

		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: 0056457

Facility Name: Pleasant View Rehab HCC

Address: 500 North Jackson St Morrison 61270
Number City Zip Code

County: Whiteside

Telephone Number: (815) 772-7288 Fax # (815)772-2399

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2009

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

Paid
Preparer

(Signed)
(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 Pleasant View Rehab HCC

0056457 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>74</u>	Skilled (SNF)	<u>74</u>	<u>27,010</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>74</u>	TOTALS	<u>74</u>	<u>27,010</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>8,586</u>	<u>1,683</u>	<u>1,120</u>	<u>11,389</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>8,586</u>	<u>1,683</u>	<u>1,120</u>	<u>11,389</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.17%

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 4/1/2009

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

YES ☒ Date 4/1/2009 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 74 and days of care provided 1,120

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ 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 Pleasant View Rehab HCC # 0056457 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	127,296	8,403		135,699		135,699	3,032	138,731			1
2	Food Purchase		75,922		75,922		75,922	(2,817)	73,105			2
3	Housekeeping	96,161	14,326		110,487		110,487	59	110,546			3
4	Laundry	1,064	4,683		5,747		5,747		5,747			4
5	Heat and Other Utilities			46,701	46,701		46,701	207	46,908			5
6	Maintenance	35,920	8,555	24,471	68,946		68,946	1,821	70,767			6
7	Other (specify):*											7
8	TOTAL General Services	260,441	111,889	71,172	443,502		443,502	2,302	445,804			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	679,948	44,814	7,626	732,388		732,388	2,613	735,001			10
10a	Therapy			126,357	126,357		126,357		126,357			10a
11	Activities	10,923	172		11,095		11,095	6,140	17,235			11
12	Social Services	17,911			17,911		17,911		17,911			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	708,782	44,986	157,983	911,751		911,751	8,753	920,504			16
	C. General Administration											
17	Administrative	69,000		119,200	188,200		188,200	(102,335)	85,865			17
18	Directors Fees											18
19	Professional Services			7,808	7,808		7,808	12,072	19,880			19
20	Dues, Fees, Subscriptions & Promotions			3,011	3,011		3,011	1,553	4,564			20
21	Clerical & General Office Expenses	27,042	914	4,687	32,643		32,643	18,775	51,418			21
22	Employee Benefits & Payroll Taxes			124,532	124,532		124,532	5,162	129,694			22
23	Inservice Training & Education							31	31			23
24	Travel and Seminar							10	10			24
25	Other Admin. Staff Transportation			642	642		642	2,173	2,815			25
26	Insurance-Prop.Liab.Malpractice			33,612	33,612		33,612	331	33,943			26
27	Other (specify):*											27
28	TOTAL General Administration	96,042	914	293,492	390,448		390,448	(62,228)	328,220			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,065,265	157,789	522,647	1,745,701		1,745,701	(51,173)	1,694,528			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			16,363	16,363		16,363	36,677	53,040			30
31	Amortization of Pre-Op. & Org.			2,156	2,156		2,156	17,247	19,403			31
32	Interest			22,805	22,805		22,805	159,754	182,559			32
33	Real Estate Taxes			32,903	32,903		32,903	119	33,022			33
34	Rent-Facility & Grounds			58,618	58,618		58,618	(58,618)				34
35	Rent-Equipment & Vehicles			6,905	6,905		6,905	1,101	8,006			35
36	Other (specify):*											36
37	TOTAL Ownership			139,750	139,750		139,750	156,280	296,030			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,764		31,764		31,764		31,764			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,693	103,693		103,693		103,693			42
43	Other (specify):*			67,352	67,352		67,352	(67,352)				43
44	TOTAL Special Cost Centers		31,764	171,045	202,809		202,809	(67,352)	135,457			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,065,265	189,553	833,442	2,088,260		2,088,260	37,755	2,126,015			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,817)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,802)	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	178	30		9
10	Interest and Other Investment Income	(2,280)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(209)	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	(7,309)	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	(51,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,577)	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	5,428	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (66,388)		\$	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	2	
		Amount	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)	104,143	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 104,143		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 37,755		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	2	3	4	
		Yes	No	Amount	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	\$ (1,414)	43	1
2	X-Rays-Part A	665	43	2
3	Disallowed Pet Expense	(415)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(28)	21	4
5	Offset Transportation Revenue	6,140	11	5
6	Disallowed Special Events	709	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(229)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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	5,428		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%	\$ 3,032	\$ 3,032	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%	59	59	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	207	207	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,821	1,821	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%	2,842	2,842	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	119,200	Petersen Health Care Management, Inc.	100.00%	16,865	(102,335)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	9,962	9,962	12
13	V								13
14	Total			\$ 119,200			\$ 34,788	\$ * (84,412)	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%	\$ 1,553	\$ 1,553	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	18,803	18,803	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	5,162	5,162	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	31	31	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	10	10	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,173	2,173	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	331	331	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	3,070	3,070	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%	150	150	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	119	119	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,101	1,101	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			\$			\$ 32,503	\$ * 32,503	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 Business, LLC	100.00%	\$	\$	15
16	V	2	Food		Petersen Health Business, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Business, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Business, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Business, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Business, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Business, LLC	100.00%			22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%			23
24	V	17	Administrative		Petersen Health Business, LLC	100.00%			24
25	V	19	Professional Services		Petersen Health Business, LLC	100.00%	2,110	2,110	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%			26
27	V	21	Clerical and General Office		Petersen Health Business, LLC	100.00%			27
28	V	22	Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%			28
29	V	23	Inservice Training & Education		Petersen Health Business, LLC	100.00%			29
30	V	24	Travel and Seminar		Petersen Health Business, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%			32
33	V	30	Depreciation		Petersen Health Business, LLC	100.00%			33
34	V	31	Amortization		Petersen Health Business, LLC	100.00%			34
35	V	32	Interest		Petersen Health Business, LLC	100.00%	5,980	5,980	35
36	V	33	Real Estate Taxes		Petersen Health Business, LLC	100.00%			36
37	V	34	Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%			38
39	Total			\$			\$ 8,090	\$ * 8,090	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	\$	Pleasant View Land, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	Pleasant View Land, LLC	100.00%			16
17	V	21	Equipment		Pleasant View Land, LLC	100.00%			17
18	V	26	Insurance-Property		Pleasant View Land, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		Pleasant View Land, LLC	100.00%			19
20	V	30	Depreciation		Pleasant View Land, LLC	100.00%	33,429	33,429	20
21	V	31	Amortization		Pleasant View Land, LLC	100.00%	17,247	17,247	21
22	V	32	Interest		Pleasant View Land, LLC	100.00%	155,904	155,904	22
23	V	33	Real Estate Taxes		Pleasant View Land, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	58,618	Pleasant View Land, LLC	100.00%		(58,618)	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			\$ 58,618			\$ 206,580	\$ * 147,962	39

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

Facility Name & ID Number

Pleasant View Rehab HCC

0056457

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

Pleasant View Rehab HCC

0056457

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

Pleasant View Rehab HCC

0056457

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

Facility Name & ID Number

Pleasant View Rehab HCC

0056457

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			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 Pleasant View Rehab HCC # 0056457 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 Pleasant View Rehab HCC

0056457

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	11,389	\$ 3,032	1
2	2	Food	Resident Days	1,282,791	75	0	0	11,389	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	11,389	59	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	11,389	207	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	11,389	1,821	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	11,389	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	11,389	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	11,389	2,842	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	11,389	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	11,389	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	11,389	16,865	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	11,389	9,962	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	11,389	1,553	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	11,389	18,803	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	11,389	5,162	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	11,389	31	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	11,389	10	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	11,389	2,173	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	11,389	331	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	11,389	3,070	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	11,389	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	11,389	150	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	11,389	119	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	11,389	1,101	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 67,291	25

Facility Name & ID Number Pleasant View Rehab HCC

0056457

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Business, 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	70,323	9	\$	\$	6,797	\$	1
2	2	Food	Resident Days	70,323	9			6,797		2
3	3	Housekeeping	Resident Days	70,323	9			6,797		3
4	4	Laundry	Resident Days	70,323	9			6,797		4
5	5	Utilities	Resident Days	70,323	9			6,797		5
6	6	Maintenance	Resident Days	70,323	9			6,797		6
7	7	Mgmt. Allocation of Benefits	Resident Days	70,323	9			6,797		7
8	10	Nursing and Medical Records	Resident Days	70,323	9			6,797		8
9	15	Mgmt. Allocation of Benefits	Resident Days	70,323	9			6,797		9
10	17	Administrative	Resident Days	70,323	9			6,797		10
11	19	Professional Services	Resident Days	70,323	9	21,833		6,797	2,110	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	70,323	9			6,797		12
13	21	Clerical and General Office	Resident Days	70,323	9			6,797		13
14	22	Employee Benefits & Payroll	Resident Days	70,323	9			6,797		14
15	23	Inservice Training & Education	Resident Days	70,323	9			6,797		15
16	24	Travel and Seminar	Resident Days	70,323	9			6,797		16
17	25	Other Admin. Staff Transport.	Resident Days	70,323	9			6,797		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	70,323	9			6,797		18
19	30	Depreciation	Resident Days	70,323	9			6,797		19
20	31	Amortization	Resident Days	70,323	9			6,797		20
21	32	Interest	Resident Days	70,323	9	61,870		6,797	5,980	21
22	33	Real Estate Taxes	Resident Days	70,323	9			6,797		22
23	34	Rent-Facility and Grounds	Resident Days	70,323	9			6,797		23
24	35	Rent-Equipment & Vehicles	Resident Days	70,323	9			6,797		24
25	TOTALS					\$ 83,703	\$		\$ 8,090	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	Bank Leumi		X	Mortgage	Varies	1/1/15	\$ 2,047,904	\$ Paid	12/31/24	Varies	\$ 22,805	1	
2	Sector		X	Mortgage	Varies	4/1/20	1,033,322	1,033,322	3/31/23	Varies	155,904	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 3,081,226	\$ 1,033,322			\$ 178,709	9	
	B. Non-Facility Related*												
10								Income Offset			(2,280)	10	
11								Home Office Allocation-PHCM			150	11	
12								Home Office Allocation-PHB			5,980	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 3,850	14	
15	TOTALS (line 9+line14)							\$ 3,081,226	\$ 1,033,322			\$ 182,559	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

[illegible]

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 Pleasant View Rehab & Health Care COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0053520

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. 09-17-130-001	Long-Term Care Facility	\$ 34,439.00	\$ 34,439.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 34,439.00	\$ 34,439.00

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: 23,743

B. General Construction Type: Exterior BrickFrame Metal

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: 51,742

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

3. Current Period Amortization: 19,403

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	23,743	2009	\$ 183,000	1
2					2
3	TOTALS	23,743		\$ 183,000	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	74		2009	1974	\$ 992,911	\$	25	\$ 39,716	\$ 39,716	\$ 456,734
5										
6										
7										
8										
	Improvement Type**									
9	Drain Line Repair			2010	2,567		7			2,567
10	Fire Alarm Panel			2010	3,300		7			3,300
11	Water Softener			2011	3,415		7			3,415
12	Generator Repair			2014	3,349		7	481	481	3,349
13	Air Conditioner			2015	4,035		15	270	270	1,215
14	Sewer Line Repair			2015	4,129		7	590	590	2,655
15	Water Heater			2016	4,309		7	616	616	2,772
16	Water Heater			2016	4,020		7	574	574	2,583
17	Air Conditioner Repair			2017	2,661		7	380	380	1,330
18	Heater/Air Conditioner-Rooftop			2017	4,350		15	290	290	1,015
19	Water Pipe Repair			2017	3,057		7	436	436	1,526
20	Heater/Air Conditioner-Rooftop			2018	4,350		15	290	290	725
21	RTU Unit			2019	11,450		15	764	764	1,146
22	Wandering Patient Door System			2019	5,450		7	778	778	1,167
23	Heating/Cooling Unit			2019	7,235		15	482	482	723
24	Furnace			2020	14,471		15	482	482	482
25	Sprinkler Repair			2020	3,177		7	227	227	227
26										
27										
28										
29										
30										
31	Building Booked					39,716			(39,716)	
32	Building Improvement Booked					6,951			(6,951)	
33										
34	2020-Home Office Allocation-Building Improvements				5,758			138	138	
35	2020-Home Office Allocation-Land Improvements				578			37	37	
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)	\$ 1,084,572	\$ 46,667		\$ 46,551	\$ (116)	\$ 486,931	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	\$ 29,225	\$ 3,024	\$ 3,392	\$ 368	5-10 yrs.	\$ 19,468	71
72	Current Year Purchases	2,822	101	202	101	7 yrs.	202	72
73	Fully Depreciated Assets	286,518					286,518	73
74	Home Office Allocation			2,895	2,895			74
75	TOTALS	\$ 318,565	\$ 3,125	\$ 6,489	\$ 3,364		\$ 306,188	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	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)	\$ 1,586,137	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,792	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 53,040	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,248	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 793,119	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. 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: \$ 8,006 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.

Pleasant View Rehab HCC
0056457
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	\$	2,702
Dishwasher		701
Copier		3,502
Home Office Allocation		<u>1,101</u>
		<u><u>8,006</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
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,666	\$ 54,987	\$	3,666	\$ 54,987	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		129	1,935		129	1,935	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,629	69,435		4,629	69,435	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				31,764		31,764	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
			hrs							
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	8,424	\$ 126,357	\$ 31,764	8,424	\$ 158,121	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	\$ (9,768)	\$ (9,768)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 227,199)	2,051,282	2,051,282	3
4	Supply Inventory (priced at Cost)	8,197	8,197	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,716	17,716	6
7	Other Prepaid Expenses		1,891	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Sec. Deposit and Emp. Ed Loans</u>	1,782	1,782	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,069,209	\$ 2,071,100	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		183,000	13
14	Buildings, at Historical Cost		998,669	14
15	Leasehold Improvements, at Historical Cost	3,177	85,903	15
16	Equipment, at Historical Cost	2,822	318,565	16
17	Accumulated Depreciation (book methods)	(139)	(793,119)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		32,339	19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds	68,472	147,661	21
22	Other Long-Term Assets (specify) <u>Goodwill</u>	650,000	650,000	22
23	Other(specify): <u>Intercompany Loans</u>	648,755	653,703	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,373,087	\$ 2,276,721	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,442,296	\$ 4,347,821	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 463,914	\$ 463,914	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,020	45,020	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,472	35,472	32
33	Accrued Interest Payable		12,392	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	57,263	57,263	36
37	<u>Accrued Management Fees</u>	13,813	13,813	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 615,482	\$ 627,874	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,033,322	40
41	Bonds Payable			41
42	Deferred Compensation	14,681	14,681	42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Loan Payable-MCAD Adv. & SBA PPP</u>	628,000	628,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 642,681	\$ 1,676,003	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,258,163	\$ 2,303,877	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,184,133	\$ 2,043,944	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,442,296	\$ 4,347,821	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 20,667	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	1,438,104	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,458,771	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	725,362	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 725,362	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,184,133	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pleasant View Rehab HCC

0056457

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	\$ 2,240,166	1
2	Discounts and Allowances for all Levels	(82,546)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,157,620	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	170,514	6
7	Oxygen	(2)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 170,512	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	2,817	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	52,496	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,424	20
21	Other Medical Services	1,756	21
22	Laundry	327	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 59,820	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,280	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,280	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	(6,140)	28
28a	Miscellaneous and COVID Stimulus Revenue	429,530	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 423,390	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,813,622	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	443,502	31
32	Health Care	911,751	32
33	General Administration	390,448	33
	B. Capital Expense		
34	Ownership	139,750	34
	C. Ancillary Expense		
35	Special Cost Centers	99,116	35
36	Provider Participation Fee	103,693	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,088,260	40
41	Income before Income Taxes (line 30 minus line 40)**	725,362	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 725,362	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,454,386	44
45	Private Pay - Net Inpatient Revenue	219,285	45
46	Medicare - Net Inpatient Revenue	483,949	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,157,620	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	2,080	2,080	\$ 67,980	\$ 32.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,024	2,132	61,690	28.94	3
4	Licensed Practical Nurses	7,122	7,268	174,257	23.98	4
5	CNAs & Orderlies	21,296	21,805	319,923	14.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	306	306	4,563	14.91	9
10	Activity Assistants	636	636	6,360	10.00	10
11	Social Service Workers	1,175	1,181	17,911	15.17	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	32,033	15.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,216	8,520	95,263	11.18	15
16	Dishwashers					16
17	Maintenance Workers	1,962	1,962	35,920	18.31	17
18	Housekeepers	9,171	9,429	96,161	10.20	18
19	Laundry	104	104	1,064	10.23	19
20	Administrator	2,048	2,080	69,000	33.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,863	1,987	27,042	13.61	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) CPC	2,005	2,005	56,098	27.98	33
34	TOTAL (lines 1 - 33)	62,088	63,575	\$ 1,065,265 *	\$ 16.76	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	24,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,394	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	10	666	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)	10	\$ 28,060		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	223	3,566	L10,C3	52
53	TOTAL (lines 50 - 52)	223	\$ 3,566		53

Facility Name & ID Number

Pleasant View Rehab HCC

STATE OF ILLINOIS

0056457

Report Period Beginning:

1/1/2020

Page 21

Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
Linda Verway		Administrator	0	\$ 69,000	Workers' Compensation Insurance		\$ 18,431	IDPH License Fee		\$ 1,990		
					Unemployment Compensation Insurance		12,144	Advertising: Employee Recruitment				
					FICA Taxes		75,365	Health Care Worker Background Check				
					Employee Health Insurance		4,631	(Indicate # of checks performed 23)				
					Employee Meals			Patient Background Checks		8 240		
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		781		
					Employee Relations		161	Home Office Allocation		1,553		
					Home Office Allocation		5,162					
					Administrator Benefits		13,800					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 69,000								
B. Administrative - Other												
Description			Amount									
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 119,200					Less: Public Relations Expense			()	
								Non-allowable advertising			()	
								Yellow page advertising			()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 119,200	TOTAL (agree to Schedule V, line 22, col.8)			\$ 129,694	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 4,564	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**				
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description		Amount		
Abilty Network		Computer Services	\$ 5,969					Out-of-State Travel		\$		
Mediacom		Computer Services	1,692									
Sector Bank		Lien Title Search-July 2020	147					In-State Travel				
				N/A								
								Seminar Expense				
								Home Office Allocation		10		
								Entertainment Expense		()		
								(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 7,808	TOTAL				TOTAL		\$ 10		

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Pleasant View Rehab HCC

0056457

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)		7,808

Home Office Allocation

Baker Tilly Virchow Krause LLP	Legal	175
Duane Morris	Legal	245
Lexis Nexis	Legal	5
Livingston, Barger, Brant, Schroeder	Legal	9
Miller, Hall, Triggs	Legal	30
Miscellaneous	Legal	11
SB2	Legal	91
SmithAmundsen LLC	Legal	560
Sorling Northrup	Legal	160
Sector Bank	Legal	1,621
CliftonLarsonAllen	Accounting	696
Ginoli & Co.	Accounting	986
Ability Network	Computer Services	1,788
Allscripts	Computer Services	282
AOD Matrix Care	Computer Services	3,140
AT&T	Computer Services	3
ATS	Computer Services	171
CCH	Computer Services	10
Charter Communications	Computer Services	16
Citrix Systems	Computer Services	53
Comcast	Computer Services	18
ITSavvy	Computer Services	83
Kemper Technology	Computer Services	408
Miscellaneous	Computer Services	79
Pearl Technology	Computer Services	74
Stratus Networks	Computer Services	324
TR Professional	Computer Services	7
David Budde	Other Prof Fees	7
DJ Howard and Associates	Other Prof Fees	14
Getzler Henrich & Associates	Other Prof Fees	55
LRI Consulting Services	Other Prof Fees	54
McQuellon Consulting	Other Prof Fees	34
Miscellaneous	Other Prof Fees	67
Optimizer	Other Prof Fees	29
Registered Agent Solutions	Other Prof Fees	16
RSM McGladrey	Other Prof Fees	177
SB2	Other Prof Fees	227
Sedgwick CMS	Other Prof Fees	305
Tarver Program Consultants	Other Prof Fees	42

Total (agree to Schedule V, line 19, column 8)	<u>19,880</u>
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Pleasant View Rehab HCC
0056457
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	2,702
Auto Repairs		701
Mileage-Travel		3,502
Home Office Allocation		<u>1,101</u>
		<u>8,006</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?
If YES, give association name and amount. No

(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?
What was the average life used for new equipment added during this period? Yes
7 yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,066 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. \$ 103,693
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. \$ 2,817

(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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
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.