9,091		4
5	5	Utilities	Resident Days	65,205	8			9,091		5
6	6	Maintenance	Resident Days	65,205	8			9,091		6
7	7	Mgmt. Allocation of Benefits	Resident Days	65,205	8			9,091		7
8	10	Nursing and Medical Records	Resident Days	65,205	8			9,091		8
9	15	Mgmt. Allocation of Benefits	Resident Days	65,205	8			9,091		9
10	17	Administrative	Resident Days	65,205	8			9,091		10
11	19	Professional Services	Resident Days	65,205	8	3,870		9,091	540	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	65,205	8			9,091		12
13	21	Clerical and General Office	Resident Days	65,205	8			9,091		13
14	22	Employee Benefits & Payroll	Resident Days	65,205	8			9,091		14
15	23	Inservice Training & Education	Resident Days	65,205	8			9,091		15
16	24	Travel and Seminar	Resident Days	65,205	8			9,091		16
17	25	Other Admin. Staff Transport.	Resident Days	65,205	8			9,091		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	65,205	8			9,091		18
19	30	Depreciation	Resident Days	65,205	8			9,091		19
20	31	Amortization	Resident Days	65,205	8			9,091		20
21	32	Interest	Resident Days	65,205	8	1,079		9,091	150	21
22	33	Real Estate Taxes	Resident Days	65,205	8			9,091		22
23	34	Rent-Facility and Grounds	Resident Days	65,205	8			9,091		23
24	35	Rent-Equipment & Vehicles	Resident Days	65,205	8			9,091		24
25	TOTALS					\$ 4,949	\$		\$ 690	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	Sector		X	Mortgage	Varies	4/1/20	\$ 1,295,888	\$ 1,295,888	3/31/23	Varies	\$ 94,695	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 1,295,888	\$ 1,295,888			\$ 94,695	9
	B. Non-Facility Related*											
10								Interest Income Offset			(20)	10
11								Home Office Allocation-PHCM			201	11
12								Home Office Allocation-PHW			150	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 331	14
15	TOTALS (line 9+line14)						\$ 1,295,888	\$ 1,295,888			\$ 95,026	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.		\$	24,896	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.)		\$	25,031	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	135	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	25,448	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	161	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	25,744	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	24,278	8	
		2016	25,548	9	
		2017	25,071	10	
		2018	24,494	11	
		2019	25,031	12	
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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,653 B. General Construction Type: Exterior Brick Frame Concrete 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: 64,889 2. Number of Years Over Which it is Being Amortized: 3
3. Current Period Amortization: 24,333 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	<u>Facility</u>	<u>43,560</u>	<u>2005</u>	<u>\$ 37,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>43,560</u>		<u>\$ 37,500</u>	<u>3</u>

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	58		2005	1970	\$ 275,500	\$	25	\$ 11,020	\$ 11,020	\$ 170,810
5										
6										
7										
8										
	Improvement Type**									
9	Original Land Improvements			2005	10,000		15	667	667	9,671
10	Sidewalks			2006	2,311		15	92	92	2,311
11	Remodel Nurses Station			2007	6,718		15	448	448	5,600
12	Water Heater-100 Gallon			2008	5,604		5			5,604
13	Painting-Exterior			2009	4,908		15	328	328	3,680
14	Sprinkler System Installation			2009	11,774		15	785	785	8,242
15	Windows Installation-(41)			2009	11,234		15	749	749	7,864
16	Dry Pendant Installation			2010	6,270		15	418	418	3,971
17	Sidewalk Replacement			2011	2,850		15	190	190	1,615
18	Roofing-Flat Section of Building			2013	10,400		15	694	694	4,511
19	Parking Lot-Asphalt			2013	23,468		25	938	938	6,097
20	Air Handler			2015	2,905		15	194	194	873
21	Parking Lot Repair			2016	4,300		7	614	614	2,149
22	Water Heater-100 Gallon			2016	4,054		7	580	580	2,030
23	Air Conditioner			2018	3,450		15	230	230	345
24	Alarm System Replacement			2018	2,935		7	420	420	630
25	Kitchen Floor Drain Repair			2019	3,590		7	256	256	256
26	Attic Insulation			2020	5,950		7	425	425	425
27	Sprinkler Repair			2020	3,441		7	246	246	246
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

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	Land Improvements Booked			241			(241)		57
58	Building Booked			11,069			(11,069)		58
59	Building Improvement Booked			8,459			(8,459)		59
60									60
61	2020-Home Office Allocation-Building Improvements		7,757			186	186		61
62	2020-Home Office Allocation-Land Improvements		778			49	49		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 410,197	\$ 19,769		\$ 19,529	\$ (240)	\$ 236,930	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	\$46,350	\$6,540	\$5,736	\$(804)	5-10 yrs.	\$29,995	71
72	Current Year Purchases	15,084	1,720	1,078	(642)	7 yrs.	1,078	72
73	Fully Depreciated Assets	97,367					97,367	73
74	Home Office Allocation			3,900	3,900			74
75	TOTALS	\$158,801	\$8,260	\$10,714	\$2,454		\$128,440	75

D. Vehicle Costs. (See instructions.)*										
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets					1	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)				\$606,498	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$28,029	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$30,243	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$2,214	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$365,370	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		\$	\$	\$
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? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 11,963 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.

Decatur Rehab Health Care Ct
0056499

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	\$	5,557
Dishwasher		701
Copier		4,222
Home Office Allocation		1,483
		<u>11,963</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.

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	

(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	\$		\$ (11,125)	\$		(11,125)	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			(3,028)			(3,028)	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs			(7,079)			(7,079)	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 prescripts				(787)		(787)	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			\$		\$ (21,232)	\$ (787)		\$ (22,019)	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (6,439)	\$ (6,439)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 159,569)	793,664	793,664	3
4	Supply Inventory (priced at Cost)	7,380	7,380	4
5	Short-Term Investments			5
6	Prepaid Insurance	14,393	14,393	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		3,583	8
9	Other(specify): Employee Education Loans	1,207	1,207	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 810,205	\$ 813,788	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		37,500	13
14	Buildings, at Historical Cost		283,257	14
15	Leasehold Improvements, at Historical Cost		126,940	15
16	Equipment, at Historical Cost	3,042	158,801	16
17	Accumulated Depreciation (book methods)	(145)	(365,370)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		64,889	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(24,333)	20
21	Restricted Funds	18,587	117,899	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	391,538	440,016	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 413,022	\$ 839,599	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,223,227	\$ 1,653,387	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 341,267	\$ 341,267	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,504	55,504	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,448	25,448	32
33	Accrued Interest Payable		15,541	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	71,465	71,465	36
37	Accrued Management Fees	12,517	12,517	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 506,201	\$ 521,742	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,295,888	40
41	Bonds Payable			41
42	Deferred Compensation	39,490	39,490	42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	357,000	357,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 396,490	\$ 1,692,378	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 902,691	\$ 2,214,120	46
47	TOTAL EQUITY (page 18, line 24)	\$ 320,536	\$ (560,733)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,223,227	\$ 1,653,387	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 155,552	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(200,925)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (45,373)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	365,909	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)	\$ 365,909	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)	\$ 320,536	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Decatur Rehab Health Care Ct

0056499

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,906,140	1
2	Discounts and Allowances for all Levels	(621,983)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,284,157	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,660	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 9,660	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	2,537	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	463	21
22	Laundry	12	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,012	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	1,626	28
28a	Miscellaneous and COVID Stimulus Revenue	362,012	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 363,638	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,660,487	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	566,327	31
32	Health Care	984,204	32
33	General Administration	433,956	33
	B. Capital Expense		
34	Ownership	164,766	34
	C. Ancillary Expense		
35	Special Cost Centers	20,604	35
36	Provider Participation Fee	124,721	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,294,578	40
41	Income before Income Taxes (line 30 minus line 40)**	365,909	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 365,909	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 727,369	44
45	Private Pay - Net Inpatient Revenue	57,850	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 785,219	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	1,966	1,974	\$ 64,793	\$ 32.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,610	5,763	159,490	27.67	3
4	Licensed Practical Nurses	6,701	6,826	141,667	20.75	4
5	CNAs & Orderlies	25,089	25,566	392,577	15.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	33,414	16.06	9
10	Activity Assistants					10
11	Social Service Workers	990	1,033	25,743	24.92	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	47,326	22.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,822	9,981	99,674	9.99	15
16	Dishwashers					16
17	Maintenance Workers	2,839	2,928	40,681	13.89	17
18	Housekeepers	10,141	10,255	134,147	13.08	18
19	Laundry	450	450	4,523	10.05	19
20	Administrator	2,016	2,176	75,000	34.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	35,536	17.08	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	646	646	12,194	18.88	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	3,905	3,945	85,092	21.57	33
34	TOTAL (lines 1 - 33)	76,415	77,783	\$ 1,351,857 *	\$ 17.38	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	16,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,614	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)		\$ 20,814		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	86	\$ 3,475	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	86	\$ 3,475		53

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

** See instructions.

Decatur Rehab Health Care Ct
0056499
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages
		Average Hourly Wage		
Care Plan Coordinator		2,084	2,124	57,601
Transportation		1,506	1,506	20,983
Restorative Aides		315	315	6,508
TOTAL		3,905	3,945	85,092

**Decatur Rehab Health Care Ct
0056499**

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)		7,600

Home Office Allocation

Baker Tilly Virchow Krause LLP	Legal	236
Duane Morris	Legal	330
Lexis Nexis	Legal	6
Livingston, Barger, Brant, Schroeder	Legal	13
Miller, Hall, Triggs	Legal	41
Miscellaneous	Legal	15
SB2	Legal	122
SmithAmundsen LLC	Legal	755
Sorling Northrup	Legal	215
Illinois Secretary of Sate	Legal	146
CliftonLarsonAllen	Accounting	938
Ginoli & Co.	Accounting	1,063
Ability Network	Computer Services	2,408
Allscripts	Computer Services	380
AOD Matrix Care	Computer Services	4,229
AT&T	Computer Services	5
ATS	Computer Services	231
CCH	Computer Services	13
Charter Communications	Computer Services	21
Citrix Systems	Computer Services	72
Comcast	Computer Services	25
ITSavvy	Computer Services	111
Kemper Technology	Computer Services	550
Miscellaneous	Computer Services	107
Pearl Technology	Computer Services	100
Stratus Networks	Computer Services	437
TR Professional	Computer Services	9
David Budde	Other Prof Fees	10
DJ Howard and Associates	Other Prof Fees	18
Getzler Henrich & Associates	Other Prof Fees	74
LRI Consulting Services	Other Prof Fees	72
McQuellon Consulting	Other Prof Fees	46
Miscellaneous	Other Prof Fees	88
Optimizer	Other Prof Fees	39
Registered Agent Solutions	Other Prof Fees	22
RSM McGladrey	Other Prof Fees	239
SB2	Other Prof Fees	305
Sedgwick CMS	Other Prof Fees	411
Tarver Program Consultants	Other Prof Fees	57

Total (agree to Schedule V, line 19, column 8)	<u>21,559</u>
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Decatur Rehab Health Care Ct
0056499
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	1,101
Auto Repairs		1,693
Mileage-Travel		-
Home Office Allocation		<u>2,927</u>
		<u><u>5,721</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. \$ 20,787 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. \$ 124,721
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. \$ 2,537

(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. \$ 1,626
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.