

		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>0056549</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>McLeansboro Rehab Hlth C Ctr</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>415 West Carpenter</u> <u>McLeansboro</u> <u>62859</u>																									
Number City Zip Code																									
County: <u>Hamilton</u>																									
Telephone Number: <u>(618) 643-3728</u> Fax # <u>(618) 643-2330</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Mark Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Mark Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Mark Petersen</u>																								
	(Title) <u>Chief Executive Officer</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: _____																									
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>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u>																									
Email Address: _____																									

Facility Name & ID Number McLeansboro Rehab Hlth C Ctr

0056549 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>43</u>	Skilled (SNF)	<u>43</u>	<u>15,695</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>43</u>	TOTALS	<u>43</u>	<u>15,695</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>5,261</u>	<u>1,045</u>	<u>408</u>	<u>6,714</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>5,261</u>	<u>1,045</u>	<u>408</u>	<u>6,714</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.78%

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/1/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 43 and days of care provided 408

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 McLeansboro Rehab Hlth C Ctr # 0056549 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	92,864	7,330		100,194		100,194	1,788	101,982			1
2	Food Purchase		51,498		51,498		51,498	(228)	51,270			2
3	Housekeeping	49,642	7,694		57,336		57,336	35	57,371			3
4	Laundry	287	2,852		3,139		3,139		3,139			4
5	Heat and Other Utilities			42,791	42,791		42,791	122	42,913			5
6	Maintenance	29,305	9,080	17,512	55,897		55,897	1,074	56,971			6
7	Other (specify):*											7
8	TOTAL General Services	172,098	78,454	60,303	310,855		310,855	2,791	313,646			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	483,911	38,941	5,719	528,571		528,571	410	528,981			10
10a	Therapy			57,283	57,283		57,283		57,283			10a
11	Activities	24,764	588	739	26,091		26,091	(13)	26,078			11
12	Social Services	35,348	18		35,366		35,366		35,366			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	544,023	39,547	72,741	656,311		656,311	397	656,708			16
	C. General Administration											
17	Administrative	69,996		63,200	133,196		133,196	(53,258)	79,938			17
18	Directors Fees											18
19	Professional Services			7,848	7,848		7,848	6,107	13,955			19
20	Dues, Fees, Subscriptions & Promotions			3,180	3,180		3,180	915	4,095			20
21	Clerical & General Office Expenses	22,645	2,194	9,002	33,841		33,841	11,023	44,864			21
22	Employee Benefits & Payroll Taxes			91,801	91,801		91,801	3,043	94,844			22
23	Inservice Training & Education							18	18			23
24	Travel and Seminar							6	6			24
25	Other Admin. Staff Transportation			713	713		713	1,281	1,994			25
26	Insurance-Prop.Liab.Malpractice			21,223	21,223		21,223	195	21,418			26
27	Other (specify):*											27
28	TOTAL General Administration	92,641	2,194	196,967	291,802		291,802	(30,670)	261,132			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	808,762	120,195	330,011	1,258,968		1,258,968	(27,482)	1,231,486			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			327	327		327	38,520	38,847			30
31	Amortization of Pre-Op. & Org.							36,262	36,262			31
32	Interest							141,269	141,269			32
33	Real Estate Taxes			8,050	8,050		8,050	70	8,120			33
34	Rent-Facility & Grounds			41,079	41,079		41,079	(41,079)				34
35	Rent-Equipment & Vehicles			13,239	13,239		13,239	649	13,888			35
36	Other (specify):*											36
37	TOTAL Ownership			62,695	62,695		62,695	175,691	238,386			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,888		9,888		9,888		9,888			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,848	61,848		61,848		61,848			42
43	Other (specify):*		55	69,117	69,172		69,172	(69,172)				43
44	TOTAL Special Cost Centers		9,943	130,965	140,908		140,908	(69,172)	71,736			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	808,762	130,138	523,671	1,462,571		1,462,571	79,037	1,541,608			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	(228)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,375)	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	(489)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(16)	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	(7,289)	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	(56,000)	43		24
25	Fund Raising, Advertising and Promotional	(432)	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	(5,400)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (71,229)		\$	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)	150,266	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 150,266		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 79,037		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	\$ (2,574)	43	1
2	X-Rays-Part A	(1,297)	43	2
3	Disallowed Special Events	(189)	43	3
4	Offset Transportation Revenue	(13)	11	4
5	Offset Miscellaneous Nursing Supplies Revenue	(1,265)	10	5
6	Offset Miscellaneous Office Supplies Revenue	(62)	21	6
7				7
8				8
9				9
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,400)		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%	\$ 1,788	\$ 1,788	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%	35	35	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	122	122	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,074	1,074	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%	1,675	1,675	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	63,200	Petersen Health Care Management, Inc.	100.00%	9,942	(53,258)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	5,873	5,873	12
13	V								13
14	Total			\$ 63,200			\$ 20,509	\$ * (42,691)	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%	\$ 915	\$ 915	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	11,085	11,085	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	3,043	3,043	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	18	18	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	6	6	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,281	1,281	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	195	195	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	1,810	1,810	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%	88	88	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	70	70	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	649	649	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			\$			\$ 19,160	\$ * 19,160	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	1	Dietary	\$	Petersen Health Operations, LLC	100.00%	\$	\$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%			22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%			23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%			24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	234	234	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%			26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%			27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%			28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%			29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%			32
33	V	30	Depreciation		Petersen Health Operations, LLC	100.00%			33
34	V	31	Amortization		Petersen Health Operations, LLC	100.00%			34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	65	65	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%			36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%			38
39	Total			\$			\$ 299	\$ * 299	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	\$	McLeansboro Land, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	McLeansboro Land, LLC	100.00%			16
17	V	21	Equipment		McLeansboro Land, LLC	100.00%			17
18	V	26	Insurance-Property		McLeansboro Land, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		McLeansboro Land, LLC	100.00%			19
20	V	30	Depreciation		McLeansboro Land, LLC	100.00%	37,199	37,199	20
21	V	31	Amortization		McLeansboro Land, LLC	100.00%	36,262	36,262	21
22	V	32	Interest		McLeansboro Land, LLC	100.00%	141,116	141,116	22
23	V	33	Real Estate Taxes		McLeansboro Land, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	41,079	McLeansboro Land, LLC	100.00%		(41,079)	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			\$ 41,079			\$ 214,577	\$ * 173,498	39

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

Facility Name & ID Number

McLeansboro Rehab Hlth C Ctr

0056549

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

McLeansboro Rehab Hlth C Ctr

0056549

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

McLeansboro Rehab Hlth C Ctr

0056549

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 McLeansboro Rehab Hlth C Ctr # 0056549 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 McLeansboro Rehab Hlth C Ctr# 0056549

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 341,562	\$ 398,718	6,714	\$ 1,788	1
2	2	Food	Resident Days	75	0	0	6,714	0	2
3	3	Housekeeping	Resident Days	75	6,607	3,056	6,714	35	3
4	5	Utilities	Resident Days	75	23,320	0	6,714	122	4
5	6	Maintenance	Resident Days	75	205,132	187,746	6,714	1,074	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	6,714	0	6
7	9	Medical Director	Resident Days	75	0	0	6,714	0	7
8	10	Nursing and Medical Records	Resident Days	75	320,057	736,064	6,714	1,675	8
9	10A	Therapy	Resident Days	75	0	0	6,714	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	6,714	0	10
11	17	Administrative	Resident Days	75	1,899,565	7,673,667	6,714	9,942	11
12	19	Professional Services	Resident Days	75	1,122,028	0	6,714	5,873	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	174,863	0	6,714	915	13
14	21	Clerical and General Office	Resident Days	75	2,117,880	2,195,755	6,714	11,085	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	581,393	0	6,714	3,043	15
16	23	Inservice Training & Education	Resident Days	75	3,513	0	6,714	18	16
17	24	Travel and Seminar	Resident Days	75	1,094	0	6,714	6	17
18	25	Other Admin. Staff Transport.	Resident Days	75	244,700	0	6,714	1,281	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	37,297	0	6,714	195	19
20	30	Depreciation	Resident Days	75	345,756	0	6,714	1,810	20
21	31	Amortization	Resident Days	75	0	0	6,714	0	21
22	32	Interest	Resident Days	75	16,842	0	6,714	88	22
23	33	Real Estate Taxes	Resident Days	75	13,451	0	6,714	70	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	124,017	0	6,714	649	24
25	TOTALS				\$ 7,579,077	\$ 11,195,006		\$ 39,669	25

Facility Name & ID Number McLeansboro Rehab Hlth C Ctr# 0056549

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 Wellness, 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	65,205	8	\$	\$	3,943	\$	1
2	2	Food	Resident Days	65,205	8			3,943		2
3	3	Housekeeping	Resident Days	65,205	8			3,943		3
4	4	Laundry	Resident Days	65,205	8			3,943		4
5	5	Utilities	Resident Days	65,205	8			3,943		5
6	6	Maintenance	Resident Days	65,205	8			3,943		6
7	7	Mgmt. Allocation of Benefits	Resident Days	65,205	8			3,943		7
8	10	Nursing and Medical Records	Resident Days	65,205	8			3,943		8
9	15	Mgmt. Allocation of Benefits	Resident Days	65,205	8			3,943		9
10	17	Administrative	Resident Days	65,205	8			3,943		10
11	19	Professional Services	Resident Days	65,205	8	3,870		3,943	234	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	65,205	8			3,943		12
13	21	Clerical and General Office	Resident Days	65,205	8			3,943		13
14	22	Employee Benefits & Payroll	Resident Days	65,205	8			3,943		14
15	23	Inservice Training & Education	Resident Days	65,205	8			3,943		15
16	24	Travel and Seminar	Resident Days	65,205	8			3,943		16
17	25	Other Admin. Staff Transport.	Resident Days	65,205	8			3,943		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	65,205	8			3,943		18
19	30	Depreciation	Resident Days	65,205	8			3,943		19
20	31	Amortization	Resident Days	65,205	8			3,943		20
21	32	Interest	Resident Days	65,205	8	1,079		3,943	65	21
22	33	Real Estate Taxes	Resident Days	65,205	8			3,943		22
23	34	Rent-Facility and Grounds	Resident Days	65,205	8			3,943		23
24	35	Rent-Equipment & Vehicles	Resident Days	65,205	8			3,943		24
25	TOTALS					\$ 4,949	\$		\$ 299	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	\$ 1,931,127	\$ 1,931,127	3/31/23	Varies	\$ 141,116	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,931,127	\$ 1,931,127			\$ 141,116	9	
	B. Non-Facility Related*												
10												10	
11								Home Office Allocation-PHCM			88	11	
12								Home Office Allocation-PHW			65	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 153	14	
15	TOTALS (line 9+line14)						\$ 1,931,127	\$ 1,931,127			\$ 141,269	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.			\$	8,292	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.)			\$	8,050	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(242)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	8,292	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.)			\$	70	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	8,120	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	8,004	8	
		2016	8,098	9	
		2017	8,131	10	
		2018	8,050	11	
		2019	8,050	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:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME McLeansboro Rehabilitation & Health Care Center COUNTY Hamilton

FACILITY IDPH LICENSE NUMBER 0053108

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.	<u>08-09-483-001</u>	<u>Long-Term Care Facility</u>	\$ <u>7,966.86</u>	\$ <u>7,966.86</u>
2.	<u>08-09-483-016</u>	<u>Long-Term Care Facility</u>	\$ <u>83.50</u>	\$ <u>83.50</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>8,050.36</u></u>	\$ <u><u>8,050.36</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,840

B. General Construction Type: Exterior BrickFrame Fire Resistant

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: 96,697

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

3. Current Period Amortization: 36,262

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	56,628	2005	\$ 40,500	1
2					2
3	TOTALS	56,628		\$ 40,500	3

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	73		2005	1973	\$ 727,500	\$	25	\$ 29,100	\$ 29,100	\$ 451,050
5										
6										
7										
8										
	Improvement Type**									
9	Original Land Improvements			2005	14,000		15	471	471	14,000
10	Water Tap			2007	2,500		15	167	167	2,254
11	Sprinkler System			2007	39,152		15	2,610	2,610	35,235
12	Grease Trap			2007	4,075		15	272	272	3,672
13	Drain Tank			2007	462		15	31	31	418
14	Fire Alarm			2007	4,283		15	286	286	3,861
15	Roof repair			2008	7,639		25	306	306	3,825
16	Asphalt in Parking Lot			2010	8,041		15	536	536	5,628
17	Nurses Station Annunicator Visual Panel			2010	4,688		7			4,688
18	Water Heater			2011	3,463		7			3,463
19	Water Heater			2012	3,856		7			3,856
20	Water Heater			2012	3,673		7			3,673
21	Hot Water Tank			2013	7,901		7	569	569	7,901
22	Rooftop Air Conditioner			2013	7,480		15	498	498	3,735
23	Floor Repair			2018	3,459		7	494	494	1,235
24	HVAC System			2018	6,196		15	414	414	1,035
25	Boiler Repair			2019	3,723		7	532	532	798
26	Parking Lot Resurfacing			2020	7,720		15	257	257	257
27										
28	Land Improvements Booked					1,403			(1,403)	
29	Building Booked					29,185			(29,185)	
30	Building Improvement Booked					4,590			(4,590)	
31										
32	2020-Home Office Allocation-Building Improvements				3,315			81	81	
33	2020-Home Office Allocation-Land Improvements				341			22	22	
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

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
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 863,467	\$ 35,178		\$ 36,646	\$ 1,468	\$ 550,584	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	\$15,048	\$2,150	\$2,031	\$(119)	5-10 yrs.	\$5,605	71
72	Current Year Purchases	2,382	198	170	(28)	7 yrs.	170	72
73	Fully Depreciated Assets	172,542					172,542	73
74	Home Office Allocation							74
75	TOTALS	\$189,972	\$2,348	\$2,201	\$(147)		\$178,317	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)	\$1,093,939	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$37,526	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$38,847	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$1,321	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$728,901	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. YESNO

		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: YESNO Terms: *

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

15. Is Movable equipment rental included in building rental? YESNO
16. Rental Amount for movable equipment: \$13,888Description: 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.

McLeansboro Rehab Hlth C Ctr
0056549

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	\$	6,936
Dishwasher		701
Copier		5,602
Home Office Allocation		649
		<u>13,888</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.
- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,778	\$ 26,670	\$	1,778	\$ 26,670	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		280	4,207		280	4,207	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,760	26,406		1,760	26,406	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				9,888		9,888	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			\$	3,818	\$ 57,283	\$ 9,888	3,818	\$ 67,171	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (9,546)	\$ (9,546)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,706)	430,434	430,434	3
4	Supply Inventory (priced at Cost)	7,186	7,186	4
5	Short-Term Investments			5
6	Prepaid Insurance	12,244	12,244	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,145	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 440,318	\$ 441,463	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		40,500	13
14	Buildings, at Historical Cost		730,815	14
15	Leasehold Improvements, at Historical Cost	7,720	132,652	15
16	Equipment, at Historical Cost	2,382	189,972	16
17	Accumulated Depreciation (book methods)	(328)	(728,901)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		96,697	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(36,262)	20
21	Restricted Funds	19,068	167,061	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	278,371	204,310	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 307,213	\$ 796,844	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 747,531	\$ 1,238,307	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 222,414	\$ 222,414	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,307	37,307	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,292	8,292	32
33	Accrued Interest Payable		23,159	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	38,495	38,495	36
37	Accrued Management Fees	11,219	11,219	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 317,727	\$ 340,886	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,931,127	40
41	Bonds Payable			41
42	Deferred Compensation	5,433	5,433	42
	Other Long-Term Liabilities(specify):			
43	N/P-SBA PPP	167,100	167,100	43
44	Loan Payable-MCAD Adv Payment	28,000	28,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 200,533	\$ 2,131,660	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 518,260	\$ 2,472,546	46
47	TOTAL EQUITY (page 18, line 24)	\$ 229,271	\$ (1,234,239)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 747,531	\$ 1,238,307	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 25,135	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(70,743)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (45,608)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	274,879	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)	\$ 274,879	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)	\$ 229,271	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number McLeansboro Rehab Hlth C Ctr

0056549

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	\$ 1,288,947	1
2	Discounts and Allowances for all Levels	(157,194)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,131,753	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,106	6
7	Oxygen	(31)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 97,075	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	228	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	16,578	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,659	20
21	Other Medical Services	12,293	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,758	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	13	28
28a	Miscellaneous and COVID Stimulus Revenue	474,851	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 474,864	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,737,450	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	310,855	31
32	Health Care	656,311	32
33	General Administration	291,802	33
	B. Capital Expense		
34	Ownership	62,695	34
	C. Ancillary Expense		
35	Special Cost Centers	79,060	35
36	Provider Participation Fee	61,848	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,462,571	40
41	Income before Income Taxes (line 30 minus line 40)**	274,879	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 274,879	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 830,005	44
45	Private Pay - Net Inpatient Revenue	175,750	45
46	Medicare - Net Inpatient Revenue	125,998	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,131,753	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	1,745	1,781	\$ 61,374	\$ 34.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,980	6,048	214,978	35.55	3
4	Licensed Practical Nurses	566	619	12,794	20.67	4
5	CNAs & Orderlies	14,320	14,545	184,665	12.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,047	2,147	24,482	11.40	9
10	Activity Assistants					10
11	Social Service Workers	1,940	2,091	35,348	16.90	11
12	Dietician					12
13	Food Service Supervisor	1,560	1,560	22,138	14.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,569	6,682	70,726	10.58	15
16	Dishwashers					16
17	Maintenance Workers	1,840	1,907	29,305	15.37	17
18	Housekeepers	4,286	4,395	49,642	11.30	18
19	Laundry	24	24	287	11.96	19
20	Administrator	1,993	1,993	69,996	35.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,239	1,259	22,645	17.99	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	338	338	10,382	30.72	33
34	TOTAL (lines 1 - 33)	44,447	45,389	\$ 808,762 *	\$ 17.82	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	9,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,049	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	125	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Telehealth</u>	2	91	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	4	\$ 11,265		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	14	\$ 694	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	96	2,760	L10,C3	52
53	TOTAL (lines 50 - 52)	110	\$ 3,454		53

McLeansboro Rehab Hlth C Ctr
0056549
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		Average Hourly Wage
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	
Care Plan Coordinator		314	314	32.17
Transportation		24	24	11.75
TOTAL		338	338	10,382

McLeansboro Rehab Hlth C Ctr

0056549

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)		7,848

Home Office Allocation

Baker Tilly Virchow Krause LLP	Legal	103
Duane Morris	Legal	145
Lexis Nexis	Legal	3
Livingston, Barger, Brant, Schroeder	Legal	6
Miller, Hall, Triggs	Legal	18
Miscellaneous	Legal	7
SB2	Legal	53
SmithAmundsen LLC	Legal	330
Sorling Northrup	Legal	94
Illinois Secretary of Sate	Legal	63
CliftonLarsonAllen	Accounting	410
Ginoli & Co.	Accounting	464
Ability Network	Computer Services	1,054
Allscripts	Computer Services	166
AOD Matrix Care	Computer Services	1,851
AT&T	Computer Services	2
ATS	Computer Services	101
CCH	Computer Services	6
Charter Communications	Computer Services	9
Citrix Systems	Computer Services	31
Comcast	Computer Services	11
ITSavvy	Computer Services	49
Kemper Technology	Computer Services	241
Miscellaneous	Computer Services	47
Pearl Technology	Computer Services	44
Stratus Networks	Computer Services	191
TR Professional	Computer Services	4
David Budde	Other Prof Fees	4
DJ Howard and Associates	Other Prof Fees	8
Getzler Henrich & Associates	Other Prof Fees	33
LRI Consulting Services	Other Prof Fees	32
McQuellon Consulting	Other Prof Fees	20
Miscellaneous	Other Prof Fees	36
Optimizer	Other Prof Fees	17
Registered Agent Solutions	Other Prof Fees	10
RSM McGladrey	Other Prof Fees	105
SB2	Other Prof Fees	134
Sedgwick CMS	Other Prof Fees	180
Tarver Program Consultants	Other Prof Fees	25

Total (agree to Schedule V, line 19, column 8)	<u>13,955</u>
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McLeansboro Rehab Hlth C Ctr
0056549
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	558
Auto Repairs		155
Mileage-Travel		-
Home Office Allocation		1,281
		<u>1,994</u>
		<u>1,994</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.

\$ 8,393

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.

\$ 61,848

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.

\$ 228

(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.

\$ 13

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.