

		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: 0055798

Facility Name: Flanagan Rehabilitation HCC

Address: 201 E Falcon Highway Flanagan 61740
Number City Zip Code

County: Livingston

Telephone Number: 815-796-2267 Fax # 815-796-4434

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2007

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Mark Petersen
(Title) Chief Executive Officer

Paid
Preparer

(Signed) _____ (Date) _____
(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 Flanagan Rehabilitation HCC

0055798 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>43</u>	Skilled (SNF)	<u>43</u>	<u>15,695</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>32</u>	Skilled (SNF)	<u>32</u>	<u>11,680</u>	5
6		ICF/DD 16 or Less			6
7	<u>75</u>	TOTALS	<u>75</u>	<u>27,375</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>6,789</u>	<u>1,230</u>	<u>8,019</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	<u>9,526</u>			<u>9,526</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,526</u>	<u>6,789</u>	<u>1,230</u>	<u>17,545</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.09%

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)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 11/1/2007

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/1/2007 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 43 and days of care provided 1,193

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 Flanagan Rehabilitation HCC # 0055798 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	175,868	22,797	433	199,098		199,098	4,672	203,770			1
2	Food Purchase		151,648		151,648		151,648	(7,482)	144,166			2
3	Housekeeping	79,304	17,834		97,138		97,138	90	97,228			3
4	Laundry	25,371	7,022		32,393		32,393		32,393			4
5	Heat and Other Utilities			57,753	57,753		57,753	319	58,072			5
6	Maintenance	41,374	5,462	22,621	69,457		69,457	2,806	72,263			6
7	Other (specify):*											7
8	TOTAL General Services	321,917	204,763	80,807	607,487		607,487	405	607,892			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	893,954	71,552	64,179	1,029,685		1,029,685	(115)	1,029,570			10
10a	Therapy		14	265,588	265,602		265,602		265,602			10a
11	Activities	25,659	27		25,686		25,686	(1,242)	24,444			11
12	Social Services	42,122			42,122		42,122		42,122			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	961,735	71,593	334,567	1,367,895		1,367,895	(1,357)	1,366,538			16
	C. General Administration											
17	Administrative	75,996		164,000	239,996		239,996	(138,019)	101,977			17
18	Directors Fees											18
19	Professional Services			11,270	11,270		11,270	15,346	26,616			19
20	Dues, Fees, Subscriptions & Promotions			2,882	2,882		2,882	2,392	5,274			20
21	Clerical & General Office Expenses	28,619	2,127	12,755	43,501		43,501	28,942	72,443			21
22	Employee Benefits & Payroll Taxes			163,943	163,943		163,943	7,952	171,895			22
23	Inservice Training & Education							48	48			23
24	Travel and Seminar							15	15			24
25	Other Admin. Staff Transportation			3,829	3,829		3,829	3,347	7,176			25
26	Insurance-Prop.Liab.Malpractice			32,284	32,284		32,284	1,781	34,065			26
27	Other (specify):*											27
28	TOTAL General Administration	104,615	2,127	390,963	497,705		497,705	(78,196)	419,509			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,388,267	278,483	806,337	2,473,087		2,473,087	(79,148)	2,393,939			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			5,273	5,273		5,273	54,032	59,305			30
31	Amortization of Pre-Op. & Org.							35,700	35,700			31
32	Interest							154,665	154,665			32
33	Real Estate Taxes			336	336		336	43,193	43,529			33
34	Rent-Facility & Grounds			231,662	231,662		231,662	(231,662)				34
35	Rent-Equipment & Vehicles			7,165	7,165		7,165	1,696	8,861			35
36	Other (specify):*											36
37	TOTAL Ownership			244,436	244,436		244,436	57,624	302,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,519		21,519		21,519		21,519			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,797	121,797		121,797		121,797			42
43	Other (specify):*		1,205	55,662	56,867		56,867	(56,867)				43
44	TOTAL Special Cost Centers		22,724	177,459	200,183		200,183	(56,867)	143,316			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,388,267	301,207	1,228,232	2,917,706		2,917,706	(78,391)	2,839,315			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,916)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,930)	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	(4,181)	30		9
10	Interest and Other Investment Income	(160)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(366)	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	(16,044)	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	(24,000)	43		24
25	Fund Raising, Advertising and Promotional	(2,080)	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	(15,772)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (74,449)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(3,942)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,942)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (78,391)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,833)	43	1
2	X-Rays-Part A	(1,534)	43	2
3	Disallowed Special Events	217	43	3
4	Offset Transportation Revenue	(1,242)	11	4
5	Pet Expense	(297)	43	5
6	Offset Nursing Supplies Revenue	(4,492)	10	6
7	Offset Office Supplies Revenue	(25)	21	7
8	Offset Meals on Wheels Revenue	(2,495)	2	8
9	Offset Vending Revenue	(71)	2	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(15,772)		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%	\$ 4,672	\$ 4,672	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%	319	319	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,806	2,806	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%	4,377	4,377	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	164,000	Petersen Health Care Management, Inc.	100.00%	25,981	(138,019)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	15,346	15,346	12
13	V								13
14	Total			\$ 164,000			\$ 53,591	\$ * (110,409)	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%	\$ 2,392	\$	2,392 15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	28,967		28,967 16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	7,952		7,952 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%	3,347		3,347 20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	510		510 21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	4,729		4,729 22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		0 23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	230		230 24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	184		184 25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,696		1,696 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			\$			\$ 50,070	\$ *	50,070 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	\$	Flanagan Land, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	Flanagan Land, LLC	100.00%			16
17	V	21	Equipment		Flanagan Land, LLC	100.00%			17
18	V	26	Insurance-Property		Flanagan Land, LLC	100.00%	1,271	1,271	18
19	V	26	Insurance-Mortgage Insurance		Flanagan Land, LLC	100.00%			19
20	V	30	Depreciation		Flanagan Land, LLC	100.00%	53,484	53,484	20
21	V	31	Amortization		Flanagan Land, LLC	100.00%	35,700	35,700	21
22	V	32	Interest		Flanagan Land, LLC	100.00%	154,596	154,596	22
23	V	33	Real Estate Taxes		Flanagan Land, LLC	100.00%	43,008	43,008	23
24	V	34	Rent-Income and Grounds	231,662	Flanagan Land, LLC	100.00%		(231,662)	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			\$ 231,662			\$ 288,059	\$ * 56,397	39

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

Facility Name & ID Number

Flanagan Rehabilitation HCC

0055798

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Flanagan Rehabilitation HCC

0055798

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

Flanagan Rehabilitation HCC

0055798

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Flanagan Rehabilitation HCC

0055798

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Flanagan Rehabilitation HCC # 0055798 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 Flanagan Rehabilitation HCC# 0055798

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	17,545	\$ 4,672	1
2	2	Food	Resident Days	1,282,791	75	0	0	17,545	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	17,545	90	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	17,545	319	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	17,545	2,806	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	17,545	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	17,545	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	17,545	4,377	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	17,545	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	17,545	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	17,545	25,981	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	17,545	15,346	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	17,545	2,392	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	17,545	28,967	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	17,545	7,952	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	17,545	48	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	17,545	15	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	17,545	3,347	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	17,545	510	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	17,545	4,729	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	17,545	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	17,545	230	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	17,545	184	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	17,545	1,696	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 103,661	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	X-Caliber		X	Mortgage	Varies	12/1/19	2,176,550	\$ 2,176,550	11/30/2029	Varies	\$ 154,595	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 2,176,550	\$ 2,176,550			\$ 154,595	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(160)	10	
11								Home Office Allocation-PHCM			230	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 70	14	
15	TOTALS (line 9+line14)						\$ 2,176,550	\$ 2,176,550			\$ 154,665	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.

FACILITY NAME Flanagan Rehabilitation and Health Care Center COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0050591

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

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

A. Square Feet:

30,000

B. General Construction Type:

Exterior

Brick

Frame

Steel

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:

71,404

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

2

3. Current Period Amortization:

35,700

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	16,000	2007	\$ 30,000	1
2					2
3	TOTALS	16,000		\$ 30,000	3

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,088,704	\$ 52,822		\$ 49,422	\$ (3,400)	\$ 440,521	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	\$ 42,701	\$ 4,637	\$ 4,774	\$ 137	5-10 yrs.	\$ 25,148	71
72	Current Year Purchases	9,085	1,298	649	(649)	7 yrs.	649	72
73	Fully Depreciated Assets	158,327					158,327	73
74	Home Office Allocation			4,460	4,460			74
75	TOTALS	\$ 210,113	\$ 5,935	\$ 9,883	\$ 3,948		\$ 184,124	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	1,328,817
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	58,757
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	59,305
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	548
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	624,645

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: \$ 8,861 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.

Flanagan Rehabilitation HCC
0055798

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	\$	1,621
Dishwasher		701
Copier		4,843
Home Office Allocation		1,696
		<u>8,861</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			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	\$	6,370	\$ 95,552	\$	6,370	\$ 95,552	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,385	35,775		2,385	35,775	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		8,951	134,261	14	8,951	134,275	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				21,519		21,519	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			\$	17,706	\$ 265,588	\$ 21,533	17,706	\$ 287,121	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	\$ 118,676	\$ 118,676	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 26,986)	1,393,123	1,393,123	3
4	Supply Inventory (priced at Cost)	6,680	6,680	4
5	Short-Term Investments			5
6	Prepaid Insurance	14,828	16,099	6
7	Other Prepaid Expenses	136,825	136,825	7
8	Accounts Receivable (owners or related parties)		21,604	8
9	Other(specify): Employee Education Loans	410	410	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,670,542	\$ 1,693,417	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,000	30,000	13
14	Buildings, at Historical Cost		818,871	14
15	Leasehold Improvements, at Historical Cost	123,268	269,833	15
16	Equipment, at Historical Cost	9,085	210,113	16
17	Accumulated Depreciation (book methods)	(5,273)	(624,645)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		71,404	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(41,650)	20
21	Restricted Funds		369,794	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	987,465	965,861	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,120,545	\$ 2,069,581	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,791,087	\$ 3,762,998	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 574,443	\$ 574,443	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,432	62,432	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	238	44,570	32
33	Accrued Interest Payable		13,401	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	80,104	80,104	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 717,217	\$ 774,950	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,176,550	40
41	Bonds Payable			41
42	Deferred Compensation	72,350	72,350	42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-SBA PPP	285,600	285,600	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 357,950	\$ 2,534,500	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,075,167	\$ 3,309,450	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,715,920	\$ 453,548	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,791,087	\$ 3,762,998	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (738,406)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	1,822,154	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,083,748	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	632,172	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)	\$ 632,172	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)	\$ 1,715,920	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Flanagan Rehabilitation HCC

0055798

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	\$ 3,004,625	1
2	Discounts and Allowances for all Levels	(193,661)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,810,964	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	416,167	6
7	Oxygen	122	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 416,289	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	7,482	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	29,402	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,509	20
21	Other Medical Services	3,277	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 48,670	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	160	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 160	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	1,242	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	272,553	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 273,795	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,549,878	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	607,487	31
32	Health Care	1,367,895	32
33	General Administration	497,705	33
	B. Capital Expense		
34	Ownership	244,436	34
	C. Ancillary Expense		
35	Special Cost Centers	78,386	35
36	Provider Participation Fee	121,797	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,917,706	40
41	Income before Income Taxes (line 30 minus line 40)**	632,172	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 632,172	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,582,100	44
45	Private Pay - Net Inpatient Revenue	779,886	45
46	Medicare - Net Inpatient Revenue	442,032	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	6,946	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,810,964	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,290	2,374	\$ 72,172	\$ 30.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,121	5,221	189,305	36.26	3
4	Licensed Practical Nurses	3,589	3,739	93,309	24.96	4
5	CNAs & Orderlies	32,046	32,799	481,344	14.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,523	1,596	25,437	15.94	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	42,122	20.25	11
12	Dietician					12
13	Food Service Supervisor	1,741	1,813	42,699	23.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,796	13,125	133,169	10.15	15
16	Dishwashers					16
17	Maintenance Workers	1,763	1,906	41,374	21.71	17
18	Housekeepers	6,624	6,758	79,304	11.73	18
19	Laundry	1,868	1,988	25,371	12.76	19
20	Administrator	1,992	2,080	75,996	36.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,033	2,129	28,619	13.44	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	2,315	2,379	58,046	24.40	33
34	TOTAL (lines 1 - 33)	77,781	79,987	\$ 1,388,267 *	\$ 17.36	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	8	\$ 433	L1, C3	35
36	Medical Director	Monthly	4,800	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,872	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	230	L10, C3	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)	12	\$ 13,335		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	1,958	54,156	L10,C3	51
52	Certified Nurse Assistants/Aides	120	1,921	L10,C3	52
53	TOTAL (lines 50 - 52)	2,078	\$ 56,077		53

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Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		Average Hourly Wage
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	
Care Plan Coordinator		2,293	2,357	24.53
Transportation		22	22	10.09
	TOTAL	2,315	2,379	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Gregory Green	Administrator	0	\$ 75,996
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,996
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 164,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 164,000
C. Professional Services			
Vendor/Payee	Type		Amount
Frontier	Computer Services		\$ 1,563
Ability Network	Computer Services		7,052
CliftonLarson Allen	Accounting Fees		1,155
RASI Entity Staffing	Professional Fees		1,500
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 11,270
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 18,161
Unemployment Compensation Insurance			25,789
FICA Taxes			97,971
Employee Health Insurance			3,339
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			317
Home Office Allocation			7,952
Employee Retirement			3,162
Administrator Benefits			15,204
TOTAL (agree to Schedule V, line 22, col.8)			\$ 171,895
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			\$ 1,729
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 16)			
Patient Background Checks	19		555
Miscellaneous Licenses & Permits			598
Home Office Allocation			2,392
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 5,274
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			15
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 15

*** Attach copy of IMRF notifications**

****See instructions.**

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Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		11,270
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	270
Duane Morris	Legal	378
Lexis Nexis	Legal	7
Livingston, Barger, Brant, Schroeder	Legal	14
Miller, Hall, Triggs	Legal	47
Miscellaneous	Legal	17
SB2	Legal	140
SmithAmundsen LLC	Legal	863
Sorling Northrup	Legal	246
CliftonLarsonAllen	Accounting	1,073
Ginoli & Co.	Accounting	766
Ability Network	Computer Services	2,754
Allscripts	Computer Services	435
AOD Matrix Care	Computer Services	4,837
AT&T	Computer Services	5
ATS	Computer Services	264
CCH	Computer Services	15
Charter Communications	Computer Services	24
Citrix Systems	Computer Services	82
Comcast	Computer Services	28
ITSavvy	Computer Services	127
Kemper Technology	Computer Services	629
Miscellaneous	Computer Services	122
Pearl Technology	Computer Services	114
Stratus Networks	Computer Services	499
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	85
LRI Consulting Services	Other Prof Fees	83
McQuellon Consulting	Other Prof Fees	52
Miscellaneous	Other Prof Fees	100
Optimizer	Other Prof Fees	45
Registered Agent Solutions	Other Prof Fees	25
RSM McGladrey	Other Prof Fees	273
SB2	Other Prof Fees	349
Sedgwick CMS	Other Prof Fees	470
Tarver Program Consultants	Other Prof Fees	65
Total (agree to Schedule V, line 19, column 8)		<u>26,616</u>

Flanagan Rehabilitation HCC
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Period Beginning 1/1/2020
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Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	790
Auto Repairs		2,841
Mileage-Travel		198
Home Office Allocation		<u>3,347</u>
		<u><u>7,176</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? No
If YES, give association name and amount. _____

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,815 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. \$ 121,797
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. \$ 4,916

(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. \$ 1,242
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.