

		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: 0050922

Facility Name: Farmer City Rehab & Health Care Center

Address: 10 Brookview Drive Farmer City 61842

County: DeWitt

Telephone Number: (309) 928-2118 Fax #: (309)928-2313

HFS ID Number:

Date of Initial License for Current Owners: 8/15/1995

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X

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

Facility Name & ID Number Farmer City Rehab & Health Care Center

0050922 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>56</u>	Skilled (SNF)	<u>56</u>	<u>20,440</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)			<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>56</u>	TOTALS	<u>56</u>	<u>20,440</u>	<u>7</u>

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>11,325</u>	<u>5,067</u>	<u>1,015</u>	<u>17,407</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>11,325</u>	<u>5,067</u>	<u>1,015</u>	<u>17,407</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.16%

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 9/20/11

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 9/20/11 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 56 and days of care provided 698

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Farmer City Rehab & Health Care Center # 0050922 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	165,785	15,353		181,138		181,138	4,635	185,773			1
2	Food Purchase		126,518		126,518		126,518	(2,820)	123,698			2
3	Housekeeping	53,738	21,118		74,856		74,856	90	74,946			3
4	Laundry	26,904	4,134		31,038		31,038		31,038			4
5	Heat and Other Utilities			53,524	53,524		53,524	316	53,840			5
6	Maintenance	66,230	13,974	16,818	97,022		97,022	2,784	99,806			6
7	Other (specify):*											7
8	TOTAL General Services	312,657	181,097	70,342	564,096		564,096	5,005	569,101			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	739,975	51,482	6,643	798,100		798,100	4,343	802,443			10
10a	Therapy	48,420		157,951	206,371		206,371		206,371			10a
11	Activities	71,891	473		72,364		72,364	(468)	71,896			11
12	Social Services	30,579			30,579		30,579		30,579			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	890,865	51,955	176,594	1,119,414		1,119,414	3,875	1,123,289			16
	C. General Administration											
17	Administrative	78,996		161,400	240,396		240,396	(135,624)	104,772			17
18	Directors Fees											18
19	Professional Services			12,743	12,743		12,743	15,225	27,968			19
20	Dues, Fees, Subscriptions & Promotions			5,241	5,241		5,241	2,373	7,614			20
21	Clerical & General Office Expenses	38,809	2,686	7,127	48,622		48,622	29,233	77,855			21
22	Employee Benefits & Payroll Taxes			133,662	133,662		133,662	7,889	141,551			22
23	Inservice Training & Education							48	48			23
24	Travel and Seminar							15	15			24
25	Other Admin. Staff Transportation			2,539	2,539		2,539	3,321	5,860			25
26	Insurance-Prop.Liab.Malpractice			1,457	1,457		1,457	28,696	30,153			26
27	Other (specify):*											27
28	TOTAL General Administration	117,805	2,686	324,169	444,660		444,660	(48,824)	395,836			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,321,327	235,738	571,105	2,128,170		2,128,170	(39,944)	2,088,226			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			8,697	8,697		8,697	44,774	53,471			30
31	Amortization of Pre-Op. & Org.							115,744	115,744			31
32	Interest			244	244		244	421,781	422,025			32
33	Real Estate Taxes			3,211	3,211		3,211	26,238	29,449			33
34	Rent-Facility & Grounds			392,624	392,624		392,624	(392,624)				34
35	Rent-Equipment & Vehicles			7,997	7,997		7,997	1,683	9,680			35
36	Other (specify):*											36
37	TOTAL Ownership			412,773	412,773		412,773	217,596	630,369			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,307		21,307		21,307		21,307			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,109	129,109		129,109		129,109			42
43	Other (specify):*		340	53,723	54,063		54,063	(54,063)				43
44	TOTAL Special Cost Centers		21,647	182,832	204,479		204,479	(54,063)	150,416			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,321,327	257,385	1,166,710	2,745,422		2,745,422	123,589	2,869,011			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	(2,820)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,698)	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	(1,539)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(210)	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	(33,061)	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				24
25	Fund Raising, Advertising and Promotional	(490)	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	(15,133)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,951)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	182,540	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 182,540		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 123,589		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	Pet Expense	\$ (1,286)	43	1
2	Labs-Part A	(11,508)	43	2
3	X-Rays-Part A	(1,351)	43	3
4	Offset Transportation Revenue	(468)	11	4
5	Offset Miscellaneous Office Supplies Income	(6)	21	5
6	Disallowed Special Events	(514)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(15,133)		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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,635	\$ 4,635	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%	90	90	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	316	316	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,784	2,784	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%	4,343	4,343	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	161,400	Petersen Health Care Management, Inc.	100.00%	25,776	(135,624)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	15,226	15,226	12
13	V								13
14	Total			\$ 161,400			\$ 53,170	\$ * (108,230)	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%	\$ 2,373	\$ 2,373	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	28,739	28,739	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	7,889	7,889	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	48	48	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	15	15	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,320	3,320	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	506	506	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	4,692	4,692	22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	229	229	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	183	183	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,683	1,683	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			\$			\$ 49,677	\$ * 49,677	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	\$	Illini Land LLC	100.00%	\$	\$	15
16	V	26	Liability Insurance	\$	Illini Land LLC	100.00%	21,206	21,206	16
17	V	26	Property Insurance		Illini Land LLC	100.00%	6,286	6,286	17
18	V	26	Mortgage Insurance		Illini Land LLC	100.00%	698	698	18
19	V	30	Depreciation		Illini Land LLC	100.00%	41,621	41,621	19
20	V	31	Amortization		Illini Land LLC	100.00%	115,744	115,744	20
21	V	32	Interest		Illini Land LLC	100.00%	421,552	421,552	21
22	V	33	Real Estate Taxes		Illini Land LLC	100.00%	26,055	26,055	22
23	V	34	Rent-Facility & Grounds	392,624	Illini Land LLC	100.00%		(392,624)	23
24	V	43	Service Charges		Illini Land LLC	100.00%	55	55	24
25	V	21	Administrative Expense		Illini Land LLC	100.00%	500	500	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			\$ 392,624			\$ 633,717	\$ * 241,093	39

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

Facility Name & ID Number Farmer City Rehab & Health Care Center # 0050922 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,	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 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 L	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 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 Farmer City Rehab & Health Care Center# 0050922

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 Farmer City Rehab & Health Care Center# 0050922

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

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 Farmer City Rehab & Health Care Center# 0050922

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	17,407	\$ 4,635	1
2	2	Food	Resident Days	1,282,791	75	0	0	17,407	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	17,407	90	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	17,407	316	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	17,407	2,784	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	17,407	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	17,407	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	17,407	4,343	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	17,407	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	17,407	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	17,407	25,776	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	17,407	15,226	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	17,407	2,373	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	17,407	28,739	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	17,407	7,889	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	17,407	48	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	17,407	15	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	17,407	3,320	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	17,407	506	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	17,407	4,692	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	17,407	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	17,407	229	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	17,407	183	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	17,407	1,683	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 102,847	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	Capmark		X	Mortgage	\$9,733.93	11/26/02	\$ 1,395,000	\$ Paid	11/26/32	0.0570	\$ 9,273	1
2	Sector		X	Mortgage	Varies	4/1/20	5,081,913	5,075,958	3/31/23	Varies	412,542	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$9,733.93		\$ 6,476,913	\$ 5,075,958			\$ 421,815	9
	B. Non-Facility Related*											
10								Interest Income Offset			(19)	10
11								Home Office Allocation-PHCM			229	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 210	14
15	TOTALS (line 9+line14)						\$ 6,476,913	\$ 5,075,958			\$ 422,025	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

[illegible]

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Farmer City Rehab & Health Care Center

COUNTY

DeWitt

FACILITY IDPH LICENSE NUMBER

0050922

CONTACT PERSON REGARDING THIS REPORT

MIKE KOCHER

TELEPHONE

(309)689-5850

FAX #:

(309)691-8622

A. **Summary of Real Estate Tax Cost**

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-28-152-006</u>	<u>Long-Term Care Facility</u>	\$ <u>27,406.08</u>	\$ <u>27,406.08</u>
2. <u>05-28-152-010</u>	<u>Long-Term Care Facility</u>	\$ <u>911.68</u>	\$ <u>911.68</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>28,317.76</u></u>	\$ <u><u>28,317.76</u></u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,024

B. General Construction Type: Exterior Brick Frame Block

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 254,467

2. Number of Years Over Which it is Being Amortized: 3

3. Current Period Amortization: 115,744

4. Dates Incurred: 2020

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	130,168	2011	\$ 101,000	1
2					2
3	TOTALS	130,168		\$ 101,000	3

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Farmer City Rehab & Health Care Center

0050922

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	56		2011	1964	\$ 757,118		25	30,285	\$ 30,285	\$ 287,707	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler Repair			2009	3,584		7			3,584	9
10	Roof			2009	12,849		25	514	514	5,911	10
11	Door-Main Entrance			2009	3,698		10			3,698	11
12	Fire Alarm Panel			2010	4,728		7			4,725	12
13	A/C Unit			2010	6,850		15	456	456	4,788	13
14	Water Heater			2011	7,523		7			7,523	14
15	Grain Softeners			2011	11,950		7			11,950	15
16	Windows			2013	37,540		25	1,502	1,502	11,265	16
17	Roof Replacement			2015	149,875		25	5,996	5,996	32,978	17
18	Water Pipe Repair			2016	3,018		7	432	432	1,944	18
19	Garage Roof Replacement			2016	4,543		7	650	650	2,925	19
20	A/C Unit-Kitchen Area			2016	3,750		15	250	250	1,125	20
21	Rocks for Parking Lot			2017	1,600		15	106	106	371	21
22	Tree Trimming			2017	3,095		7	442	442	1,547	22
23	Air Conditioner			2018	4,910		15	328	328	820	23
24	Painting of Patient Hallways, Dining Room Walls			2018	15,450		15	1,030	1,030	2,575	24
25	Water Heater			2019	9,858		7	1,408	1,408	2,112	25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					1,502			(1,502)		30
31	Building Booked					30,285			(30,285)		31
32	Building Improvement Booked					14,393			(14,393)		32
33											33
34	2020-Home Office Allocation-Building Improvements				8,801			211	211		34
35	2020-Home Office Allocation-Land Improvements				883			56	56		35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$1,051,623	\$46,180		\$43,666	\$(2,514)	\$387,548	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	\$56,883	\$3,327	\$4,772	\$1,445	5-10 yrs.	\$43,711	71
72	Current Year Purchases	8,510	811	608	(203)	7 yrs.	608	72
73	Fully Depreciated Assets	174,278					174,378	73
74	Home Office Allocation			4,425	4,425			74
75	TOTALS	\$239,671	\$4,138	\$9,805	\$5,667		\$218,697	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	2012 Van	2012	\$18,742	\$	\$	\$		\$18,742	76
77										77
78										78
79										79
80	TOTALS			\$18,742	\$	\$	\$		\$18,742	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)	\$1,411,03681
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$50,31882
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$53,47183
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$3,15384
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$624,98785

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: \$ 9,680 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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

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

* 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.

Farmer City Rehab & Health Care Center
0050922

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	\$	2,768
Dishwasher		701
Copier		4,528
Home Office Allocation		<u>1,683</u>
		<u><u>9,680</u></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	\$	4,485	\$ 67,281	\$	4,485	\$ 67,281	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		299	4,490		299	4,490	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	3080 hrs	48,420	5,745	86,180		8,825	134,600	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				21,307		21,307	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			\$ 48,420	10,529	\$ 157,951	\$ 21,307	13,609	\$ 227,678	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	\$ 1,118,929	\$ 1,119,129	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 75,483)	284,356	284,356	3
4	Supply Inventory (priced at Cost)	7,857	7,857	4
5	Short-Term Investments			5
6	Prepaid Insurance	44,179	21,046	6
7	Other Prepaid Expenses	392,749	392,749	7
8	Accounts Receivable (owners or related parties)	1,515,154	1,532,912	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,363,224	\$ 3,358,049	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		101,000	13
14	Buildings, at Historical Cost		765,919	14
15	Leasehold Improvements, at Historical Cost	120,541	285,704	15
16	Equipment, at Historical Cost	95,413	258,413	16
17	Accumulated Depreciation (book methods)	(151,209)	(624,987)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		254,467	19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs		(106,860)	20
21	Restricted Funds	40,136	448,902	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	2,689,083	2,689,083	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,793,964	\$ 4,071,641	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,157,188	\$ 7,429,690	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 471,420	\$ 477,428	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,077	56,077	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	71,212	71,212	31
32	Accrued Real Estate Taxes(Sch.IX-B)	(24,195)	29,160	32
33	Accrued Interest Payable		60,944	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	253	253	36
37	Accrued Management Fees	24,944	24,944	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 599,711	\$ 720,018	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,075,958	40
41	Bonds Payable			41
42	Deferred Compensation	450,774	450,774	42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	991,546	(3,046,036)	43
44	Loan Payable-MCAD Adv. Payment	30,000	30,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,472,320	\$ 2,510,696	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,072,031	\$ 3,230,714	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,085,157	\$ 4,198,976	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,157,188	\$ 7,429,690	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,599,459	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(75,632)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,523,827	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,561,330	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,561,330	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)	\$ 4,085,157	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Farmer City Rehab & Health Care Center

0050922

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	\$ 3,318,193	1
2	Discounts and Allowances for all Levels	(357,452)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,960,741	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	230,526	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 230,526	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	2,820	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	28,175	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,954	20
21	Other Medical Services	1,414	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 35,363	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	468	28
28a	Miscellaneous and IL Cares Act Revenue	1,079,654	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,080,122	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,306,752	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	564,096	31
32	Health Care	1,119,414	32
33	General Administration	444,660	33
	B. Capital Expense		
34	Ownership	412,773	34
	C. Ancillary Expense		
35	Special Cost Centers	75,370	35
36	Provider Participation Fee	129,109	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,745,422	40
41	Income before Income Taxes (line 30 minus line 40)**	1,561,330	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,561,330	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,730,922	44
45	Private Pay - Net Inpatient Revenue	906,716	45
46	Medicare - Net Inpatient Revenue	262,319	46
47	Other-(specify) Insurance Net Inpatient Revenue	60,784	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,960,741	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	1,907	1,907	\$ 69,000	\$ 36.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	726	726	22,699	31.27	3
4	Licensed Practical Nurses	7,047	7,238	177,429	24.51	4
5	CNAs & Orderlies	28,673	29,073	374,786	12.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,947	3,080	48,420	15.72	8
9	Activity Director	2,031	2,069	29,852	14.43	9
10	Activity Assistants	1,644	1,648	21,104	12.81	10
11	Social Service Workers	1,988	2,068	30,579	14.79	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	44,696	21.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,494	10,700	121,089	11.32	15
16	Dishwashers					16
17	Maintenance Workers	4,066	4,157	66,230	15.93	17
18	Housekeepers	3,453	3,579	53,738	15.01	18
19	Laundry	1,858	1,914	26,904	14.06	19
20	Administrator	2,080	2,080	78,996	37.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,883	1,915	38,809	20.27	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	2,092	2,179	59,934	27.51	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	3,102	3,187	57,062	17.90	33
34	TOTAL (lines 1 - 33)	78,071	79,600	\$ 1,321,327 *	\$ 16.60	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	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,460	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)		\$ 17,460		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	37	1,183	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	37	\$ 1,183		53

Farmer City Rehab & Health Care Center
0050922
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		1,347	1,349	26.78
Transportation		1,755	1,838	11.39
	TOTAL	3,102	3,187	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Crystal Simmons	Administrator	0	\$ 78,996
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 78,996
(List each licensed administrator separately.)			
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 161,400
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 161,400
(Attach a copy of any management service agreement)			
C. Professional Services			
Vendor/Payee	Type		Amount
Mediacom	Computer Services		\$ 1,716
Ginoli & Co.	Accounting Fees		4,380
Ability Network	Computer Services		6,024
Illinois Secretary of State	Legal Fees		150
Sector	Legal Fees		473
TOTAL (agree to Schedule V, line 19, column 3)			\$ 12,743
(For legal fee disclosure, see page 39 of instructions)			
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 13,534
Unemployment Compensation Insurance			7,190
FICA Taxes			91,713
Employee Health Insurance			4,554
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			700
Home Office Allocation			7,889
Employee Retirement			167
Administrator Benefits			15,804
TOTAL (agree to Schedule V, line 22, col.8)			\$ 141,551
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,990
Advertising: Employee Recruitment			1,735
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks	24		720
Miscellaneous Licenses & Permits			796
Home Office Allocation			2,373
Less: Public Relations Expense		(	
Non-allowable advertising		(	
Yellow page advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 7,614
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			15
Entertainment Expense		(	
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 15

*** Attach copy of IMRF notifications**

****See instructions.**

Farmer City Rehab & Health Care Center
0050922
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)		12,743
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	268
Duane Morris	Legal	375
Lexis Nexis	Legal	7
Livingston, Barger, Brant, Schroeder	Legal	14
Miller, Hall, Triggs	Legal	46
Miscellaneous	Legal	17
SB2	Legal	138
SmithAmundsen LLC	Legal	856
Sorling Northrup	Legal	244
CliftonLarsonAllen	Accounting	1,064
Ginoli & Co.	Accounting	760
Ability Network	Computer Services	2,732
Allscripts	Computer Services	431
AOD Matrix Care	Computer Services	4,799
AT&T	Computer Services	5
ATS	Computer Services	262
CCH	Computer Services	15
Charter Communications	Computer Services	24
Citrix Systems	Computer Services	81
Comcast	Computer Services	28
ITSavvy	Computer Services	126
Kemper Technology	Computer Services	624
Miscellaneous	Computer Services	180
Pearl Technology	Computer Services	113
Stratus Networks	Computer Services	496
TR Professional	Computer Services	11
David Budde	Other Prof Fees	11
DJ Howard and Associates	Other Prof Fees	21
Getzler Henrich & Associates	Other Prof Fees	84
LRI Consulting Services	Other Prof Fees	82
McQuellon Consulting	Other Prof Fees	52
Miscellaneous	Other Prof Fees	41
Optimizer	Other Prof Fees	44
Registered Agent Solutions	Other Prof Fees	25
RSM McGladrey	Other Prof Fees	271
SB2	Other Prof Fees	346
Sedgwick CMS	Other Prof Fees	467
Tarver Program Consultants	Other Prof Fees	65
Total (agree to Schedule V, line 19, column 8)		27,968

Farmer City Rehab & Health Care Center
0050922

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

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	1,448
Auto Repairs		1,091
Home Office Allocation		<u>3,321</u>
		<u>5,860</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?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
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.
\$
Line

24,256
10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$
129,109
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
\$
Has any meal income been offset against related costs?
Indicate the amount. \$

0
Yes
2,820
- (16)

Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No
Yes
468
100
Yes
Yes
- g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli and Company
- (18)

Have all costs which do not relate to the provision of long term care been adjusted 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.
Attach invoices and a summary of services for all architect and appraisal fees.

No