

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: <u>0056531</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Lebanon Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>1201 North Alton</u> <u>Lebanon</u> <u>62254</u>			
Number City Zip Code			
County: <u>St Clair</u>			
Telephone Number: <u>(618) 537-4401</u> Fax # <u>(618) 537-4447</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>7/31/2007</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Mike Kocher</u>			
Telephone Number: <u>(309) 689-5850</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Mark Petersen</u>	
		(Title) <u>Chief Executive Officer</u>	
		Paid Preparer	
		(Signed) _____ (Date) _____	
		(Print Name and Title) _____	
		(Firm Name & Address) _____	
		(Telephone) <u>()</u> Fax # <u>()</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE	
		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES	
		201 S. Grand Avenue East	
		Springfield, IL 62763-0001	
		Phone # (217) 782-1630	

Facility Name & ID Number Lebanon Care Center

0056531 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,850</u>	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	<u>90</u>	TOTALS	<u>90</u>	<u>32,850</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,457</u>	<u>1,673</u>	<u>1,210</u>	<u>21,340</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,457</u>	<u>1,673</u>	<u>1,210</u>	<u>21,340</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.96%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/31/2007

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/31/2007 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 90 and days of care provided 1,174

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Lebanon Care Center # 0056531 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	172,401	17,210	3,654	193,265		193,265	5,682	198,947			1
2	Food Purchase		151,637		151,637		151,637	(219)	151,418			2
3	Housekeeping	152,465	25,931		178,396		178,396	110	178,506			3
4	Laundry	16,663	11,629		28,292		28,292		28,292			4
5	Heat and Other Utilities			79,778	79,778		79,778	388	80,166			5
6	Maintenance	26,153	2,224	31,988	60,365		60,365	3,413	63,778			6
7	Other (specify):*											7
8	TOTAL General Services	367,682	208,631	115,420	691,733		691,733	9,374	701,107			8
	B. Health Care and Programs											
9	Medical Director			15,990	15,990		15,990		15,990			9
10	Nursing and Medical Records	926,961	99,989	993,411	2,020,361		2,020,361	3,167	2,023,528			10
10a	Therapy			215,432	215,432		215,432		215,432			10a
11	Activities	47,815	670		48,485		48,485	(18)	48,467			11
12	Social Services	43,394			43,394		43,394		43,394			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,018,170	100,659	1,224,833	2,343,662		2,343,662	3,149	2,346,811			16
	C. General Administration											
17	Administrative	69,000		189,500	258,500		258,500	(157,900)	100,600			17
18	Directors Fees											18
19	Professional Services			32,019	32,019		32,019	18,912	50,931			19
20	Dues, Fees, Subscriptions & Promotions			3,921	3,921		3,921	2,909	6,830			20
21	Clerical & General Office Expenses	38,142	3,017	9,591	50,750		50,750	35,094	85,844			21
22	Employee Benefits & Payroll Taxes			167,233	167,233		167,233	9,672	176,905			22
23	Inservice Training & Education							58	58			23
24	Travel and Seminar							18	18			24
25	Other Admin. Staff Transportation			1,687	1,687		1,687	4,071	5,758			25
26	Insurance-Prop.Liab.Malpractice			45,018	45,018		45,018	620	45,638			26
27	Other (specify):*											27
28	TOTAL General Administration	107,142	3,017	448,969	559,128		559,128	(86,546)	472,582			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,492,994	312,307	1,789,222	3,594,523		3,594,523	(74,023)	3,520,500			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.

Facility Name & ID Number Lebanon Care Center #0056531 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			25,017	25,017		25,017	58,370	83,387			30
31	Amortization of Pre-Op. & Org.			5,655	5,655		5,655	45,240	50,895			31
32	Interest			28,975	28,975		28,975	169,618	198,593			32
33	Real Estate Taxes			72,306	72,306		72,306	224	72,530			33
34	Rent-Facility & Grounds			308,280	308,280		308,280	(308,280)				34
35	Rent-Equipment & Vehicles			20,141	20,141		20,141	2,063	22,204			35
36	Other (specify):*											36
37	TOTAL Ownership			460,374	460,374		460,374	(32,765)	427,609			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,651		17,651		17,651		17,651			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,301	171,301		171,301		171,301			42
43	Other (specify):*	1,938		145,606	147,544		147,544	(147,544)				43
44	TOTAL Special Cost Centers	1,938	17,651	316,907	336,496		336,496	(147,544)	188,952			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,494,932	329,958	2,566,503	4,391,393		4,391,393	(254,332)	4,137,061			45

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

VI. ADJUSTMENT DETAIL

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

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(219)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,446)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,993	30		9
10	Interest and Other Investment Income	(7)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(101)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(23,167)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(95,000)	43		24
25	Fund Raising, Advertising and Promotional	(500)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(18,643)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (147,090)		\$	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)	(107,242)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (107,242)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (254,332)		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	Labs-Part A	\$ (10,575)	43	1
2	X-Rays-Part A	(3,862)	43	2
3	Offset Transportation Revenue	(18)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(138)	21	4
5	Offset Miscellaneous Nursing Supplies Revenue	(2,157)	10	5
6	Special Events	45	43	6
7	Disallowed Marketing Expense	(1,938)	43	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
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21				21
22				22
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(18,643)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 5,682	\$ 5,682	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	110	110	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	388	388	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,413	3,413	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	5,324	5,324	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	189,500	Petersen Health Care Management, Inc.	100.00%	31,600	(157,900)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	18,666	18,666	12
13	V								13
14	Total			\$ 189,500			\$ 65,183	\$ * (124,317)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,909	\$ 2,909	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	35,232	35,232	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	9,672	9,672	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	58	58	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	18	18	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,071	4,071	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	620	620	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	5,752	5,752	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	280	280	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	224	224	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	2,063	2,063	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 60,899	\$ * 60,899	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 Dietary	\$	Petersen Health Group, LLC	100.00%	\$	\$	15
16	V	2 Food		Petersen Health Group, LLC	100.00%			16
17	V	3 Housekeeping		Petersen Health Group, LLC	100.00%			17
18	V	4 Laundry		Petersen Health Group, LLC	100.00%			18
19	V	5 Utilities		Petersen Health Group, LLC	100.00%			19
20	V	6 Maintenance		Petersen Health Group, LLC	100.00%			20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Group, LLC	100.00%			21
22	V	10 Nursing and Medical Records		Petersen Health Group, LLC	100.00%			22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Group, LLC	100.00%			23
24	V	17 Administrative		Petersen Health Group, LLC	100.00%			24
25	V	19 Professional Services		Petersen Health Group, LLC	100.00%	246	246	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Group, LLC	100.00%			26
27	V	21 Clerical and General Office		Petersen Health Group, LLC	100.00%			27
28	V	22 Employee Benefits & Payroll		Petersen Health Group, LLC	100.00%			28
29	V	23 Inservice Training & Education		Petersen Health Group, LLC	100.00%			29
30	V	24 Travel and Seminar		Petersen Health Group, LLC	100.00%			30
31	V	25 Other Admin. Staff Transport.		Petersen Health Group, LLC	100.00%			31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Group, LLC	100.00%			32
33	V	30 Depreciation		Petersen Health Group, LLC	100.00%			33
34	V	31 Amortization		Petersen Health Group, LLC	100.00%			34
35	V	32 Interest		Petersen Health Group, LLC	100.00%	265	265	35
36	V	33 Real Estate Taxes		Petersen Health Group, LLC	100.00%			36
37	V	34 Rent-Facility and Grounds		Petersen Health Group, LLC	100.00%			37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Group, LLC	100.00%			38
39	Total		\$			\$ 511	\$ * 511	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	\$	Lebanon Land, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	Lebanon Land, LLC	100.00%			16
17	V	21	Equipment		Lebanon Land, LLC	100.00%			17
18	V	26	Insurance-Property		Lebanon Land, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		Lebanon Land, LLC	100.00%			19
20	V	30	Depreciation		Lebanon Land, LLC	100.00%	49,625	49,625	20
21	V	31	Amortization		Lebanon Land, LLC	100.00%	45,239	45,239	21
22	V	32	Interest		Lebanon Land, LLC	100.00%	169,080	169,080	22
23	V	33	Real Estate Taxes		Lebanon Land, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	308,279	Lebanon Land, LLC	100.00%		(308,279)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 308,279			\$ 263,944	\$ * (44,335)	39

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

Facility Name & ID Number

Lebanon Care Center

0056531

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Lebanon Care Center

0056531

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Lebanon Care Center

0056531

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Lebanon Care Center # 0056531 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Lebanon Care Center# 0056531 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Petersen Health Care Management, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

	1	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	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	21,340	\$ 5,682	1
2	2	Food	Resident Days	1,282,791	75	0	0	21,340	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	21,340	110	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	21,340	388	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	21,340	3,413	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	21,340	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	21,340	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	21,340	5,324	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	21,340	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	21,340	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	21,340	31,600	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	21,340	18,666	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	21,340	2,909	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	21,340	35,232	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	21,340	9,672	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	21,340	58	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	21,340	18	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	21,340	4,071	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	21,340	620	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	21,340	5,752	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	21,340	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	21,340	280	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	21,340	224	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	21,340	2,063	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 126,082	25

Facility Name & ID Number Lebanon Care Center# 0056531

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Petersen Health Group, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	23,543	2	\$	\$	12,874	\$	1
2	2	Food	Resident Days	23,543	2			12,874		2
3	3	Housekeeping	Resident Days	23,543	2			12,874		3
4	4	Laundry	Resident Days	23,543	2			12,874		4
5	5	Utilities	Resident Days	23,543	2			12,874		5
6	6	Maintenance	Resident Days	23,543	2			12,874		6
7	7	Mgmt. Allocation of Benefits	Resident Days	23,543	2			12,874		7
8	10	Nursing and Medical Records	Resident Days	23,543	2			12,874		8
9	15	Mgmt. Allocation of Benefits	Resident Days	23,543	2			12,874		9
10	17	Administrative	Resident Days	23,543	2			12,874		10
11	19	Professional Services	Resident Days	23,543	2	450		12,874	246	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	23,543	2			12,874		12
13	21	Clerical and General Office	Resident Days	23,543	2			12,874		13
14	22	Employee Benefits & Payroll	Resident Days	23,543	2			12,874		14
15	23	Inservice Training & Education	Resident Days	23,543	2			12,874		15
16	24	Travel and Seminar	Resident Days	23,543	2			12,874		16
17	25	Other Admin. Staff Transport.	Resident Days	23,543	2			12,874		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	23,543	2			12,874		18
19	30	Depreciation	Resident Days	23,543	2			12,874		19
20	31	Amortization	Resident Days	23,543	2			12,874		20
21	32	Interest	Resident Days	23,543	2	485		12,874	265	21
22	33	Real Estate Taxes	Resident Days	23,543	2			12,874		22
23	34	Rent-Facility and Grounds	Resident Days	23,543	2			12,874		23
24	35	Rent-Equipment & Vehicles	Resident Days	23,543	2			12,874		24
25	TOTALS					\$ 935	\$		\$ 511	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Sector		X	Mortgage	Varies	4/1/20	\$ 2,710,353	\$ 2,710,353	3/31/23	Varies	\$ 198,055	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 2,710,353	\$ 2,710,353			\$ 198,055	9	
	B. Non-Facility Related*												
10								Interest Income			(7)	10	
11								Home Office Allocation-PHCM			280	11	
12								Home Office Allocation-PHG			265	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 538	14	
15	TOTALS (line 9+line14)						\$ 2,710,353	\$ 2,710,353			\$ 198,593	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	73,386	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.)			\$	71,772	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,614)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	73,920	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.)			\$	224	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	72,530	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	69,796	8		
	2016	71,462	9		
	2017	72,361	10		
	2018	69,247	11		
	2019	71,772	12		
Accrual based on prior year tax bill.					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lebanon Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0053959

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 05-18.0-300-018	Long-Term Care Facility	\$ 2,004.84	\$ 2,004.84
2. 05-18.0-309-012	Long-Term Care Facility	\$ 69,767.18	\$ 69,767.18
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 71,772.02	\$ 71,772.02

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:

31,919

B. General Construction Type:

Exterior Brick

Frame Concrete & Steel

Number of Stories

1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

135,716

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

3

3. Current Period Amortization:

50,895

4. Dates Incurred:

2020

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	17,240	2007	\$ 100,000	1
2					2
3	TOTALS	17,240		\$ 100,000	3

HFS 3745 (N-4-99)

IL478-2471

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	90		2007	1986	\$ 1,425,000	\$	25	\$ 57,000	\$ 57,000	\$ 769,500
5										
6										
7										
8										
	Improvement Type**									
9	Original Land Improvements			2007	15,000		15	1,000	1,000	12,500
10	Lobby Carpet			2007	2,050		7			2,050
11	Facility Sign			2007	640		7			640
12	Wood Blinds			2007	1,158		7			1,158
13	Cable Equipment Installation			2009	7,263		7			7,263
14	Generator Repair			2010	3,400		7			3,400
15	Fabrication work			2010	107,400		20	5,370	5,370	51,015
16	Fire Sprinkler Repair			2011	9,853		7			9,853
17	Water Heater			2011	3,373		7			3,373
18	Heat Exchanger			2011	3,700		15	246	246	2,091
19	Roof Replacement on West Wing			2011	26,346		25	1,054	1,054	8,959
20	Roof Repairs			2012	2,902		7	211	211	2,902
21	Smoke Detector			2012	6,570		15	438	438	3,285
22	Generator Repair			2013	3,438		7	492	492	3,198
23	Landscaping			2013	3,475		15	232	232	1,508
24	Grease Trap			2013	4,895		7	700	700	4,550
25	Nurse Call System			2013	7,277		7	1,040	1,040	6,760
26	Wall Removal, Patching, Cabinet Replacement in Nurses Station			2014	13,568		15	905	905	4,978
27	Roof Replacement on West Wing			2014	31,125		25	1,245	1,245	6,848
28	Water Main Drain			2014	11,120		15	741	741	4,076
29	Air Conditioner-Rooftop			2014	14,920		15	995	995	5,473
30	Air Conditioner-Rooftop			2015	11,400		15	760	760	3,420
31	Water Heater			2017	4,394		7	628	628	1,570
32	Furnace			2020	12,298		15	410	410	410
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lebanon Care Center

0056531

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57	Land Improvements Booked			1,000			(1,000)		57
58	Building Booked			57,000			(57,000)		58
59	Building Improvement Booked			14,783			(14,783)		59
60									60
61	2020-Home Office Allocation-Building Improvements		10,790			259	259		61
62	2020-Home Office Allocation-Land Improvements		1,082			69	69		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,744,437	\$ 72,783		\$ 73,795	\$ 1,012	\$ 920,780	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 36,107	\$ 1,859	\$ 4,168	\$ 2,309	5-10 yrs.	\$ 23,902	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	293,842					293,842	73
74	Home Office Allocation			5,424	5,424			74
75	TOTALS	\$ 329,949	\$ 1,859	\$ 9,592	\$ 7,733		\$ 317,744	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)	\$ 2,174,386	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,642	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,387	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,745	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,238,524	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.

		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: \$ 22,204 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Lebanon Care Center
0056531
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs
 B. Equipment
 16. Description of rental amount for movable equipment

Medical Equipment	\$	15,923
Dishwasher		701
Copier		3,517
Home Office Allocation		<u>2,063</u>
		<u><u>22,204</u></u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,882	\$ 58,236	\$	3,882	\$ 58,236	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		4,731	70,966		4,731	70,966	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,749	86,230		5,749	86,230	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				17,651		17,651	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	14,362	\$ 215,432	\$ 17,651	14,362	\$ 233,083	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	\$ (23,892)	\$ (23,892)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 119,572)	2,336,119	2,336,119	3
4	Supply Inventory (priced at Cost)	9,431	9,431	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	409,139	419,083	7
8	Accounts Receivable (owners or related parties)	79,696	79,696	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,810,493	\$ 2,820,437	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		1,435,790	14
15	Leasehold Improvements, at Historical Cost	12,298	308,647	15
16	Equipment, at Historical Cost		329,949	16
17	Accumulated Depreciation (book methods)	(205)	(1,238,524)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		84,823	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	80,097	287,807	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	944,095	944,095	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,036,285	\$ 2,252,587	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,846,778	\$ 5,073,024	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 924,614	\$ 924,614	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,729	57,729	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,920	73,920	32
33	Accrued Interest Payable		32,504	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	78,749	78,749	36
37	Accrued Management Fees	9,944	9,944	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,144,956	\$ 1,177,460	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,710,353	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	763,496	576,674	43
44	Loan Payable-MCAD Adv. Payment	492,200	492,200	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,255,696	\$ 3,779,227	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,400,652	\$ 4,956,687	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,446,126	\$ 116,337	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,846,778	\$ 5,073,024	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,369,009	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(575,245)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 793,764	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	652,362	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)	\$ 652,362	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,446,126	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lebanon Care Center

0056531

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,999,655	1
2	Discounts and Allowances for all Levels	(653,442)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,346,213	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	391,649	6
7	Oxygen	28	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 391,677	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	219	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	28,448	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,174	20
21	Other Medical Services	4,812	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 48,653	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	18	28
28a	Miscellaneous and COVID Stimulus Revenue	1,257,187	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,257,205	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,043,755	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	691,733	31
32	Health Care	2,343,662	32
33	General Administration	559,128	33
	B. Capital Expense		
34	Ownership	460,374	34
	C. Ancillary Expense		
35	Special Cost Centers	165,195	35
36	Provider Participation Fee	171,301	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,391,393	40
41	Income before Income Taxes (line 30 minus line 40)**	652,362	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 652,362	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,626,219	44
45	Private Pay - Net Inpatient Revenue	275,994	45
46	Medicare - Net Inpatient Revenue	433,896	46
47	Other-(specify) Insurance Net Inpatient Revenue	10,104	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,346,213	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	1,427	1,437	\$ 48,317	\$ 33.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,826	2,873	100,380	34.94	3
4	Licensed Practical Nurses	11,165	11,687	339,790	29.07	4
5	CNAs & Orderlies	21,362	22,190	337,080	15.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,565	1,606	32,432	20.19	9
10	Activity Assistants	335	335	4,339	12.95	10
11	Social Service Workers	2,020	2,041	43,394	21.26	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,387	16.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,461	12,699	138,014	10.87	15
16	Dishwashers					16
17	Maintenance Workers	1,706	1,713	26,153	15.27	17
18	Housekeepers	12,057	12,566	152,465	12.13	18
19	Laundry	1,597	1,657	16,663	10.06	19
20	Administrator	2,080	2,080	69,000	33.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,895	1,922	38,142	19.84	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,236	1,251	39,851	31.86	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	3,004	3,179	74,525	23.44	33
34	TOTAL (lines 1 - 33)	78,816	81,316	\$ 1,494,932 *	\$ 18.38	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	73	\$ 3,654	L1, C3	35
36	Medical Director	Monthly	15,990	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,897	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	80	4,264	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Telehealth</u>	Monthly	11,970	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	153	\$ 41,775		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	4,901	215,647	L10,C3	51
52	Certified Nurse Assistants/Aides	25,700	755,633	L10,C3	52
53	TOTAL (lines 50 - 52)	30,601	\$ 971,280		53

Lebanon Care Center
0056531
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period Total	Average
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Salaries, Wages	Hourly Wage
Care Plan Coordinator	1,549	1,668	50,644	30.36
Transportation	1,040	1,040	11,044	10.62
Alzheimer's Coordinator	319	375	10,899	29.06
Marketing	96	96	1,938	20.19
TOTAL	3,004	3,179	74,525	

STATE OF ILLINOIS

Facility Name & ID Number

Lebanon Care Center

0056531

Report Period Beginning:

1/1/2020

Page 21

Ending:

12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
David Baker		Administrator	0	\$ 69,000	Workers' Compensation Insurance		\$ 21,793	IDPH License Fee		\$ 1,990		
					Unemployment Compensation Insurance		19,253	Advertising: Employee Recruitment				
					FICA Taxes		108,084	Health Care Worker Background Check				
					Employee Health Insurance		4,303	(Indicate # of checks performed 19)				
					Employee Meals			Patient Background Checks		36 1,080		
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		851		
					Administrator Benefits		13,800	Home Office Allocation		2,909		
					Home Office Allocation		9,672					
TOTAL (agree to Schedule V, line 17, col. 1)												
(List each licensed administrator separately.)				\$ 69,000								
B. Administrative - Other												
Description				Amount								
Management Fees-See Page 6, Eliminated on P 3, C 7				\$ 189,500								
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 189,500	TOTAL (agree to Schedule V,			\$ 176,905	TOTAL (agree to Sch. V,			
(Attach a copy of any management service agreement)					line 22, col.8)				line 20, col. 8)			
C. Professional Services					E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**				
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount	
Charter Communications		Computer Services		\$ 1,080					Out-of-State Travel		\$	
Ability Network		Computer Services		6,567								
Duane Morris LLP		Legal Fees-Mar-May, Oct		24,090								
Sector		Legal Fees-July 2020		282					In-State Travel			
					N/A							
									Seminar Expense			
									Home Office Allocation		18	
									Entertainment Expense		(	
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL			\$	(agree to Sch. V,			
(For legal fee disclosure, see page 39 of instructions)				\$ 32,019					line 24, col. 8)			\$ 18

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Lebanon Care Center

0056531

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

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		32,019
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	329
Duane Morris	Legal	459
Lexis Nexis	Legal	9
Livingston, Barger, Brant, Schroeder	Legal	18
Miller, Hall, Triggs	Legal	57
Miscellaneous	Legal	21
SB2	Legal	170
SmithAmundsen LLC	Legal	1,050
Sorling Northrup	Legal	299
CliftonLarsonAllen	Accounting	1,305
Ginoli & Co.	Accounting	1,177
Ability Network	Computer Services	3,350
Allscripts	Computer Services	529
AOD Matrix Care	Computer Services	5,883
AT&T	Computer Services	6
ATS	Computer Services	321
CCH	Computer Services	19
Charter Communications	Computer Services	30
Citrix Systems	Computer Services	100
Comcast	Computer Services	34
ITSavvy	Computer Services	155
Kemper Technology	Computer Services	764
Miscellaneous	Computer Services	148
Pearl Technology	Computer Services	138
Stratus Networks	Computer Services	607
TR Professional	Computer Services	13
David Budde	Other Prof Fees	13
DJ Howard and Associates	Other Prof Fees	25
Getzler Henrich & Associates	Other Prof Fees	104
LRI Consulting Services	Other Prof Fees	101
McQuellon Consulting	Other Prof Fees	64
Miscellaneous	Other Prof Fees	122
Optimizer	Other Prof Fees	54
Registered Agent Solutions	Other Prof Fees	30
RSM McGladrey	Other Prof Fees	332
SB2	Other Prof Fees	425
Sedgwick CMS	Other Prof Fees	572
Tarver Program Consultants	Other Prof Fees	79
Total (agree to Schedule V, line 19, column 8)		<u>50,931</u>

Lebanon Care Center
0056531
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	189
Auto Repairs		933
Meals-Travel		334
Mileage-Travel		231
Home Office Allocation		<u>4,071</u>
		<u><u>5,758</u></u>

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

7 yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 24,896

Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 171,301

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 219

(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.

\$ 18

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Ginoli and Company

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

No

Attach invoices and a summary of services for all architect and appraisal fees.

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