

		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: 0056432

Facility Name: Piper City Rehab Living Ctr

Address: 600 S Maple St Bx 68 Piper City 60959
Number City Zip Code

County: Ford

Telephone Number: (815) 686-2277 Fax # (815) 686-2326

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2010

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

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

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Piper City Rehab Living Ctr

0056432 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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	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	8,466	5,814	741	15,021	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,466	5,814	741	15,021	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.59%

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)

Independent Living, Meals on Wheels

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1/1/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 60 and days of care provided 686

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 **Piper City Rehab Living Ctr** # **0056432** 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	159,893	13,663	1,922	175,478		175,478	(17,775)	157,703			1
2	Food Purchase		124,416		124,416		124,416	(16,883)	107,533			2
3	Housekeeping	125,979	18,951		144,930		144,930	(17,907)	127,023			3
4	Laundry		7,584		7,584		7,584	(941)	6,643			4
5	Heat and Other Utilities			54,309	54,309		54,309	(6,466)	47,843			5
6	Maintenance	37,527	10,804	36,960	85,291		85,291	(8,182)	77,109			6
7	Other (specify):*											7
8	TOTAL General Services	323,399	175,418	93,191	592,008		592,008	(68,154)	523,854			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	822,520	52,177	119,227	993,924		993,924	1,185	995,109			10
10a	Therapy			173,398	173,398		173,398		173,398			10a
11	Activities	24,690	1,106		25,796		25,796	(2,173)	23,623			11
12	Social Services	27,858			27,858		27,858		27,858			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	875,068	53,283	299,825	1,228,176		1,228,176	(988)	1,227,188			16
	C. General Administration											
17	Administrative	62,004		141,200	203,204		203,204	(118,957)	84,247			17
18	Directors Fees											18
19	Professional Services			135,234	135,234		135,234	(90,117)	45,117			19
20	Dues, Fees, Subscriptions & Promotions			4,020	4,020		4,020	2,200	6,220			20
21	Clerical & General Office Expenses	28,550	1,804	6,433	36,787		36,787	24,733	61,520			21
22	Employee Benefits & Payroll Taxes			141,849	141,849		141,849	6,808	148,657			22
23	Inservice Training & Education							41	41			23
24	Travel and Seminar							13	13			24
25	Other Admin. Staff Transportation			2,090	2,090		2,090	2,865	4,955			25
26	Insurance-Prop.Liab.Malpractice			37,670	37,670		37,670	437	38,107			26
27	Other (specify):*											27
28	TOTAL General Administration	90,554	1,804	468,496	560,854		560,854	(171,977)	388,877			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,289,021	230,505	861,512	2,381,038		2,381,038	(241,119)	2,139,919			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							53,046	53,046			30
31	Amortization of Pre-Op. & Org.							57,255	57,255			31
32	Interest			3,195	3,195		3,195	238,322	241,517			32
33	Real Estate Taxes			35,311	35,311		35,311	158	35,469			33
34	Rent-Facility & Grounds			360,678	360,678		360,678	(360,678)				34
35	Rent-Equipment & Vehicles			15,530	15,530		15,530	1,452	16,982			35
36	Other (specify):*											36
37	TOTAL Ownership			414,714	414,714		414,714	(10,445)	404,269			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		13,692		13,692		13,692		13,692			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,043	103,043		103,043		103,043			42
43	Other (specify):*			51,705	51,705		51,705	(51,705)				43
44	TOTAL Special Cost Centers		13,692	154,748	168,440		168,440	(51,705)	116,735			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,289,021	244,197	1,430,974	2,964,192		2,964,192	(303,269)	2,660,923			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	(831)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,878)	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	2,764	30		9
10	Interest and Other Investment Income	(6)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(99)	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	(26,503)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(104,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,420)	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	(92,108)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (242,081)		\$	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)	(61,188)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (61,188)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (303,269)		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	\$ (3,221)	43	1
2	X-Rays-Part A	439	43	2
3	Offset Transportation Revenue	(2,173)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(67)	21	4
5	Resident Flowers	(85)	43	5
6	Disallowed Special Events	(938)	43	6
7	Independent Living Dietary Cost Offset	(21,775)	1	7
8	Independent Living Food Cost Offset	(15,439)	2	8
9	Independent Living Housekeeping Cost Offset	(17,984)	3	9
10	Independent Living Laundry Cost Offset	(941)	4	10
11	Independent Living Utilities Cost Offset	(6,739)	5	11
12	Independent Living Maintenance Cost Offset	(10,584)	6	12
13	Independent Living Depreciation Cost Offset	(9,425)	30	13
14	Offset Miscellaneous Nursing Supplies Revenue	(2,563)	10	14
15	Disallowed Meals on Wheels Revenue	(613)	2	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(92,108)		49

VII. RELATED PARTIES

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

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

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

☒

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,000	\$ 4,000	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%	77	77	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	273	273	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,402	2,402	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%	3,748	3,748	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	141,200	Petersen Health Care Management, Inc.	100.00%	22,243	(118,957)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	13,139	13,139	12
13	V								13
14	Total			\$ 141,200			\$ 45,882	\$ * (95,318)	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%	\$ 2,048	\$ 2,048	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	24,800	24,800	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	6,808	6,808	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	41	41	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	13	13	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,865	2,865	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	437	437	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	4,049	4,049	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%	197	197	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	158	158	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,452	1,452	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			\$			\$ 42,868	\$ * 42,868	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	\$	Midwest Health Operations, LLC	100.00%	\$	\$	15
16	V	2	Food		Midwest Health Operations, LLC	100.00%			16
17	V	3	Housekeeping		Midwest Health Operations, LLC	100.00%			17
18	V	5	Utilities		Midwest Health Operations, LLC	100.00%			18
19	V	6	Maintenance		Midwest Health Operations, LLC	100.00%			19
20	V	7	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%			20
21	V	9	Medical Director		Midwest Health Operations, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Midwest Health Operations, LLC	100.00%			22
23	V	10A	Therapy		Midwest Health Operations, LLC	100.00%			23
24	V	15	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%			24
25	V	17	Administrative		Midwest Health Operations, LLC	100.00%			25
26	V	19	Professional Services		Midwest Health Operations, LLC	100.00%	744	744	26
27	V	20	Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	152	152	27
28	V	21	Clerical and General Office		Midwest Health Operations, LLC	100.00%			28
29	V	22	Employee Benefits and Payroll Taxes		Midwest Health Operations, LLC	100.00%			29
30	V	23	Inservice Training & Education		Midwest Health Operations, LLC	100.00%			30
31	V	24	Travel and Seminar		Midwest Health Operations, LLC	100.00%			31
32	V	25	Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%			32
33	V	26	Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%			33
34	V	30	Depreciation		Midwest Health Operations, LLC	100.00%			34
35	V	31	Amortization		Midwest Health Operations, LLC	100.00%			35
36	V	32	Interest		Midwest Health Operations, LLC	100.00%	177	177	36
37	V	33	Real Estate Taxes		Midwest Health Operations, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%			38
39	Total			\$			\$ 1,073	\$ * 1,073	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.

☒ X

 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	\$	Piper City Land, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	Piper City Land, LLC	100.00%			16
17	V	21	Equipment		Piper City Land, LLC	100.00%			17
18	V	26	Insurance-Property		Piper City Land, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		Piper City Land, LLC	100.00%			19
20	V	30	Depreciation		Piper City Land, LLC	100.00%	55,658	55,658	20
21	V	31	Amortization		Piper City Land, LLC	100.00%	57,255	57,255	21
22	V	32	Interest		Piper City Land, LLC	100.00%	237,954	237,954	22
23	V	33	Real Estate Taxes		Piper City Land, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	360,678	Piper City Land, LLC	100.00%		(360,678)	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			\$ 360,678			\$ 350,867	\$ * (9,811)	39

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

Facility Name & ID Number

Piper City Rehab Living Ctr

0056432

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

Piper City Rehab Living Ctr

0056432

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

Piper City Rehab Living Ctr

0056432

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 Piper City Rehab Living Ctr # 0056432 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 Piper City Rehab Living Ctr# 0056432

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 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	15,021	\$ 4,000	1
2	2	Food	Resident Days	1,282,791	75	0	0	15,021	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	15,021	77	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	15,021	273	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	15,021	2,402	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	15,021	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	15,021	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	15,021	3,748	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	15,021	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	15,021	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	15,021	22,243	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	15,021	13,139	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	15,021	2,048	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	15,021	24,800	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	15,021	6,808	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	15,021	41	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	15,021	13	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	15,021	2,865	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	15,021	437	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	15,021	4,049	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	15,021	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	15,021	197	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	15,021	158	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	15,021	1,452	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 88,750	25

Facility Name & ID Number Piper City Rehab Living Ctr# 0056432

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

Midwest Health Operations, 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	63,788	6	\$	\$	9,205	\$	1
2	2	Food	Resident Days	63,788	6			9,205		2
3	3	Housekeeping	Resident Days	63,788	6			9,205		3
4	5	Utilities	Resident Days	63,788	6			9,205		4
5	6	Maintenance	Resident Days	63,788	6			9,205		5
6	7	Mgmt. Allocation of Benefits	Resident Days	63,788	6			9,205		6
7	9	Medical Director	Resident Days	63,788	6			9,205		7
8	10	Nursing and Medical Records	Resident Days	63,788	6			9,205		8
9	10A	Therapy	Resident Days	63,788	6			9,205		9
10	15	Mgmt. Allocation of Benefits	Resident Days	63,788	6			9,205		10
11	17	Administrative	Resident Days	63,788	6			9,205		11
12	19	Professional Services	Resident Days	63,788	6	5,155		9,205	744	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	63,788	6	1,050		9,205	152	13
14	21	Clerical and General Office	Resident Days	63,788	6			9,205		14
15	22	Employee Benefits and Payroll Ta	Resident Days	63,788	6			9,205		15
16	23	Inservice Training & Education	Resident Days	63,788	6			9,205		16
17	24	Travel and Seminar	Resident Days	63,788	6			9,205		17
18	25	Other Admin. Staff Transport.	Resident Days	63,788	6			9,205		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	63,788	6			9,205		19
20	30	Depreciation	Resident Days	63,788	6			9,205		20
21	31	Amortization	Resident Days	63,788	6			9,205		21
22	32	Interest	Resident Days	63,788	6	1,229		9,205	177	22
23	33	Real Estate Taxes	Resident Days	63,788	6			9,205		23
24	35	Rent-Equipment & Vehicles	Resident Days	63,788	6			9,205		24
25	TOTALS					\$ 7,434	\$		\$ 1,073	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	Morton Community Bank		X	Mortgage	\$20,000.00	8/28/17	\$ 1,796,875	\$ Paid	9/28/22	6.0000	\$ 3,195	1	
2	Sector		X	Mortgage	Varies	4/1/20	3,049,148	3,049,148	3/31/23	Varies	237,954	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$20,000.00		\$ 4,846,023	\$ 3,049,148			\$ 241,149	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(6)	10	
11								Home Office Allocation-PHCM			197	11	
12								Home Office Allocation-MHO			177	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 368	14	
15	TOTALS (line 9+line14)						\$ 4,846,023	\$ 3,049,148			\$ 241,517	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.			\$	36,127	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.)			\$	35,186	2															
3. Under or (over) accrual (line 2 minus line 1).			\$	(941)	3															
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	36,252	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.)				158	6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	35,469	7															
Real Estate Tax History:																				
Real Estate Tax Bill for Calendar Year:		2015 2016 2017 2018 2019	36,847 36,548 36,322 35,075 35,186	8 9 10 11 12	<table><tr><td></td><td>FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2019</td><td>\$</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td></tr></table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2019	\$	14	PLUS APPEAL COST FROM LINE 5	\$	15	LESS REFUND FROM LINE 6	\$	16	AMOUNT TO USE FOR RATE CALCULATION	\$
	FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2019	\$																		
14	PLUS APPEAL COST FROM LINE 5	\$																		
15	LESS REFUND FROM LINE 6	\$																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$																		
Accrual based on prior year tax bill.																				

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 Piper City Rehabilitation and Living Center COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0050773

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>04-04-03-300-003</u>	<u>Nursing Facility</u>	\$ <u>24,985.18</u>	\$ <u>24,985.18</u>
2. <u>04-04-03-302-003</u>	<u>Nursing Facility</u>	\$ <u>10,200.90</u>	\$ <u>10,200.90</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>35,186.08</u></u>	\$ <u><u>35,186.08</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.

A. Square Feet:

20,804

B. General Construction Type:

Exterior

Brick/Wood

Frame

Wood

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:

152,680

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

3

3. Current Period Amortization:

57,255

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	20,804	2011	\$ 40,500	1
2					2
3	TOTALS	20,804		\$ 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	60		2011		\$ 744,500	\$	25	\$ 29,780	\$ 29,780	\$ 282,910
5										
6										
7										
8										
	Improvement Type**									
9	Concrete Replacement			2010	7,606		15	508	508	4,826
10	Roof Replacement			2013	9,330		15	622	622	4,665
11	Alarm System Panel Replacement			2013	3,705		7	260	260	3,705
12	Generator			2014	20,000		15	1,333	1,333	8,665
13	Nurses Station			2014	13,750		15	917	917	5,961
14	Sprinkler system			2014	19,700		7	2,814	2,814	18,291
15	Tile for 4 Shower Stall Walls and Floors			2016	13,600		15	906	906	4,077
16	Foyer Repair & Mechanical Room Door Replacement			2016	5,000		7	714	714	3,213
17	Air Conditioner			2016	12,100		15	806	806	3,627
18	HVAC Rooftop Unit			2017	9,921		15	662	662	2,317
19	Sewer Line Repair			2017	4,397		7	628	628	2,198
20	Sewer Line Repair			2018	3,597		7	514	514	1,285
21	Air Conditioner-Rooftop			2018	9,653		15	644	644	1,610
22	Nurses Station Annunciator Panel			2018	2,846		7	406	406	1,015
23	Nurses Station Annunciator Panel Installation Completion			2020	2,846		7	203	203	203
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					507			(507)	
31	Building Booked					29,780			(29,780)	
32	Building Improvement Booked					9,967			(9,967)	
33										
34	2020-Home Office Allocation-Building Improvements				7,595			182	182	
35	2020-Home Office Allocation-Land Improvements				762			48	48	
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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 890,908	\$ 40,254		\$ 41,947	\$ 1,693	\$ 348,568	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	\$66,685	\$5,979	\$7,280	\$1,301	5-10 yrs.	\$51,772	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,819	3,819			74
75	TOTALS	\$66,685	\$5,979	\$11,099	\$5,120		\$51,772	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	998,093
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	46,233
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	53,046
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	6,813
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	400,340

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	Flooring for Assisted Living Facility	\$13,740	\$916	\$6,641
87	Assisted Living Facility	190,000	7,600	74,100
88	Foyer Repair	4,787	684	2,964
89	Air Conditioner	3,387	225	357
90				
91	TOTALS	\$211,914	\$9,425	\$84,062

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? X YES NO
16. Rental Amount for movable equipment: \$ 16,982 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.

Piper City Rehab Living Ctr
0056432
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	\$	9,843
Dishwasher		1,403
Copier		4,284
Home Office Allocation		<u>1,452</u>
		<u><u>16,982</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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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				
					Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,777	\$ 101,654	\$	6,777	\$ 101,654	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,798	26,969		1,798	26,969	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,985	44,775		2,985	44,775	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				13,692		13,692	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	11,560	\$ 173,398	\$ 13,692	11,560	\$ 187,090	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	\$ (27,878)	\$ (27,878)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 37,920)	902,944	902,944	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,127	17,127	6
7	Other Prepaid Expenses	478,105	478,105	7
8	Accounts Receivable (owners or related parties)	25,000	35,054	8
9	Other(specify): Security Deposit	1,971	1,971	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,397,269	\$ 1,407,323	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		752,095	14
15	Leasehold Improvements, at Historical Cost		138,813	15
16	Equipment, at Historical Cost		66,685	16
17	Accumulated Depreciation (book methods)		(400,340)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		152,680	19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs		(57,255)	20
21	Restricted Funds	38,490	272,164	21
22	Other Long-Term Assets (specify):	23,777	23,777	22
23	Other(specify): Building-Assisted Living		127,852	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 62,267	\$ 1,116,971	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,459,536	\$ 2,524,294	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 768,172	\$ 768,172	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,017	50,017	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,252	36,252	32
33	Accrued Interest Payable		36,566	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	131,171	131,171	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 985,612	\$ 1,022,178	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,049,148	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,195,312	1,024,678	43
44	Notes Payable-SBA PPP	252,800	252,800	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,448,112	\$ 4,326,626	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,433,724	\$ 5,348,804	46
47	TOTAL EQUITY (page 18, line 24)	\$ (974,188)	\$ (2,824,510)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,459,536	\$ 2,524,294	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (913,132)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(176,561)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,089,693)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	115,505	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)	\$ 115,505	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)	\$ (974,188)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Piper City Rehab Living Ctr

0056432

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	\$ 2,697,833	1
2	Discounts and Allowances for all Levels	(350,970)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,346,863	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	43,824	5
6	Therapy	334,483	6
7	Oxygen	11,715	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 390,022	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	1,444	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,293	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,609	20
21	Other Medical Services	12,534	21
22	Laundry	(25)	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 43,855	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	2,173	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	296,778	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 298,951	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,079,697	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	592,008	31
32	Health Care	1,228,176	32
33	General Administration	560,854	33
	B. Capital Expense		
34	Ownership	414,714	34
	C. Ancillary Expense		
35	Special Cost Centers	65,397	35
36	Provider Participation Fee	103,043	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,964,192	40
41	Income before Income Taxes (line 30 minus line 40)**	115,505	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 115,505	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,238,185	44
45	Private Pay - Net Inpatient Revenue	970,865	45
46	Medicare - Net Inpatient Revenue	126,491	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	11,322	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,346,863	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	647	688	\$ 22,072	\$ 32.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,556	2,610	81,708	31.31	3
4	Licensed Practical Nurses	10,498	10,868	312,988	28.80	4
5	CNAs & Orderlies	24,919	25,436	360,840	14.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,850	2,043	24,690	12.09	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	27,858	13.39	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	31,114	14.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,415	13,739	128,779	9.37	15
16	Dishwashers					16
17	Maintenance Workers	2,156	2,188	37,527	17.15	17
18	Housekeepers	9,315	9,527	125,979	13.22	18
19	Laundry					19
20	Administrator	2,009	2,113	62,004	29.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,849	1,881	28,550	15.18	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	1,891	2,073	36,017	17.37	31
32	Other Health Care(specify)					32
33	Other(specify) CPC	314	314	8,895	28.33	33
34	TOTAL (lines 1 - 33)	75,579	77,640	\$ 1,289,021 *	\$ 16.60	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	32	\$ 1,922	L1, C3	35
36	Medical Director	Monthly	7,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,559	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	6	358	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	38	\$ 14,039		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	228	\$ 7,760	L10,C3	50
51	Licensed Practical Nurses	3,239	89,111	L10,C3	51
52	Certified Nurse Assistants/Aides	750	17,439	L10,C3	52
53	TOTAL (lines 50 - 52)	4,217	\$ 114,310		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Cyra Kennedy	Administrator	0	\$ 34,346
Kimberly Denault	Administrator	0	27,658
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,004
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7		\$	141,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 141,200
C. Professional Services			
Vendor/Payee	Type		Amount
Frontier	Computer Services	\$	2,715
Ability Network	Computer Services		4,937
All Scripts	Data Services		1,829
Jerry Brown	Legal Settlement		104,000
Duane Morris LLP	Legal Fees-J. Brown Case		21,444
Sector	Title Lien Search-July 2020		309
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 135,234
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	17,434
Unemployment Compensation Insurance			18,296
FICA Taxes			90,983
Employee Health Insurance			2,017
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			360
Home Office Allocation			6,808
Employee Retirement			363
Administrator Benefits			12,396
TOTAL (agree to Schedule V, line 22, col.8)			\$ 148,657
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,990
Advertising: Employee Recruitment			1,159
Health Care Worker Background Check (Indicate # of checks performed)	15		
Patient Background Checks	1		20
Miscellaneous Licenses & Permits			851
Home Office Allocation			2,200
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 6,220
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			
Home Office Allocation			13
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	13

*** Attach copy of IMRF notifications**

****See instructions.**

**Piper City Rehab Living Ctr
0056432**

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)		135,234
Non-Allowable Legal Settlement		(104,000)
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	231
Duane Morris	Legal	323
Lexis Nexis	Legal	6
Livingston, Barger, Brant, Schroeder	Legal	12
Miller, Hall, Triggs	Legal	40
Miscellaneous	Legal	15
SB2	Legal	119
SmithAmundsen LLC	Legal	739
Sorling Northrup	Legal	211
Illinois Secretary of State	Legal	95
CliftonLarsonAllen	Accounting	918
Ginoli & Co.	Accounting	1,305
Ability Network	Computer Services	2,358
Allscripts	Computer Services	372
AOD Matrix Care	Computer Services	4,141
AT&T	Computer Services	4
ATS	Computer Services	226
CCH	Computer Services	13
Charter Communications	Computer Services	21
Citrix Systems	Computer Services	70
Comcast	Computer Services	24
ITSavvy	Computer Services	109
Kemper Technology	Computer Services	538
Miscellaneous	Computer Services	104
Pearl Technology	Computer Services	97
Stratus Networks	Computer Services	428
TR Professional	Computer Services	9
David Budde	Other Prof Fees	9
DJ Howard and Associates	Other Prof Fees	18
Getzler Henrich & Associates	Other Prof Fees	73
LRI Consulting Services	Other Prof Fees	71
McQuellon Consulting	Other Prof Fees	45
Miscellaneous	Other Prof Fees	88
Optimizer	Other Prof Fees	38
Registered Agent Solutions	Other Prof Fees	21
RSM McGladrey	Other Prof Fees	234
SB2	Other Prof Fees	299
Sedgwick CMS	Other Prof Fees	403
Tarver Program Consultants	Other Prof Fees	56
Total (agree to Schedule V, line 19, column 8)		<u><u>45,117</u></u>

Piper City Rehab Living Ctr
0056432
Period Beginning 1/1/2020
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Schedule 21B

25. Administrative and Staff Transportation

Gas	\$ 1,094
Auto Repairs	996
Mileage-Travel	-
Home Office Allocation	<u>2,865</u>
	<u><u>4,955</u></u>

XX. GENERAL INFORMATION:

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

No

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

No

If YES, give association name and amount.

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

No

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

N/A

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

No

If YES, what is the capacity?

N/A

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

Yes

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

7 yrs.

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

\$ 17,196

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.

\$ 103,043

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.

\$ 831

(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.

\$ 2,173

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.

HFS 3745 (N-4-99)

IL478-2471

Piper City Rehabilitation and Living Center
0050773
Period Beginning 1/1/2020
Period End 12/31/2020

Independent Living Offset

Schedule 23A

Census Days Summary:

	Days	%
Independent Living	2,128	12.41%
Nursing Home	15,021	87.59%
	17,149	100.00%

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	175,478	12.41%	21,775	Census	1
Food	124,416	12.41%	15,439	Census	2
Housekeeping	144,930	12.41%	17,984	Census	3
Laundry	7,584	12.41%	941	Census	4
Utilities	54,309	12.41%	6,739	Census	5
Maintenance	85,291	12.41%	10,584	Census	6
Depreciation (Building)	9,425	100.00%	9,425	Beds	30
Total	601,433		82,887		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on total number of beds.
Independent Living overhead and depreciation costs have been offset on P5A.