

		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: <u>0014464</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>THE IROQUOIS RESIDENT HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/2019</u> to <u>09/30/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>200 FAIRMAN AVENUE</u> <u>WATSEKA</u> <u>60970</u>																									
Number City Zip Code																									
County: <u>IROQUOIS COUNTY</u>																									
Telephone Number: <u>815-432-5841</u> Fax # <u>815-432-7870</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>SHAWN ADAMS</u> <u>SENIOR MANAGER</u></td></tr><tr><td>(Firm Name & Address) <u>BLUE & CO., LLC</u> <u>2650 EASTPOINT PKWY, LOUISVILLE KY 40223</u></td></tr><tr><td>(Telephone) <u>502-992-3500</u> Fax # <u>502-992-3508</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>SHAWN ADAMS</u> <u>SENIOR MANAGER</u>	(Firm Name & Address) <u>BLUE & CO., LLC</u> <u>2650 EASTPOINT PKWY, LOUISVILLE KY 40223</u>	(Telephone) <u>502-992-3500</u> Fax # <u>502-992-3508</u>												
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	(Telephone) <u>502-992-3500</u> Fax # <u>502-992-3508</u>																								
Date of Initial License for Current Owners: <u>1958</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Shawn Adams</u> Telephone Number: <u>502-992-3500</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE IROQUOIS RESIDENT HOME

0014464 Report Period Beginning: 10/01/2019 Ending: 09/30/2020

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

	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	35	Skilled (SNF)	35	12,810	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	35	TOTALS	35	12,810	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	3,935	5,531	969	10,434	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,935	5,531	969	10,434	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.45%

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)

NONE

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

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

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

I. On what date did you start providing long term care at this location? Date started 1958

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

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 44 and days of care provided 835

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 09/30/2020 Fiscal Year: 09/30/2020 * All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE IROQUOIS RESIDENT HOME # 0014464 Report Period Beginning: 10/01/2019 Ending: 09/30/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary											1
2	Food Purchase											2
3	Housekeeping											3
4	Laundry											4
5	Heat and Other Utilities											5
6	Maintenance			3,155	3,155		3,155		3,155			6
7	Other (specify):*											7
8	TOTAL General Services			3,155	3,155		3,155		3,155			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,011,502			1,011,502		1,011,502		1,011,502			10
10a	Therapy	99,202			99,202		99,202		99,202			10a
11	Activities	35,130			35,130		35,130		35,130			11
12	Social Services	37,017			37,017		37,017		37,017			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Med supplies & cont s	94,951	6,241	67,471	168,663		168,663		168,663			15
16	TOTAL Health Care and Programs	1,277,802	6,241	67,471	1,351,514		1,351,514		1,351,514			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses		39,563	656	40,219		40,219		40,219			21
22	Employee Benefits & Payroll Taxes			10,510	10,510		10,510		10,510			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration		39,563	11,166	50,729		50,729		50,729			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,277,802	45,804	81,792	1,405,398		1,405,398		1,405,398			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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											30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,160	5,160		5,160		5,160			35
36	Other (specify):*											36
37	TOTAL Ownership			5,160	5,160		5,160		5,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):* BED TAX			67,282	67,282		67,282		67,282			43
44	TOTAL Special Cost Centers			67,282	67,282		67,282		67,282			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,277,802	45,804	154,234	1,477,840		1,477,840		1,477,840			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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				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				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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))	\$		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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE IROQUOIS RESIDENT HOME# 0014464

Report Period Beginning:

10/01/2019

Ending:

09/30/2020**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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE IROQUOIS RESIDENT HOME # 0014464 Report Period Beginning: 10/01/2019 Ending: 09/30/2020

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	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
IROQUOIS MEMORIAL HOSPITAL	100			IROQUOIS HOME C	WATSEKA	DME RETAILER

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	ROGER DITTRICH	BOD						1
2	STEVEN KNAPP	BOD						2
3	DAN TINCHER	BOD						3
4	RHONDA PENCE	BOD						4
5	MEL WARD	BOD						5
6	DOUG DEIGER	BOD						6
7	PHILIP ZUMMWALT, MD	BOD						7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
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20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **THE IROQUOIS RESIDENT HOME** # **0014464** Report Period Beginning: **10/01/2019** Ending: **09/30/2020**

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											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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE IROQUOIS RESIDENT HOME# 0014464

Report Period Beginning:

10/01/2019Ending: 9/30/2020

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE BENEFITS	GROSS SALARIES	13,751,942	\$ 2,019,620	\$ 185,186	1,277,801	\$ 187,659	1
2	21	ADMITTING	GROSS CHARGES	51,257,173	268,558	211,313	3,034,026	15,897	2
3	10	PURCH, REV, & STORES	COSTED REQ'S	1,557,014	104,131	61,588	44,895	3,003	3
4	21	DATA PROCESSING	TIME SPENT	592,197	828,717	279,079	64,903	90,825	4
5	21	COMMUNICATIONS	# OF PHONES	345	307,325	0	12	10,690	5
6	21	BUSINESS OFFICE	GROSS CHARGES	51,257,173	500,792	311,123	3,034,026	29,643	6
7	17	ADMIN & GENERAL	ACCUMULATED COST	24,255,346	2,324,755	474,336	1,902,726	182,367	7
8	6	MAINTENANCE	SQUARE FEET	103,856	1,377,365	326,540	9,791	129,851	8
9	4	LAUNDRY	POUNDS	128,340	111,716	43,451	51,575	44,894	9
10	3	HOUSEKEEPING	SQUARE FEET	100,893	466,361	289,083	9,791	45,257	10
11	1	DIETARY	MEALS	41,381	691,315	393,860	29,366	490,591	11
12	22	CAFETERIA	FTE'S	155	163,749	118,197	28	29,580	12
13	30	CAPITAL BLDG & FIXT	SQUARE FEET	141,319	973,389	0	9,791	67,439	13
14	30	CAPITAL MVBLE EQUIP	DOLLAR VALUE	1,354,505	704,867	0	37,928	19,737	14
15	27	CENTRAL SUPPLY	COSTED REQ'S	1,431,357	131,705	0	44,895	4,131	15
16	10	MEDICAL RECORDS	GROSS CHARGES	51,257,173	348,560	251,668	3,034,026	20,632	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 11,322,925	\$ 2,945,424		\$ 1,372,196	25

SEE ACCOUNTANTS' PREPARATION REPORT

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							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	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.) SEE ACCOUNTANTS' PREPARATION REPORT

** 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.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE IROQUOIS RESIDENT HOME COUNTY IROQUOIS COUNTY

FACILITY IDPH LICENSE NUMBER 0014464

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,791

B. General Construction Type: Exterior BRICKFrameNumber of Stories

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).
HOSPITAL (25 BEDS), HOME HEALTH, HOSPICE, RURAL HEALTH CLINICS AND CLINICS
TOTAL OTHER SQUARE FEET - 126,793

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		9,791	1958	\$	1
2					2
3	TOTALS	9,791		\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1958	1958	\$ 296,212	\$	40	\$	\$	296,212	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFING			1976	27,273		20			27,273	9
10	CENTRAL A/C			1976	108,539		15			108,539	10
11	SPRINKLER SYSTEM			1977	20,560		20			20,560	11
12	5 DOOR SENSORS			1986	5,087		10			5,087	12
13	INSULATION WORK			1987	56,995		10			56,995	13
14	SEAL & WATERPROOF			1988	6,517		10			6,517	14
15	PAINT & WALLPAPER HALLS			1989	5,363		5			5,363	15
16	FLOORING			1989	6,243		10			6,243	16
17	ARCHITECT FEES			1990	500		15			500	17
18	LAND PREP RH GARDEN			1990	3,935		20			3,935	18
19	SHELVING			1990	619		20			619	19
20	SHELVING			1990	619		20			619	20
21	PAINTING, WALLPAPER, ETC.			1990	5,250		5			5,250	21
22	REMODELING			1990	6,684		10			6,684	22
23	RH GARDEN PATIO MASONRY WORK			1991	45,275		20			45,275	23
24	RH GARDEN IRRIGATION			1991	3,900		15			3,900	24
25	LANDSCAPING			1992	3,754		20			3,754	25
26	FENCING - GARDEN			1992	2,111		20			2,111	26
27	FENCING - CHAIN LENGTH			1992	2,595		20			2,595	27
28	PAVILLION			1992	6,540		20			6,540	28
29	GUTTERS			1992	1,200		15			1,200	29
30	LIGHTING			1992	7,000		15			7,000	30
31	PAINTING & PAPERING			1992	9,245		5			9,245	31
32	PARKING LOT NE			1995	58,302		20			58,302	32
33	RH GARDEN SIDEWALK			1995	2,480		15			2,480	33
34	8 X 8 PAIR ALUM DOORS			1995	3,093		10			3,093	34
35	PINE HAND RAILS			1995	383		10			383	35
36	LOT LITE POLE FEED			1996	1,081		20			1,081	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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE IROQUOIS RESIDENT HOME

0014464

Report Period Beginning:

10/01/2019 Ending: 09/30/2020

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	PARKING LOT	1997	\$ 144,218	\$	20	\$	\$	\$ 144,218	37
38	LANDSCAPING - RH	1998	7,810		10			7,810	38
39	ARCH FEES	1998	19,585		15			19,585	39
40	BEDS	1998	57,478		12			57,478	40
41	CUBICAL CURTAINS	1999	32,980		5			32,980	41
42	SIDE WALKS WEST & SOUTH	1999	2,305		15			2,305	42
43	REMODELING RH	1999	17,488		5			17,488	43
44	#2529 HOME DELTA LAU FAUCETS (14)	1999	2,085		20			2,085	44
45	REMODELING RESTROOMS	1999	69,743		20			69,743	45
46	TILE	1999	22,658		5			22,658	46
47	GIFT HAND RAIL 1.5 ROUND	1999	1,708		15			1,708	47
48	RH REMODELING	1999	27,360		15			27,360	48
49	SIDEWALKS M & K CENTER	1999	833		15			833	49
50	NURST CALL SYSTEM	1999	13,747		10			13,747	50
51	FLOOR TILE	1999	19,932		15			19,932	51
52	RH REMODELING	2000	1,360		5			1,360	52
53	ASBESTOS PROGRAM	2000	6,212		5			6,212	53
54	LIGHTS & WIRING	2000	5,885		15			5,885	54
55	ARCH FEES	2000	580		5			580	55
56	RH REMODELING	2000	45,000		15			45,000	56
57	OAK CABINETS	2000	6,160		15			6,160	57
58	RH REMODELING & PAINT	2001	356		5			356	58
59	RH REMODELING - COUNTERTOPS (16)	2001	1,794		20			1,572	59
60	HEADS IN REST ROOMS (4)	2001	735	37	20	37	0	734	60
61	FAUCETS (3)	2001	517	26	20	26	0	490	61
62	CERAMIX TILE & FLOOR FIVE ROOMS	2001	4,650	233	20	233	1	4,303	62
63	REMODELING - ELECTRICAL (8 ROOMS)	2001	2,524		15			2,524	63
64	RH - REMODELING ELECTRICAL	2001	43,796		15			43,796	64
65	CABINETS, 8 DRAWER OAK	2002	2,710		15			2,710	65
66	FAN COIL UNIT	2002	11,469		15			11,469	66
67	REMODELING RH	2002	81,294		15			81,294	67
68	ARCH FEES	2003	13,259		5			13,259	68
69	DOOR & FRAME	2003	6,665		15			6,665	69
70	TOTAL (lines 4 thru 69)		\$ 1,372,251	\$ 295		\$ 296	\$ 1	\$ 1,371,654	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number THE IROQUOIS RESIDENT HOME

0014464

Report Period Beginning:

10/01/2019 Ending: 09/30/2020

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		\$ 1,372,251	\$ 295		\$ 296	\$ 1	\$ 1,371,654	1
2	RH-IDPH	2003	7,027		5			7,027	2
3	RH-IDPH	2003	8,376		5			8,376	3
4	LEVEL & LOCK ANDERSON LOCK	2004	4,965		10			4,965	4
5	SCONCES & HANGING PENDANT BALLACOR	2004	5,875	392	15	392	0	6,072	5
6	PAINTING (DEXTER DECORATING)	2004	13,848		5			13,848	6
7	PLUMBING (JENTER INC)	2004	32,604	1,630	20	1,630	(0)	25,267	7
8	ENTIRE WHITE CABINETRY & VINIONEER	2004	5,663	378	15	378	0	5,853	8
9	FLOORING - KINDON'S	2004	14,315	954	15	954	(0)	14,791	9
10	PENNER PT CARE - CASCADE WHIRPOOL SYSTEM	2004	13,695		10			13,695	10
11	REMODELING RH	2004	45,388	3,026	15	3,026	0	46,902	11
12	CERAMIC TIME	2004	28,590	1,430	20	1,430	1	22,159	12
13	CARPET SHAW	2004	17,968		5			17,968	13
14	FIXTURES	2004	13,017		10			13,017	14
15	MISC REMODELING - RH	2004	7,104		10			7,104	15
16	SMOKE DETECTOR - IDPH - SIMPLEX	2004	4,201		10			4,201	16
17	NURSES STATION	2004	23,000		10			23,000	17
18	CHART RACK CABINET	2004	2,317	116	20	116	0	1,796	18
19	PIPE RH CHILLED WATER LOOP	2005	8,450	338	25	338		4,901	19
20	PIPE RH CHILLED WATER LOOP	2006	13,663		10			13,663	20
21	CONCRETE SIDEWALK & HAND RAILS	2009	12,760	851	15	851	0	8,933	21
22	STEEL SMOKE BARRIER - RH	2012	8,694	580	15	580	0	4,058	22
23	RH CANOPY-AWNING	2013	6,710	447	15	447	(0)	2,907	23
24	INSTALL RH HEATING/VENTILATION & AC UPGRADE	2013	310,794	20,720	15	20,720	0	139,858	24
25	HALI VANDER LIFT	2016	5,840	584	10	584		2,239	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,987,115	\$ 31,739		\$ 31,742	\$ 3	\$ 1,784,254	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 46,748	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	26,041						73
74								74
75	TOTALS	\$ 72,789	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 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)	\$ 2,059,904	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,739	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,742	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,784,254	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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. ☐ 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: \$ _____ Description: _____
(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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(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.

SEE ACCOUNTANTS' PREPARATION REPORT

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			\$		\$	\$		\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$	\$ 5,938,044	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	605,305	1,194,293	3
4	Supply Inventory (priced at)		853,376	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		321,063	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		600,337	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 605,305	\$ 8,907,113	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		332,950	13
14	Buildings, at Historical Cost	1,987,115	26,181,100	14
15	Leasehold Improvements, at Historical Cost		483,750	15
16	Equipment, at Historical Cost	72,789	16,711,814	16
17	Accumulated Depreciation (book methods)	(1,784,254)	(34,542,012)	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):		7,436,087	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 275,650	\$ 16,603,689	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 880,955	\$ 25,510,802	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 7,420,677	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		6,941,545	29
30	Accrued Salaries Payable		939,963	30
31	Accrued Taxes Payable (excluding real estate taxes)		(909)	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 15,301,276	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,791,481	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)	\$	\$ 4,791,481	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 20,092,757	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,119,022	\$ 5,418,045	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,119,022	\$ 25,510,802	48

SEE ACCOUNTANTS' PREPARATION REPORT *(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 901,005	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 901,005	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,218,017	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,218,017	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)	\$ 2,119,022	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE IROQUOIS RESIDENT HOME

0014464

Report Period Beginning: 10/01/2019

Ending: 09/30/2020

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	\$ 3,034,027	1
2	Discounts and Allowances for all Levels	(338,170)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,695,857	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,695,857	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,155	31
32	Health Care	1,351,514	32
33	General Administration	50,729	33
	B. Capital Expense		
34	Ownership	5,160	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	BED TAX	67,282	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,477,840	40
41	Income before Income Taxes (line 30 minus line 40)**	1,218,017	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,218,017	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 10,438	44
45	Private Pay - Net Inpatient Revenue	8,610	45
46	Medicare - Net Inpatient Revenue	2,274,948	46
47	Other-(specify)	401,861	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,695,857	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,889	1,889	\$ 67,595	\$ 35.78	1
2	Assistant Director of Nursing	2,129	2,129	55,349	26.00	2
3	Registered Nurses	9,296	9,296	260,283	28.00	3
4	Licensed Practical Nurses	7,844	7,844	195,761	24.96	4
5	CNAs & Orderlies	28,255	28,255	430,317	15.23	5
6	CNA Trainees					6
7	Licensed Therapist	587	587	23,348	39.78	7
8	Rehab/Therapy Aides	3,068	3,068	75,854	24.72	8
9	Activity Director	2,123	2,123	29,983	14.12	9
10	Activity Assistants	541	541	5,586	10.33	10
11	Social Service Workers	2,257	2,257	37,017	16.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	96	96	960	10.00	18
19	Laundry					19
20	Administrator	2,213	2,213	91,127	41.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2	2	47	23.50	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)	236	236	4,574	19.38	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	60,536	60,536	\$ 1,277,801 *	\$ 21.11	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions					
Name		Function	Ownership %	Amount	Description			Description		Amount			
				\$	Workers' Compensation Insurance		\$	IDPH License Fee		\$			
					Unemployment Compensation Insurance			Advertising: Employee Recruitment					
					FICA Taxes		597	Health Care Worker Background Check					
					Employee Health Insurance			(Indicate # of checks performed)					
					Employee Meals			Patient Background Checks					
					Illinois Municipal Retirement Fund (IMRF)*			DUES		2,110			
					VACATION		7,803						
					MILEAGE								
					EDUCATION								
					OTHER								
								Less: Public Relations Expense		()			
								Non-allowable advertising		()			
								Yellow page advertising		()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$	TOTAL (agree to Schedule V, line 22, col.8)				\$	TOTAL (agree to Sch. V, line 20, col. 8)			
									\$	2,110			
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**				
Description				Amount	Description		Line #	Amount	Description		Amount		
				\$				\$	Out-of-State Travel		\$		
									In-State Travel				
									Seminar Expense				
									Entertainment Expense		()		
									(agree to Sch. V,				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	TOTAL				\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$	
C. Professional Services													
Vendor/Payee		Type		Amount									
				\$									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- | | | |
|------|--|--|
| (1) | Are nursing employees (RN,LPN,NA) represented by a union? | <u>NO</u> |
| (2) | Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. | <u>YES</u>
<u>ILLINOIS HEALTH CARE ASSN</u> |
| (3) | Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report? | <u>NO</u> |
| (4) | Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity? | <u>YES</u>
<u>44</u> |
| (5) | Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? | <u>YES</u>
<u>15 YEARS</u> |
| (6) | Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. | \$ _____ Line _____ |
| (7) | Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation. | <u>YES</u> |
| (8) | Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. | <u>NO</u> |
| (9) | Are you presently operating under a sublease agreement? | YES _____ NO <u>X</u> |
| (10) | Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. | YES _____ NO <u>X</u> |
| (11) | Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V. | \$ _____ |
| (12) | Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation. | <u>NO</u> |

SEE ACCOUNTANTS' PREPARATION REPORT