

		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: 0035246 Facility Name: Henderson County Ret Center Address: 604 Oakwood Drive Stronghurst 61480 Number City Zip Code County: Hendersson Telephone Number: 309-924-1123 Fax # 309-924-1926 HFS ID Number: Date of Initial License for Current Owners: 06/28/89 Type of Ownership: ☒ VOLUNTARY, NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501c3 ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: James G. Hull, CPA Telephone Number: 217-228-1950

Email Address:

Henderson County Retirement Center, Inc.
#0035246
01/01/20 to 12/31/20

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$3,649.43
REPAIRS & MAINT LAUNDRY	\$148.30
REPAIRS & MAINT HSK	\$0.00
OUTSIDE SERVICES	\$10,999.31
REPAIRS & MAINT BUILDING	\$12,487.21
REPAIRS & MAINT EQUIP	\$3,338.40
REPAIRS & MAINT GROUNDS	\$4,059.29
CABLE	\$10,485.56
REFUSE	\$6,373.33
EXTERMINATOR	\$1,885.00
REPAIRS & MAINT GEN/ADM	\$1,981.67
TOTAL	<u>\$55,407.50</u>

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	\$6,438.30
BOARD MINUTES	\$250.00
TOTAL	<u>\$6,688.30</u>

Schedule V. Line 14 & 25, Column 2

Auto Exp. & Service	\$1,209.07
Auto Gas & Oil	\$1,993.67
Business Mileage Expense	\$468.21

	<u>\$3,670.95</u>
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Schedule V. Line 43, Column3

Bad Debt
Rounding

\$3,967.00
<u>\$3,967.00</u>

Schedule V. Line 27, Column3

Contributions
Sales Tax
Misc Exp.
Rounding
bank fees

\$0.00
\$546.23
\$2,759.75
\$0.00
\$7.50
<u>\$3,313.48</u>

Schedule XX. Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Transportation Income-Pvt
Transportation Income-IDPA
Suppliments
WheelChair Rental
Admission Income
Uniform Sales
Activities Program Income
Personal Purchase income
Education, In-Servive

\$5,634.60
\$0.00
\$8,397.00
\$2,963.29
\$500.00
\$312.41
\$0.00
\$0.00
\$0.00

SLF Allocations-Clerical	\$8,319.96
SLF Allocations-Maintenance	\$14,617.20
Gain or Loss on Sale of Asset	\$3,500.00
Rebates	\$87.00
Discounts	\$0.00
Dues	\$0.00
Misc. Income	\$1,992.61
Rounding	
	<u>\$46,324.07</u>

Schedule XIX, Section F.

Leading Age	Dues	\$3,274.32
Assoc of Nutrition	Dues	\$157.00
Amazon	Subscription	\$96.85
AADNS	Membership	\$207.00
Creative Forcasters	Subscription	\$72.00
CNASU	Membership	\$30.00
Misc Subscriptions	subscriptions per DK	\$297.00
Activity Connect	Web Subscription/Dues	\$180.00
IL Charity Buraeu	990-g Fee	\$15.00
Secretary of State	Fees	\$176.00
Crister's Title	Vehicle Title	\$89.00
		<u>\$4,594.17</u>

Schedule XIX, Section C.

Go Daddy	Website	\$2,201.23
Dment	Website Hosting	\$383.40
Ability	Date Processing	\$2,639.35

TimeTrak

Payroll Software

\$2,901.50

\$8,125.48

Schedule XI, Section D.

Use	Make, Model and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
79 Patient Transport	Van	2012	\$9,105.00	\$0.00	\$0.00		5	\$9,105.00
80 Patient Transport	2014 Dodge Caravan	2014	\$38,078.27	\$0.00	\$0.00		5	\$38,078.27
81 Maintenance	Used Ford f350 Truck	2020	\$11,175.00	\$372.50	\$372.50		5	\$372.50
82 Maintenance	Snow Plow	2020	\$5,750.00	\$95.83	\$95.83		5	\$95.83
			<u>\$64,108.27</u>	<u>\$468.33</u>	<u>\$468.33</u>	<u>\$0.00</u>		<u>\$47,651.60</u>

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	187,973	25,585	5,266	218,824		218,824		218,824			1
2	Food Purchase		112,407		112,407		112,407	(2,761)	109,646			2
3	Housekeeping	86,810	12,111		98,921		98,921		98,921			3
4	Laundry	34,544	320		34,864		34,864	(764)	34,100			4
5	Heat and Other Utilities			62,432	62,432		62,432		62,432			5
6	Maintenance	79,145	10,978	55,408	145,531		145,531	(14,617)	130,914			6
7	Other (specify):*											7
8	TOTAL General Services	388,472	161,401	123,106	672,979		672,979	(18,142)	654,837			8
	B. Health Care and Programs											
9	Medical Director			14,296	14,296		14,296		14,296			9
10	Nursing and Medical Records	1,064,842	113,497	3,214	1,181,553		1,181,553		1,181,553			10
10a	Therapy		128	162,119	162,247		162,247		162,247			10a
11	Activities	63,880	7,292	1,512	72,684		72,684		72,684			11
12	Social Services	45,498		1,512	47,010		47,010		47,010			12
13	CNA Training											13
14	Program Transportation	3,037			3,037		3,037		3,037			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,177,257	120,917	182,653	1,480,827		1,480,827		1,480,827			16
	C. General Administration											
17	Administrative	98,629			98,629		98,629		98,629			17
18	Directors Fees											18
19	Professional Services			62,261	62,261		62,261		62,261			19
20	Dues, Fees, Subscriptions & Promotions			13,064	13,064		13,064	(4,119)	8,945			20
21	Clerical & General Office Expenses	40,942	10,750	6,688	58,380		58,380	(8,320)	50,060			21
22	Employee Benefits & Payroll Taxes			277,189	277,189		277,189		277,189			22
23	Inservice Training & Education			965	965		965		965			23
24	Travel and Seminar			489	489		489		489			24
25	Other Admin. Staff Transportation		3,671		3,671		3,671		3,671			25
26	Insurance-Prop.Liab.Malpractice			62,628	62,628		62,628		62,628			26
27	Other (specify):*			3,313	3,313		3,313	(546)	2,767			27
28	TOTAL General Administration	139,571	14,421	426,597	580,589		580,589	(12,985)	567,604			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,705,300	296,739	732,356	2,734,395		2,734,395	(31,127)	2,703,268			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			122,061	122,061		122,061	(12,033)	110,028			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,452	13,452		13,452	(12,398)	1,054			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,096	1,096		1,096		1,096			35
36	Other (specify):*											36
37	TOTAL Ownership			136,609	136,609		136,609	(24,431)	112,178			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,164		39,164		39,164		39,164			39
40	Barber and Beauty Shops		606	1,654	2,260		2,260		2,260			40
41	Coffee and Gift Shops		7,786		7,786		7,786		7,786			41
42	Provider Participation Fee			102,757	102,757		102,757		102,757			42
43	Other (specify):*			3,967	3,967		3,967	(3,967)				43
44	TOTAL Special Cost Centers		47,556	108,378	155,934		155,934	(3,967)	151,967			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,705,300	344,295	977,343	3,026,938		3,026,938	(59,525)	2,967,413			45

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

Henderson County Retirement Center, Inc.

#0035246

01/01/20 to 12/31/20

Board Members

Diana Doran, Pres
Box 417
Carman, IL 61425

Judy Roessler
RR1, Box 11
Media, IL 61460

Jayne Olson
Box 1
Gladstone, IL 61437

Cindy Leake
PO Box 468
Dallas City, IL 62330

Mary Reed, Treas.
RR 1, Box 80
Little York, IL 61453

Tom Pullen
Box 199
Gladstone, IL 61437

Nancy Stevenson, Sec.
RR 1
Gladstone, IL 61437

David Gerst
RR 1, Box 111
Lomax, IL 61454

Ralph Tatge, Vice Pres.
Box 535
Stronghurst, IL 61480

Honorary Board Members

Laura Kent Donahue
Zach Stamp

Diana Doran's insurance agency is the agent for the Commercial Package Policy.
The agency also provides the surety bond for the nursing home.

Henderson County Retirement Center, Inc.
#0035246
01/01/20 to 12/31/20

Reclassifications

1 Reclassify \$

2 Reclassify \$

3 Reclassify \$

4 Reclassify \$

5 Reclassify \$

6 Reclassify \$

Henderson County Retirement Center, Inc.
#0035246
01/01/20 to 12/31/20

Schedule V. Line 23, Column 3

Check Date	When Attended	Vendor Name	Name of In-Service	Amount
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\$	-
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Henderson County Retirement Center, Inc.
#0035246
01/01/20 to 12/31/20

Schedule V. Line 24, Column 3

Check Date	Vendor Name	Who Attended	When Attended	Where Attended	Name of Seminar	Expense	Amount	Totals	Training
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Henderson County Retirement Center, Inc.
#0035246
01/01/20 to 12/31/20

Schedule XIV Attatchment

Service	Sched V	Outside Practitioner Units	Cost	Supplies	Total Units	Total Costs
Labs-Medicare	10a-3		\$3,280.85		\$0.00	\$3,280.85
EEG-Medicare	10a-3		\$477.60		\$0.00	\$477.60
Radiology-Medicare	10a-3		\$3,496.89		\$0.00	\$3,496.89
IV Therapy	10a-3		\$0.00		\$0.00	\$0.00
Total		0	\$7,255.34	0	0	\$7,255.34

* Units for Therapy are in billed by minute.

2020 Census
01/01/20 to 12/31/20

Months	Pvt Pay	Medicaid	Medicare	Managed Care	Totals	Total columus
20-Jan	599	455	146	0	1200	1200
20-Feb	613	440	139		1192	1192
20-Mar	622	482	94	0	1198	1198
20-Apr	560	526	9		1095	1095
20-May	502	503	79		1084	1084
20-Jun	432	539	193		1164	1164
20-Jul	451	557	204		1212	1212
20-Aug	377	567	122		1066	1066
20-Sep	361	510	65		936	936
20-Oct	324	543	53	22	942	942
20-Nov	358	548	21	1	928	928
20-Dec	315	477	89	13	894	894
Totals	5514	6147	1214	36	12911	12911

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	(2,674)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(764)	4		8
9	Non-Straightline Depreciation	(37)	30		9
10	Interest and Other Investment Income	(12,398)	32		10
11	Discounts, Allowances, Rebates & Refunds	(87)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(546)	27		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				18
19	Entertainment				19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,967)	43		24
25	Fund Raising, Advertising and Promotional	(4,119)	20		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	(34,933)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (59,525)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (59,525)		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	Lease Buyout	\$ (11,996)	30	1
2	Allocation of Wages SLF-Clerical	(8,320)	21	2
3	Allocation of Wages SLF-Maintenance	(14,617)	6	3
4				4
5				5
6				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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(34,933)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Henderson County Ret Center

0035246

Report Period Beginning:

01/01/20

Ending:

12/31/20

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,761)	0	0	0	0	0	0	0	0	0	0	(2,761)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(764)	0	0	0	0	0	0	0	0	0	0	(764)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(14,617)	0	0	0	0	0	0	0	0	0	0	(14,617)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(18,142)	0	0	0	0	0	0	0	0	0	0	(18,142)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,119)	0	0	0	0	0	0	0	0	0	0	(4,119)	20
21	Clerical & General Office Expenses	(8,320)	0	0	0	0	0	0	0	0	0	0	(8,320)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(546)	0	0	0	0	0	0	0	0	0	0	(546)	27
28	TOTAL General Administration	(12,985)	0	0	0	0	0	0	0	0	0	0	(12,985)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(31,127)	0	0	0	0	0	0	0	0	0	0	(31,127)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/20 Ending: 12/31/20

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(12,033)	0	0	0	0	0	0	0	0	0	0	(12,033)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,398)	0	0	0	0	0	0	0	0	0	0	(12,398)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(24,431)	0	0	0	0	0	0	0	0	0	0	(24,431)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(3,967)	0	0	0	0	0	0	0	0	0	0	(3,967)	43
44	TOTAL Special Cost Centers	(3,967)	0	0	0	0	0	0	0	0	0	0	(3,967)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(59,525)	0	0	0	0	0	0	0	0	0	0	(59,525)	45

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

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

X 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
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

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								1
2								2
3								3
4								4
5								5
6								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 Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/20 Ending: 12/31/20

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											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.

Ending: 12/31/20**Fax Number**

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	Security Savings		X	Mortgage	\$10,306.88	10/22/08	\$ 849,849	\$ 227,254	08/01/39	4.2500	\$ 13,452	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$10,306.88		\$ 849,849	\$ 227,254			\$ 13,452	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 849,849	\$ 227,254			\$ 13,452	15	

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015		8	
		2016		9	
		2017		10	
		2018		11	
		2019		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

FACILITY NAME Henderson County Ret Center COUNTY Hendersson

FACILITY IDPH LICENSE NUMBER 0035246

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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

B. Real Estate Tax Cost Allocations

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

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

Page 10A

A. Square Feet: 18,636

B. General Construction Type: Exterior BrickFrame Wood/SteelNumber 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).
3 Non-Healthcare Related Rental Homes
30 Bed Supportive Living Center

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:

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

3. Current Period Amortization:

4. Dates Incurred:

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	Care Related	2,176,000	1988	\$ 15,000	1
2					2
3	TOTALS	2,176,000		\$ 15,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60		1989	1988	\$ 1,260,000	\$	30	\$	\$	1,260,000	4
5	6		2000	2000	530,989	13,301	30	13,275	(26)	270,732	5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT/LANDSCAPING			1989	25,102		20			25,102	9
10	LANDSCAPING			1990	937		20			937	10
11	LAND IMPROVEMENT			1995	1,839		20			1,839	11
12	BRICK SIGN			1996	12,915		20			12,915	12
13	LAND IMPROVEMENT			1992	2,003		20			2,003	13
14	LIGHTNING RODS			1998	3,600		15			3,600	14
15	NEW SOFFITS			1998	26,138		15			26,138	15
16	PHONE SYSTEM			1998	6,738		15			6,738	16
17	SIDE WALKS			1998	4,500		20			4,500	17
18	ALARM SYSTEM			1998	8,266		10			8,266	18
19	LAUNDRY/GARAGE BLDG			1999	50,330		15			50,330	19
20	STORAGE BLDG			1999	8,911		15			8,911	20
21	NEW ROOF			1999	16,311		15			16,311	21
22	LANDSCAPING			2000	1,706	71	20	71		1,706	22
23	FURNICE			2001	2,848		10			2,848	23
24	NEW EXIT			2001	1,645		15			1,645	24
25	LANDSCAPING			2002	954		10			954	25
26	GARAGE/STORAGE BUILDING			2002	12,800		15			12,800	26
27	ROOFING/SHINGLES			2003	17,838		15			17,838	27
28	Walk-in Freezer			2007	20,883	1,044	20	1,044		13,661	28
29	Window Tinting			2007	2,985	149	20	149		1,974	29
30	Door Closures			2007	4,345		10			4,345	30
31	Window Tinting			2008	1,164	58	20	58		747	31
32	Generator			2009	101,961	5,098	20	5,098		59,053	32
33	Fire Sprinkler			2010	17,425	1,162	15	1,162		12,198	33
34	Sprinkler Heads			2011	17,425	1,162	15	1,162		11,326	34
35	Parking Lot/Driveway			2011	30,280	2,030	15	2,019	(11)	19,623	35
36	400 Hall-Painting Labor			2012	11,822	591	20	590	(1)	4,923	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Henderson County Ret Center

0035246

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Dining Room Paint	2012	\$ 5,415	\$ 271	20	\$ 271	\$	\$ 2,188	37
38	Dining Room Flooring	2012	18,677	934	20	934		7,549	38
39	400 Hall-new Handraiols, Kickplates, Wall Coverings	2012	11,842	592	20	593	1	4,940	39
40	Door Alarms	2013	3,272	164	20	164		1,199	40
41	100 Hall-Flooring	2014	27,954	1,398	20	1,398		8,502	41
42	100 Hall-Painting Labor	2014	12,011	601	20	601		3,654	42
43	100 Hall-Construction Labor	2014	20,838	1,042	20	1,042		6,338	43
44	100 Hall-Wall Coverings	2014	8,363	418	20	418		2,544	44
45	100 Hall-Wall Plates	2014	1,724	86	20	86		525	45
46	100 Hall-Trim	2014	1,496	75	20	75		455	46
47	100 Hall-Building Materials	2014	10,572	529	20	529		3,216	47
48	100 Hall-Doors	2014	2,116	212	10	212		1,287	48
49	100 Hall-Shutters	2014	1,910	191	10	191		1,162	49
50	Storage Unit	2015	3,975	199	20	199		1,012	50
51	Flooring-Old Dining Room	2015	13,789	689	20	689		3,504	51
52	200 Hall-paint/wall paper	2016	12,497	625	20	625		3,124	52
53	200 Hall Door Frame Protectors	2016	3,485	174	20	174		871	53
54	200 Hall Flooring	2016	19,944	997	20	997		4,986	54
55	200 Hall Labor	2016	8,500	425	20	425		2,125	55
56	200 Hall-Water Line	2016	7,448	372	20	372		1,862	56
57	200 Hall-building Material	2016	2,504	125	20	125		626	57
58	200 Hall-Labor	2016	10,560	528	20	528		2,640	58
59	PT Room-Cabinetry	2017	8,799	440	20	440		1,613	59
60	PT Room-Materials/Labor	2017	64,213	3,211	20	3,211		11,773	60
61	PT Room-Glass Door	2017	5,074	254	20	254		930	61
62	PT Room-Flooring	2017	5,912	296	20	296		1,084	62
63	PT Room-Electric	2017	11,061	553	20	553		2,028	63
64	PT Room-Decorating Labor	2017	3,564	178	20	178		653	64
65	Day Room-Material/Labor	2017	22,869	1,143	20	1,143		4,002	65
66	Day Room-Flooring	2017	6,743	337	20	337		1,180	66
67	Day Room-WoodWork	2017	6,635	332	20	332		1,161	67
68	Day Room-Lighting	2017	2,418	121	20	121		423	68
69	Foyer-Material/Labor	2017	16,706	835	20	835		2,576	69
70	TOTAL (lines 4 thru 69)		\$ 2,567,546	\$ 43,013		\$ 42,976	\$ (37)	\$ 1,955,695	70

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

Facility Name & ID Number Henderson County Ret Center

0035246

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,567,546	\$ 43,013		\$ 42,976	\$ (37)	\$ 1,955,695	1
2	Foyer-Flooring	2017	24,730	1,236	20	1,236		3,812	2
3	Floyer-Lighting	2017	601	30	20	30		93	3
4	Central Core-Wall Coverings	2017	2,464	123	20	123		442	4
5	New Roof Nursing Home	2018	44,280	2,952	15	2,952		7,380	5
6	300 Hall-Flooring	2018	26,974	1,349	20	1,349		3,147	6
7	300 Hall-Plumbing	2018	2,433	122	20	122		284	7
8	300 Hall-Material/Labor	2018	31,103	1,555	20	1,555		3,629	8
9	300 Hall-Cabinets	2018	1,965	196	10	196		458	9
10	300 Hall-Shutters	2018	4,610	461	10	461		1,076	10
11	300 Hall-Lighting	2018	3,030	303	10	303		707	11
12	Shower Fire Door	2019	1,553	78	20	78		129	12
13	Parking Lot Resurface	2019	53,690	3,579	15	3,579		5,667	13
14	Rear Parking Lot Resurface	2019	51,760	3,451	15	3,451		5,176	14
15	Nursing Core- Counter tops/cabinets	2019	18,925	946	20	946		1,735	15
16	Nursing Core-Handrails	2019	1,447	72	20	72		133	16
17	Nursing Core- Flooring	2019	7,135	357	20	357		654	17
18	ATTIC FIREWALL	2020	1,854	77	20	77		77	18
19	NORTHWEST WING REMODEL	2020	6,912	288	20	288		288	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,853,011	\$ 60,188		\$ 60,151	\$ (37)	\$ 1,990,582	34

**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	\$ 389,359	\$ 43,412	\$ 43,412	\$	10	\$ 188,393	71
72	Current Year Purchases	25,142	2,094	2,094		8	2,094	72
73	Fully Depreciated Assets	811,782	3,903	3,903		10	811,782	73
74								74
75	TOTALS	\$ 1,226,283	\$ 49,409	\$ 49,409	\$		\$ 1,002,269	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	Patient Transportation	07 Dodge Caravan	2007	\$ 17,725	\$	\$	\$	5	\$ 17,725	76
77	Patient Transportation	06 Ford E450	2008	35,095				5	35,095	77
78	Maintenance & Snow Remov	1995 Ford F250	2011	9,000				5	9,000	78
79	See List	See List	See List	64,108	468	468		5	47,652	79
80	TOTALS			\$ 125,928	\$ 468	\$ 468	\$		\$ 109,472	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)	\$ 4,220,222	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 110,065	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 110,028	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (37)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,102,323	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Rental House	\$ 87,254	\$ 2,965	\$ 36,237	86
87	Rental House	60,160	2,039	12,066	87
88	Rental House	85,175	3,127	16,790	88
89	Assisted Living	3,331,043	105,678	696,139	89
90					90
91	TOTALS	\$ 3,563,632	\$ 113,809	\$ 761,232	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:
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.

		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:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$1,096Description: Oxygen Lease \$110.00, Copier Rent \$985.53
(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.

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

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	7,832	\$ 67,304	\$	7,832	\$ 67,304	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		81	8,239		81	8,239	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,008	79,321		1,008	79,321	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				39,164		39,164	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See List					7,255			7,255	13
14	TOTAL			\$	8,921	\$ 162,119	\$ 39,164	8,921	\$ 201,283	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	\$ 1,179,492	\$ 1,364,363	1
2	Cash-Patient Deposits		(32,280)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	338,622	422,628	3
4	Supply Inventory (priced at)	44,492	70,437	4
5	Short-Term Investments	568,012	611,018	5
6	Prepaid Insurance	26,641	44,200	6
7	Other Prepaid Expenses	9,783	14,903	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,167,042	\$ 2,495,269	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,500	22,500	13
14	Buildings, at Historical Cost	3,114,870	6,364,421	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,467,077	1,781,159	16
17	Accumulated Depreciation (book methods)	(3,435,060)	(4,196,291)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP</u>	1,181	10,645	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,170,568	\$ 3,982,434	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,337,610	\$ 6,477,703	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 59,293	\$ 65,669	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,635	110,412	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,037	4,037	31
32	Accrued Real Estate Taxes(Sch.IX-B)		4,982	32
33	Accrued Interest Payable	794	4,783	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Wage Garnishment</u>	(20)	(20)	36
37	<u>Rounding</u>		1	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 153,739	\$ 189,864	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	227,254	1,723,104	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 227,254	\$ 1,723,104	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 380,993	\$ 1,912,968	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,956,617	\$ 4,564,735	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,337,610	\$ 6,477,703	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,549,033	1
2	Restatements (describe):		2
3	Prior Period	(10,519)	3
4	PPP Loan Forgiveness	395,000	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,933,514	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	475,225	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) Supportive Division	161,442	15
16	Other (describe) Rental Division	(5,446)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 631,221	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)	\$ 4,564,735	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Henderson County Ret Center

0035246

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,631,920	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,631,920	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,776	6
7	Oxygen	560	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,336	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	2,580	12
13	Barber and Beauty Care	7,792	13
14	Non-Patient Meals	2,674	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	32,724	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	764	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 46,534	23
	D. Non-Operating Revenue		
24	Contributions	761,653	24
25	Interest and Other Investment Income***	12,398	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 774,051	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See List Attached</u>	46,324	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 46,324	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,502,165	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	672,979	31
32	Health Care	1,480,827	32
33	General Administration	580,589	33
	B. Capital Expense		
34	Ownership	136,609	34
	C. Ancillary Expense		
35	Special Cost Centers	53,177	35
36	Provider Participation Fee	102,757	36
	D. Other Expenses (specify):		
37	<u>Rounding</u>	2	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,026,940	40
41	Income before Income Taxes (line 30 minus line 40)**	475,225	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 475,225	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,003,821	44
45	Private Pay - Net Inpatient Revenue	969,360	45
46	Medicare - Net Inpatient Revenue	653,186	46
47	Other-(specify) <u>Managed Care</u>	5,553	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,631,920	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	1,877	2,091	\$ 74,531	\$ 35.64	1
2	Assistant Director of Nursing	755	898	27,098	30.18	2
3	Registered Nurses	5,482	6,311	188,356	29.85	3
4	Licensed Practical Nurses	8,885	10,158	243,466	23.97	4
5	CNAs & Orderlies	28,101	31,490	491,849	15.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,670	1,883	30,367	16.13	9
10	Activity Assistants	2,160	2,261	33,513	14.82	10
11	Social Service Workers	2,316	2,627	45,498	17.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,719	2,080	31,999	15.38	14
15	Cook Helpers/Assistants	4,900	5,239	66,215	12.64	15
16	Dishwashers	6,228	7,041	89,759	12.75	16
17	Maintenance Workers	4,216	4,517	79,145	17.52	17
18	Housekeepers	6,376	6,890	86,810	12.60	18
19	Laundry	1,749	2,140	34,544	16.14	19
20	Administrator	1,827	2,091	98,629	47.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,915	2,091	40,942	19.58	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 C: Care Plan	1,145	1,326	39,542	29.82	32
33	Other(specify) Transportation	130	130	3,037	23.36	33
34	TOTAL (lines 1 - 33)	81,451	91,264	\$ 1,705,300 *	\$ 18.69	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	64	\$ 5,266	1-3	35
36	Medical Director	contract	14,296	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	27	2,030	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	1,512	11-3	44
45	Social Service Consultant	12	1,512	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	115	\$ 24,616		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	37	1,184	10-3	52
53	TOTAL (lines 50 - 52)	37	\$ 1,184		53

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? Yes
If YES, give association name and amount. Leading Age 3274
- (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? _____
- (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? _____
- (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? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,624 Line 10-2
- (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. _____
- (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. \$ 102,757
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? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,674
- (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. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 99
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: Bennet & Middendorf
- (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.

Facility Name & ID Number Henderson County Ret Center

0035246 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 _____

	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	58	Skilled (SNF)	58	21,228	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	58	TOTALS	58	21,228	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	6,147	5,550	1,214	12,911	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,147	5,550	1,214	12,911	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.82%

D. How many bed reserve days during this year were paid by the Department? 0 (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)

n/a

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 06/28/1988

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 58 and days of care provided 1,214

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: 12/31/19 Fiscal Year: 12/31/19
* All facilities other than governmental must report on the accrual basis.