

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0053322</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Rock River Gardens</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>3601 Sixteenth Ave</u> <u>Sterling</u> <u>61081</u>																									
Number City Zip Code																									
County: <u>Whiteside</u>																									
Telephone Number: <u>(815) 626-0233</u> Fax # <u>(815) 626-6740</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Mark Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mark Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Mark Petersen</u>																								
	(Title) <u>Chief Executive Officer</u>																								
	(Signed) _____																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>11/1/2014</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u>																									
Email Address: _____																									

Facility Name & ID Number Rock River Gardens

0053322 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		Skilled (SNF)					1
2		Skilled Pediatric (SNF/PED)					2
3	70	Intermediate (ICF)		70	25,550		3
4		Intermediate/DD					4
5		Sheltered Care (SC)					5
6		ICF/DD 16 or Less					6
7	70	TOTALS		70	25,550		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
9	SNF/PED				9
10	ICF	17,908	247	18,155	10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	17,908	247	18,155	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.06%

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 11/1/2014

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

YES ☒ Date 11/1/2014 NO ☐

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

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

Medicare Intermediary N/A

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 **Rock River Gardens** # **0053322** 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	149,758	17,871		167,629		167,629	4,834	172,463			1
2	Food Purchase		129,147		129,147		129,147	(1,151)	127,996			2
3	Housekeeping	85,882	14,594		100,476		100,476	94	100,570			3
4	Laundry		5,584		5,584		5,584		5,584			4
5	Heat and Other Utilities			37,364	37,364		37,364	330	37,694			5
6	Maintenance	52,234	5,158	22,064	79,456		79,456	2,903	82,359			6
7	Other (specify):*											7
8	TOTAL General Services	287,874	172,354	59,428	519,656		519,656	7,010	526,666			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	715,918	26,701	140,895	883,514		883,514	4,476	887,990			10
10a	Therapy											10a
11	Activities	49,003	73		49,076		49,076		49,076			11
12	Social Services	63,703			63,703		63,703		63,703			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	828,624	26,774	158,895	1,014,293		1,014,293	4,476	1,018,769			16
	C. General Administration											
17	Administrative	62,004		134,000	196,004		196,004	(107,116)	88,888			17
18	Directors Fees											18
19	Professional Services			1,293	1,293		1,293	17,347	18,640			19
20	Dues, Fees, Subscriptions & Promotions			1,603	1,603		1,603	2,524	4,127			20
21	Clerical & General Office Expenses	32,609	2,082	12,077	46,768		46,768	29,959	76,727			21
22	Employee Benefits & Payroll Taxes			134,751	134,751		134,751	8,228	142,979			22
23	Inservice Training & Education							50	50			23
24	Travel and Seminar							15	15			24
25	Other Admin. Staff Transportation			3,334	3,334		3,334	3,463	6,797			25
26	Insurance-Prop.Liab.Malpractice			40,579	40,579		40,579	528	41,107			26
27	Other (specify):*											27
28	TOTAL General Administration	94,613	2,082	327,637	424,332		424,332	(45,002)	379,330			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,211,111	201,210	545,960	1,958,281		1,958,281	(33,516)	1,924,765			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			58,488	58,488		58,488	6,330	64,818			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			607	607		607	448	1,055			32
33	Real Estate Taxes			9,953	9,953		9,953	190	10,143			33
34	Rent-Facility & Grounds			30,240	30,240		30,240		30,240			34
35	Rent-Equipment & Vehicles			7,016	7,016		7,016	1,755	8,771			35
36	Other (specify):*											36
37	TOTAL Ownership			106,304	106,304		106,304	8,723	115,027			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,541	148,541		148,541		148,541			42
43	Other (specify):*			37,878	37,878		37,878	(37,878)				43
44	TOTAL Special Cost Centers			186,419	186,419		186,419	(37,878)	148,541			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,211,111	201,210	838,683	2,251,004		2,251,004	(62,671)	2,188,333			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	(1,151)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,220)	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	1,437	30		9
10	Interest and Other Investment Income	(140)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(123)	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	(16,101)	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	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,426)	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	673	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,051)		\$	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)	(24,620)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (24,620)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (62,671)		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

Rock River Gardens

	ID#	0053322
Report Period Beginning:		1/1/2020
Ending:		12/31/2020

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Offset Miscellaneous Office Supplies Revenue	\$ (15)	21	1
2	Disallowed Special Events	773	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	\$ (54)	10	3
4	Labs-Part A	(31)	43	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	673		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%	\$ 4,834	\$ 4,834	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%	94	94	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	330	330	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,903	2,903	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%	4,530	4,530	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	134,000	Petersen Health Care Management, Inc.	100.00%	26,884	(107,116)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	15,880	15,880	12
13	V								13
14	Total			\$ 134,000			\$ 55,455	\$ * (78,545)	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%	\$ 2,475	\$	2,475 15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	29,974		29,974 16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	8,228		8,228 17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	50		50 18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	15		15 19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,463		3,463 20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	528		528 21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	4,893		4,893 22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		0 23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	238		238 24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	190		190 25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,755		1,755 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			\$			\$ 51,809	\$ *	51,809 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	4	Laundry		Midwest Health Operations, LLC	100.00%			18
19	V	5	Utilities		Midwest Health Operations, LLC	100.00%			19
20	V	6	Maintenance		Midwest Health Operations, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Midwest Health Operations, LLC	100.00%			22
23	V	15	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%			23
24	V	17	Administrative		Midwest Health Operations, LLC	100.00%			24
25	V	19	Professional Services		Midwest Health Operations, LLC	100.00%			25
26	V	20	Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	1,467	1,467	26
27	V	21	Clerical and General Office		Midwest Health Operations, LLC	100.00%	299	299	27
28	V	22	Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%			28
29	V	23	Inservice Training & Education		Midwest Health Operations, LLC	100.00%			29
30	V	24	Travel and Seminar		Midwest Health Operations, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%			32
33	V	30	Depreciation		Midwest Health Operations, LLC	100.00%			33
34	V	31	Amortization		Midwest Health Operations, LLC	100.00%			34
35	V	32	Interest		Midwest Health Operations, LLC	100.00%			35
36	V	33	Real Estate Taxes		Midwest Health Operations, LLC	100.00%	350	350	36
37	V	34	Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%			38
39	Total			\$			\$ 2,116	\$ * 2,116	39

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

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 Syster	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	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

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

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 Rock River Gardens # 0053322 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 Rock River Gardens# 0053322

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 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	1,282,791	75	\$ 341,562	\$ 398,718	18,155	\$ 4,834	1
2	2	Food	Resident Days	1,282,791	75	0	0	18,155	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	18,155	94	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	18,155	330	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	18,155	2,903	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	18,155	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	18,155	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	18,155	4,530	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	18,155	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	18,155	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	18,155	26,884	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	18,155	15,880	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	18,155	2,475	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	18,155	29,974	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	18,155	8,228	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	18,155	50	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	18,155	15	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	18,155	3,463	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	18,155	528	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	18,155	4,893	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	18,155	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	18,155	238	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	18,155	190	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	18,155	1,755	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 107,264	25

Facility Name & ID Number Rock River Gardens# 0053322

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	\$	\$	18,155	\$	1
2	2	Food	Resident Days	63,788	6			18,155		2
3	3	Housekeeping	Resident Days	63,788	6			18,155		3
4	5	Utilities	Resident Days	63,788	6			18,155		4
5	6	Maintenance	Resident Days	63,788	6			18,155		5
6	7	Mgmt. Allocation of Benefits	Resident Days	63,788	6			18,155		6
7	9	Medical Director	Resident Days	63,788	6			18,155		7
8	10	Nursing and Medical Records	Resident Days	63,788	6			18,155		8
9	10A	Therapy	Resident Days	63,788	6			18,155		9
10	15	Mgmt. Allocation of Benefits	Resident Days	63,788	6			18,155		10
11	17	Administrative	Resident Days	63,788	6			18,155		11
12	19	Professional Services	Resident Days	63,788	6	5,155		18,155	1,467	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	63,788	6	1,050		18,155	299	13
14	21	Clerical and General Office	Resident Days	63,788	6			18,155		14
15	22	Employee Benefits and Payroll Ta	Resident Days	63,788	6			18,155		15
16	23	Inservice Training & Education	Resident Days	63,788	6			18,155		16
17	24	Travel and Seminar	Resident Days	63,788	6			18,155		17
18	25	Other Admin. Staff Transport.	Resident Days	63,788	6			18,155		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	63,788	6			18,155		19
20	30	Depreciation	Resident Days	63,788	6			18,155		20
21	31	Amortization	Resident Days	63,788	6			18,155		21
22	32	Interest	Resident Days	63,788	6	1,229		18,155	350	22
23	33	Real Estate Taxes	Resident Days	63,788	6			18,155		23
24	35	Rent-Equipment & Vehicles	Resident Days	63,788	6			18,155		24
25	TOTALS					\$ 7,434	\$		\$ 2,116	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	H & I Properties		X	Mortgage	Varies	10/1/18	\$ 954,800	\$ 70,458	9/30/42	Varies	\$ 607	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 954,800	\$ 70,458			\$ 607	9
	B. Non-Facility Related*											
10								Interest Income Offset			(140)	10
11								Home Office Allocation-MHO			238	11
12								Home Office Allocation-PHCM			350	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 448	14
15	TOTALS (line 9+line14)						\$ 954,800	\$ 70,458			\$ 1,055	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.)

B. Real Estate Taxes

16	AMOUNT TO USE FOR RATE CALCULATION \$	16
-----------	--	-----------

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.

FACILITY NAME	<u>Rock River Gardens</u>	COUNTY	<u>Whiteside</u>
FACILITY IDPH LICENSE NUMBER	<u>0053322</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>MIKE KOCHER</u>		
TELEPHONE	<u>(309)689-5850</u>	FAX #:	<u>(309)691-8622</u>

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.

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.)

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: 17,130

B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 2

C. Does the Operating Entity? X(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? X(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? YESXNO

If so, please complete the following:

1. Total Amount Incurred:2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land	217,800		\$ 62,000	1
2					2
3	TOTALS	217,800		\$ 62,000	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	70		2018	1958	\$ 796,100	\$	25	\$ 31,844	\$ 31,844	\$ 47,766
5										
6										
7										
8										
	Improvement Type**									
9	Water Heater			2015	6,645		7	950	950	5,225
10	Sprinkler Repair			2016	8,815		7	1,260	1,260	5,670
11	Smoke Detector Repair			2017	5,004		7	714	714	2,499
12	Water Pipe Repair			2019	2,844		7	406	406	609
13	Water Pipe Repair			2020	13,101		7	936	936	936
14	Sprinkler Repair			2020	3,519		7	251	251	251
15	Resurfacing of Parking Lot			2020	3,500		7	250	250	250
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					233			(233)	
31	Building Booked					31,844			(31,844)	
32	Building Improvement Booked					3,097			(3,097)	
33										
34	2020-Home Office Allocation-Building Improvements				9,179			220	220	
35	2020-Home Office Allocation-Land Improvements				921			58	58	
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rock River Gardens

0053322

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									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)		\$ 849,628	\$ 35,174		\$ 36,889	\$ 1,715	\$ 63,206	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	\$ 152,700	\$ 21,814	\$ 21,814	\$	5-10 yrs.	\$ 54,535	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,615	4,615			74
75	TOTALS	\$ 152,700	\$ 21,814	\$ 26,429	\$ 4,615		\$ 54,535	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	Facility	2012 Ford E150 Van	2017	4,000	\$ 800	\$ 800	\$	5 yrs.	\$ 2,800
77	Facility	2010 Ford E150 Van	2019	3,500	700	700	175	5 yrs.	1,050
78									
79									
80	TOTALS			\$ 7,500	\$ 1,500	\$ 1,500	\$ 175		\$ 3,850

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)			\$ 1,071,828	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 58,488	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 64,818	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 6,505	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 121,591	

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		\$	\$	
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

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:

H & I Properties
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:	1958	70	9/1/2015	\$30,240			3
4	Additions							4
5								5
6								6
7	TOTAL		70		\$30,240			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease.

9. Option to Buy:

☐ YES☐ NO

Terms: *

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

15. Is Movable equipment rental included in building rental?

☒ YES☐ NO
16. Rental Amount for movable equipment: \$8,771

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.

10. Effective dates of current rental agreement:

Beginning9/1/15

Ending8/31/20

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

Rock River Gardens
0053322
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	\$	330
Dishwasher		829
Copier		5,857
Home Office Allocation		<u>1,755</u>
		<u>8,771</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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	N/A	# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Other (specify):									11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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	\$ 344,575	\$ 344,575	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 116,924)	1,145,264	1,145,264	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,469	22,469	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposits	535	535	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,512,843	\$ 1,512,843	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	62,000	62,000	13
14	Buildings, at Historical Cost	796,100	805,279	14
15	Leasehold Improvements, at Historical Cost	43,428	44,349	15
16	Equipment, at Historical Cost	160,200	160,200	16
17	Accumulated Depreciation (book methods)	(139,629)	(121,591)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 922,099	\$ 950,237	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,434,942	\$ 2,463,080	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 297,779	\$ 297,779	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,263	53,263	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,382	20,382	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	127,511	127,511	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 498,935	\$ 498,935	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	70,458	70,458	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	400,000	400,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 470,458	\$ 470,458	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 969,393	\$ 969,393	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,465,549	\$ 1,493,687	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,434,942	\$ 2,463,080	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 305,506	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(175,643)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 129,863	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,335,686	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,335,686	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,465,549	24 *

* This must agree with page 17, line 47.

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,061,609	1
2	Discounts and Allowances for all Levels	(385,585)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,676,024	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,810	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,810	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	1,151	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	(945)	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 206	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	140	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 140	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous and COVID Stimulus Revenue	906,510	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 906,510	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,586,690	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	519,656	31
32	Health Care	1,014,293	32
33	General Administration	424,332	33
	B. Capital Expense		
34	Ownership	106,304	34
	C. Ancillary Expense		
35	Special Cost Centers	37,878	35
36	Provider Participation Fee	148,541	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,251,004	40
41	Income before Income Taxes (line 30 minus line 40)**	1,335,686	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,335,686	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,636,504	44
45	Private Pay - Net Inpatient Revenue	39,520	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,676,024	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,056	1,074	\$ 40,083	\$ 37.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,243	6,283	211,508	33.66	3
4	Licensed Practical Nurses	2,104	2,104	58,531	27.82	4
5	CNAs & Orderlies	18,888	19,480	332,920	17.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	749	749	10,772	14.38	9
10	Activity Assistants	2,032	2,080	26,852	12.91	10
11	Social Service Workers	5,944	6,031	63,703	10.56	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,864	13.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,099	10,184	120,894	11.87	15
16	Dishwashers					16
17	Maintenance Workers	2,370	2,434	52,234	21.46	17
18	Housekeepers	7,459	7,863	85,882	10.92	18
19	Laundry					19
20	Administrator	2,080	2,080	62,004	29.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,060	2,080	32,609	15.68	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	4,051	4,215	84,255	19.99	33
34	TOTAL (lines 1 - 33)	67,215	68,737	\$ 1,211,111 *	\$ 17.62	34

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	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,597	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	5	275	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)	5	\$ 23,872		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,905	\$ 62,435	L10,C3	50
51	Licensed Practical Nurses	1,301	35,114	L10,C3	51
52	Certified Nurse Assistants/Aides	2,811	37,474	L10,C3	52
53	TOTAL (lines 50 - 52)	6,017	\$ 135,023		53

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

** See instructions.

Rock River Gardens
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Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,088	1,164	35,838	30.79
Transportation	925	925	11,379	12.30
Pscyh Assistant	2,038	2,126	37,038	17.42
TOTAL	4,051	4,215	84,255	

STATE OF ILLINOIS

Facility Name & ID Number

Rock River Gardens

0053322Report Period Beginning:1/1/2020Ending:12/31/2020

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Nikaela Rivera

Administrator

0

\$ 62,004

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

\$ 134,000

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 134,000

C. Professional Services

Vendor/Payee

Type

Amount

Comcast Cable

Computer Services

\$ 1,293

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 1,293

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 16,950

Unemployment Compensation Insurance

14,041

FICA Taxes

86,177

Employee Health Insurance

5,087

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Employee Relations

100

Home Office Allocation

8,228

Administrator Benefits

12,396

TOTAL (agree to Schedule V, line 22, col.8)

\$ 142,979

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

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

(Indicate # of checks performed 6)

Patient Background Checks

12

355

Miscellaneous Licenses & Permits

930

Miscellaneous Dues & Subscriptions

318

Home Office Allocation

2,774

Less: Public Relations Expense

(250)

Non-allowable advertising

(

)

Yellow page advertising

(

)

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 4,127

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

Home Office Allocation

15

Entertainment Expense

(

)

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 15

* Attach copy of IMRF notifications

**See instructions.

Rock River Gardens
0053322
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)		1,293
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	280
Duane Morris	Legal	391
Lexis Nexis	Legal	8
Livingston, Barger, Brant, Schroeder	Legal	15
Miller, Hall, Triggs	Legal	48
Miscellaneous	Legal	18
SB2	Legal	144
SmithAmundsen LLC	Legal	893
Sorling Northrup	Legal	255
Illinois Secretary of State	Legal	186
CliftonLarsonAllen	Accounting	1,110
Ginoli & Co.	Accounting	2,073
Ability Network	Computer Services	2,850
Allscripts	Computer Services	450
AOD Matrix Care	Computer Services	5,005
AT&T	Computer Services	5
ATS	Computer Services	273
CCH	Computer Services	16
Charter Communications	Computer Services	25
Citrix Systems	Computer Services	85
Comcast	Computer Services	29
ITSavvy	Computer Services	132
Kemper Technology	Computer Services	650
Miscellaneous	Computer Services	126
Pearl Technology	Computer Services	118
Stratus Networks	Computer Services	517
TR Professional	Computer Services	11
David Budde	Other Prof Fees	11
DJ Howard and Associates	Other Prof Fees	22
Getzler Henrich & Associates	Other Prof Fees	88
LRI Consulting Services	Other Prof Fees	86
McQuellon Consulting	Other Prof Fees	54
Miscellaneous	Other Prof Fees	103
Optimizer	Other Prof Fees	46
Registered Agent Solutions	Other Prof Fees	26
RSM McGladrey	Other Prof Fees	283
SB2	Other Prof Fees	361
Sedgwick CMS	Other Prof Fees	487
Tarver Program Consultants	Other Prof Fees	67
Total (agree to Schedule V, line 19, column 8)		<u>18,640</u>

Rock River Gardens
0053322
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	1,289
Auto Repairs		1,659
Mileage-Travel		386
Home Office Allocation		<u>3,463</u>
		<u><u>6,797</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?
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. \$ 0 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. \$ 148,541
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. \$ 1,151
- (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 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.