

		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: 0053140

Facility Name: South Elgin Rehabilitation & Health Care Center

Address: 746 West Spring Street South Elgin 60177
Number City Zip Code

County: Kane

Telephone Number: (847) 697-0565 Fax # (847) 697-0568

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2005

Type of Ownership:

☐	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		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	Mark Petersen	
Paid Preparer	(Title)	Chief Executive Officer	
	(Signed)		(Date)
	(Print Name and Title)		
	(Firm Name & Address)		
	(Telephone)	()	Fax # ()

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

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center

0053140 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	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	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	641	1,295	1,936	8	
9	SNF/PED				9	
10	ICF	19,127		19,127	10	
11	ICF/DD				11	
12	SC				12	
13	DD 16 OR LESS				13	
14	TOTALS	19,127	641	1,295	21,063	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.12%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 10/1/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 14 and days of care provided 1,218

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

* All facilities other than governmental must report on the accrual basis.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	202,012	28,305		230,317		230,317	5,608	235,925			1
2	Food Purchase		131,163		131,163		131,163		131,163			2
3	Housekeeping	159,279	39,302		198,581		198,581	108	198,689			3
4	Laundry		7,055		7,055		7,055		7,055			4
5	Heat and Other Utilities			60,165	60,165		60,165	383	60,548			5
6	Maintenance	39,566	7,571	23,002	70,139		70,139	13,160	83,299			6
7	Other (specify):*											7
8	TOTAL General Services	400,857	213,396	83,167	697,420		697,420	19,259	716,679			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,253,515	122,205	139,389	1,515,109		1,515,109	(4,573)	1,510,536			10
10a	Therapy	1,205		453,963	455,168		455,168		455,168			10a
11	Activities	21,441	565	1,459	23,465		23,465	47	23,512			11
12	Social Services	48,938			48,938		48,938		48,938			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,325,099	122,770	608,011	2,055,880		2,055,880	(4,526)	2,051,354			16
	C. General Administration											
17	Administrative	92,850		226,900	319,750		319,750	(195,710)	124,040			17
18	Directors Fees											18
19	Professional Services			9,420	9,420		9,420	29,049	38,469			19
20	Dues, Fees, Subscriptions & Promotions			5,974	5,974		5,974	2,871	8,845			20
21	Clerical & General Office Expenses	38,663	4,319	14,742	57,724		57,724	34,701	92,425			21
22	Employee Benefits & Payroll Taxes			292,976	292,976		292,976	9,546	302,522			22
23	Inservice Training & Education							58	58			23
24	Travel and Seminar							18	18			24
25	Other Admin. Staff Transportation			2,905	2,905		2,905	4,018	6,923			25
26	Insurance-Prop.Liab.Malpractice			1,335	1,335		1,335	68,565	69,900			26
27	Other (specify):*											27
28	TOTAL General Administration	131,513	4,319	554,252	690,084		690,084	(46,884)	643,200			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,857,469	340,485	1,245,430	3,443,384		3,443,384	(32,151)	3,411,233			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			32,356	32,356		32,356	15,414	47,770			30
31	Amortization of Pre-Op. & Org.							3,968	3,968			31
32	Interest			909	909		909	204,976	205,885			32
33	Real Estate Taxes							60,338	60,338			33
34	Rent-Facility & Grounds			424,518	424,518		424,518	(424,518)				34
35	Rent-Equipment & Vehicles			22,298	22,298		22,298	2,036	24,334			35
36	Other (specify):*											36
37	TOTAL Ownership			480,081	480,081		480,081	(137,786)	342,295			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,429		35,429		35,429		35,429			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			159,514	159,514		159,514		159,514			42
43	Other (specify):*	49,156		88,520	137,676		137,676	(137,676)				43
44	TOTAL Special Cost Centers	49,156	35,429	248,034	332,619		332,619	(137,676)	194,943			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,906,625	375,914	1,973,545	4,256,084		4,256,084	(307,613)	3,948,471			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				4
5	Telephone, TV & Radio in Resident Rooms	(8,331)	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	(1,324)	30		9
10	Interest and Other Investment Income	(4,253)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(22,176)	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	(1,867)	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	(64,157)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (153,108)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(154,505)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (154,505)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (307,613)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (3,965)	43	1
2	X-Rays-Part A	(1,206)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(9,828)	10	3
4	Offset Transportation Revenue	47	11	4
5	Offset Miscellaneous Office Supplies Revenue	(74)	21	5
6	Disallowed Special Events	25	43	6
7	Offset Marketing Salaries	(49,156)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(64,157)		49

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 5,608	\$ 5,608	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%	108	108	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	383	383	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,368	3,368	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	5,255	5,255	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	226,900	Petersen Health Care Management, Inc.	100.00%	31,190	(195,710)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	18,423	18,423	12
13	V								13
14	Total			\$ 226,900			\$ 64,335	\$ * (162,565)	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%	\$ 2,871	\$ 2,871	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	34,775	34,775	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	9,546	9,546	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	58	58	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	18	18	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,018	4,018	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	612	612	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	5,677	5,677	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%	277	277	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	221	221	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	2,036	2,036	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 60,109	\$ * 60,109	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 Properties, LLC	100.00 %	\$	\$	15
16	V	2	Food		Petersen Health Properties, LLC	100.00 %			16
17	V	3	Housekeeping		Petersen Health Properties, LLC	100.00 %			17
18	V	4	Laundry		Petersen Health Properties, LLC	100.00 %			18
19	V	5	Utilities		Petersen Health Properties, LLC	100.00 %			19
20	V	6	Maintenance		Petersen Health Properties, LLC	100.00 %			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Properties, LLC	100.00 %			21
22	V	10	Nursing and Medical Records		Petersen Health Properties, LLC	100.00 %			22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Properties, LLC	100.00 %			23
24	V	17	Administrative		Petersen Health Properties, LLC	100.00 %			24
25	V	19	Professional Services		Petersen Health Properties, LLC	100.00 %	4,876	4,876	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Properties, LLC	100.00 %			26
27	V	21	Clerical and General Office		Petersen Health Properties, LLC	100.00 %			27
28	V	22	Employee Benefits & Payroll		Petersen Health Properties, LLC	100.00 %			28
29	V	23	Inservice Training & Education		Petersen Health Properties, LLC	100.00 %			29
30	V	24	Travel and Seminar		Petersen Health Properties, LLC	100.00 %			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Properties, LLC	100.00 %			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Properties, LLC	100.00 %			32
33	V	30	Depreciation		Petersen Health Properties, LLC	100.00 %			33
34	V	31	Amortization		Petersen Health Properties, LLC	100.00 %			34
35	V	32	Interest		Petersen Health Properties, LLC	100.00 %	3,306	3,306	35
36	V	33	Real Estate Taxes		Petersen Health Properties, LLC	100.00 %			36
37	V	34	Rent-Facility and Grounds		Petersen Health Properties, LLC	100.00 %			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Properties, LLC	100.00 %			38
39	Total			\$			\$ 8,182	\$ * 8,182	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	\$	South Elgin Land, LLC	100.00%	\$ 9,792	\$ 9,792	15
16	V	19	Professional Fees	\$	South Elgin Land, LLC	100.00%	5,750	5,750	16
17	V	21	Equipment		South Elgin Land, LLC	100.00%			17
18	V	26	Insurance-Liability		South Elgin Land, LLC	100.00%	19,758	19,758	18
19	V	26	Insurance-Property		South Elgin Land, LLC	100.00%	15,479	15,479	19
20	V	26	Insurance-MIP		South Elgin Land, LLC	100.00%	32,716	32,716	20
21	V	30	Depreciation		South Elgin Land, LLC	100.00%	11,061	11,061	21
22	V	31	Amortization of Pre-Op. & Org.		South Elgin Land, LLC	100.00%	3,968	3,968	22
23	V	32	Interest	607	South Elgin Land, LLC	100.00%	206,253	205,646	23
24	V	33	Real Estate Taxes		South Elgin Land, LLC	100.00%	60,117	60,117	24
25	V	34	Rent-Facility and Grounds	424,518	South Elgin Land, LLC	100.00%		(424,518)	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			\$ 425,125			\$ 364,894	\$ * (60,231)	39

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

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center# 0053140

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, L	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 System	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 M	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 Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	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 South Elgin Rehabilitation & Health Care Center# 0053140

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 South Elgin Rehabilitation & Health Care Center# 0053140

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 South Elgin Rehabilitation & Health Care Center# 0053140

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 South Elgin Rehabilitation & Health Care C # 0053140 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 South Elgin Rehabilitation & Health Care Center # 0053140 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	21,063	\$ 5,608	1
2	2	Food	Resident Days	1,282,791	75	0	0	21,063	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	21,063	108	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	21,063	383	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	21,063	3,368	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	21,063	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	21,063	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	21,063	5,255	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	21,063	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	21,063	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	21,063	31,190	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	21,063	18,423	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	21,063	2,871	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	21,063	34,775	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,282,791	75	581,393	0	21,063	9,546	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	21,063	58	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	21,063	18	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	21,063	4,018	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	21,063	612	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	21,063	5,677	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	21,063	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	21,063	277	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	21,063	221	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	21,063	2,036	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 124,444	25

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center# 0053140

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 Properties, 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	45,811	3	\$		21,063	\$	1
2	2	Food	Resident Days	45,811	3			21,063		2
3	3	Housekeeping	Resident Days	45,811	3			21,063		3
4	5	Utilities	Resident Days	45,811	3			21,063		4
5	6	Maintenance	Resident Days	45,811	3			21,063		5
6	7	Mgmt. Allocation of Benefits	Resident Days	45,811	3			21,063		6
7	9	Medical Director	Resident Days	45,811	3			21,063		7
8	10	Nursing and Medical Records	Resident Days	45,811	3			21,063		8
9	10A	Therapy	Resident Days	45,811	3			21,063		9
10	15	Mgmt. Allocation of Benefits	Resident Days	45,811	3			21,063		10
11	17	Administrative	Resident Days	45,811	3			21,063		11
12	19	Professional Services	Resident Days	45,811	3			21,063		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	45,811	3	10,605		21,063	4,876	13
14	21	Clerical and General Office	Resident Days	45,811	3			21,063		14
15	22	Employee Benefits and Payroll Tax	Resident Days	45,811	3			21,063		15
16	23	Inservice Training & Education	Resident Days	45,811	3			21,063		16
17	24	Travel and Seminar	Resident Days	45,811	3			21,063		17
18	25	Other Admin. Staff Transport.	Resident Days	45,811	3			21,063		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	45,811	3			21,063		19
20	30	Depreciation	Resident Days	45,811	3			21,063		20
21	31	Amortization	Resident Days	45,811	3			21,063		21
22	32	Interest	Resident Days	45,811	3	7,191		21,063	3,306	22
23	33	Real Estate Taxes	Resident Days	45,811	3			21,063		23
24	35	Rent-Equipment & Vehicles	Resident Days	45,811	3			21,063		24
25	TOTALS					\$ 17,796	\$		\$ 8,182	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	Busey Bank		X	Mortgage	Varies	1/1/2015	5,499,260	\$ 4,992,788	12/31/2044	Varies	\$ 206,253	1
2	Dodge		X	Mortgage	Varies	5/26/20	48,483	44,041	5/25/25	Varies	909	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 5,547,743	\$ 5,036,829			\$ 207,162	9
	B. Non-Facility Related*											
10								Interest Income Offset			(4,860)	10
11								Home Office Allocation-PHCM			277	11
12								Home Office Allocation-PHP			3,306	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (1,277)	14
15	TOTALS (line 9+line14)						\$ 5,547,743	\$ 5,036,829			\$ 205,885	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 32,716 Line # 26

* 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.)

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.		\$	49,547	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	54,020	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	4,473	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	55,644	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	221	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	60,338	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	49,195	8	
		2016	49,424	9	
		2017	47,924	10	
		2018	47,169	11	
		2019	54,020	12	
Accrual based on prior year tax bill.					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2019 \$	13	
		14	PLUS APPEAL COST FROM LINE 5 \$	14	
		15	LESS REFUND FROM LINE 6 \$	15	
		16	AMOUNT TO USE FOR RATE CALCULATION\$	16	

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

South Elgin Rehabilitation & Health Care Center

COUNTY

Kane

FACILITY IDPH LICENSE NUMBER

0053140

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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 06-34-226-014	Long-Term Care Facility	\$ 54,019.52	\$ 54,019.52
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 54,019.52	\$ 54,019.52

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: 15,169
- B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1
- C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: 119,050
2. Number of Years Over Which it is Being Amortized: 30
3. Current Period Amortization: 3,968
4. Dates Incurred: 2015

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	131,116	2005	\$ 467,500	1
2					2
3	TOTALS	131,116		\$ 467,500	3

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center

0053140

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2005	1970	\$ ***	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wheelchair			2006	15,515		25	621	621	9,004	9
10	Backflow Prevention			2006	14,325		25	573	573	8,309	10
11	Walls			2006	3,550		25	142	142	2,059	11
12	7 Rooms-Floor Replacement, Painting, Wallpaper, Trim Labor			2007	10,400		20	520	520	7,020	12
13	7 Rooms-Floor Tile, Sink, Supplies, Paint, Wallpaper			2007	5,100		20	255	255	3,360	13
14	Fire Sprinkler System Repair			2008	2,580		15	172	172	2,150	14
15	Dry Pipe Valve Accelerator Replacement			2008	8,436		15	562	562	7,025	15
16	Sprinkler System Repairs			2008	5,156		15	344	344	4,300	16
17	Water Line Repairs			2008	6,969		15	464	464	5,800	17
18	Sprinkler System Replacement			2009	27,836		20	1,392	1,392	16,008	18
19	Pendant Sprinkler System			2010	5,462		7			5,462	19
20	Water Heater			2011	5,120		7			5,120	20
21	Air Conditioner			2012	3,046		15	204	204	1,734	21
22	Water Heater			2012	11,870		7			11,870	22
23	Sewer Line Repair			2013	2,816		7	203	203	2,816	23
24	Fire Sprinkler System Repair			2013	22,855		15	1,524	1,524	11,430	24
25	Paving in front of building			2013	3,960		15	264	264	1,980	25
26	Alarm System Replacement			2013	7,256		7	522	522	7,256	26
27	Grease Interceptor			2014	10,500		15	700	700	4,550	27
28	Water Heater			2014	4,981		7	712	712	4,628	28
29	Steel Pipe Repair			2015	9,510	\$	7	\$ 1,359	1,359	7,474	29
30	Water Heater			2015	4,020		7	574	574	3,157	30
31	Plumbing Repair			2016	4,225		7	604	604	2,718	31
32	Stonehenge Stone			2016	20,394		15	1,360	1,360	6,120	32
33	Retaining Wall			2016	21,122		15	1,408	1,408	6,336	33
34	Entry and Patio Door Replacement			2016	5,263		7	752	752	2,632	34
35											35
36											36

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

See Page 12A, Line 70 for total

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

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	Water Heater	2016	6,675		7	954	\$ 954	\$ 4,293	37
38	Roof Replacement	2017	17,230		25	690	690	2,415	38
39	Air Compressor	2017	3,700		7	528	528	1,848	39
40	Water Pipe Repair	2017	12,000		7	1,714	1,714	5,999	40
41	Sprinkler Repair	2018	3,819		7	546	546	1,365	41
42	Plumbing Repair	2018	2,620		7	374	374	935	42
43	Insulation Throughout Building	2019	13,000		15	866	866	1,299	43
44	Water Heater	2019	9,197		7	1,314	1,314	1,971	44
45	Parking Lot Resurfacing and Concrete Repairs	2019	43,320		15	2,888	2,888	4,332	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	Building Improvement Booked			26,299			(26,299)		59
60									60
61	2020-Home Office Allocation-Building Improvements		10,650			256	256		61
62	2020-Home Office Allocation-Land Improvements		1,068			68	68		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 365,546	\$ 26,299		\$ 25,429	\$ (870)	\$ 174,775	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	\$ 103,496	\$ 11,462	\$ 12,140	\$ 678	5-10 yrs.	\$ 70,274	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	162,841					162,841	73
74	Home Office Allocation			5,353	5,353			74
75	TOTALS	\$ 266,337	\$ 11,462	\$ 17,493	\$ 6,031		\$ 233,115	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	2018 Dodge Ram	2020	\$ 48,483	\$ 5,656	\$ 4,848	\$ (808)	5 yrs.	\$ 4,848	76
77										77
78										78
79										79
80	TOTALS			\$ 48,483	\$ 5,656	\$ 4,848	\$ (808)		\$ 4,848	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)	\$ 1,147,866 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,417 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,770 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,353 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 412,738 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?
- ☒ YES☐ NO
16. Rental Amount for movable equipment: \$24,334
- 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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

Annual Rent

12. /2021 \$

13. /2022 \$

14. /2023 \$

* 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.

South Elgin Rehabilitation & Health Care Center
0053140

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

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	15,937
Dishwasher		701
Floor Cleaner		(16)
Copier		5,676
Home Office Allocation		2,036
		<u>24,334</u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	9,102	\$ 136,530	\$	9,102	\$ 136,530	1
2	Licensed Speech and Language Development Therapist	10A(1), 10A(3)	129 hrs	1,205	789	11,840		918	13,045	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		20,373	305,593		20,373	305,593	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 prescripts				35,429		35,429	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 1,205	30,264	\$ 453,963	\$ 35,429	30,393	\$ 490,597	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	\$ 1,457,118	\$ 1,457,118	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 146,565)	4,967,155	4,967,155	3
4	Supply Inventory (priced at Cost)	12,521	12,521	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,168	43,624	6
7	Other Prepaid Expenses		45,999	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,451,962	\$ 6,526,417	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		467,500	13
14	Buildings, at Historical Cost		10,650	14
15	Leasehold Improvements, at Historical Cost	168,146	354,896	15
16	Equipment, at Historical Cost	130,511	314,820	16
17	Accumulated Depreciation (book methods)	(124,271)	(412,738)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		101,193	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		233,553	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans		55,003	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 174,386	\$ 1,124,877	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,626,348	\$ 7,651,294	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 978,833	\$ 981,453	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,280	81,280	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		55,644	32
33	Accrued Interest Payable		17,017	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	112,779	112,779	36
37	Accrued Management Fees	45,999	45,999	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,218,891	\$ 1,294,172	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	44,041	44,041	39
40	Mortgage Payable		4,992,788	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	3,500,000	3,500,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,544,041	\$ 8,536,829	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,762,932	\$ 9,831,001	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,863,416	\$ (2,179,707)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,626,348	\$ 7,651,294	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,225,182	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(1,654,350)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 570,832	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,292,584	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)	\$ 1,292,584	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)	\$ 1,863,416	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0053140 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	\$ 5,020,213	1
2	Discounts and Allowances for all Levels	(1,392,250)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,627,963	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	846,182	6
7	Oxygen	1,159	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 847,341	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	51,749	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,352	20
21	Other Medical Services	(7,133)	21
22	Laundry	51	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 51,019	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,253	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,253	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	(47)	28
28a	Miscellaneous and Illinois Cares Revenue	1,018,139	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,018,092	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,548,668	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	697,420	31
32	Health Care	2,055,880	32
33	General Administration	690,084	33
	B. Capital Expense		
34	Ownership	480,081	34
	C. Ancillary Expense		
35	Special Cost Centers	173,105	35
36	Provider Participation Fee	159,514	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,256,084	40
41	Income before Income Taxes (line 30 minus line 40)**	1,292,584	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,292,584	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,158,789	44
45	Private Pay - Net Inpatient Revenue	120,330	45
46	Medicare - Net Inpatient Revenue	323,626	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	25,218	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,627,963	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
2	Assistant Director of Nursing					2
3	Registered Nurses	10,248	10,726	368,654	34.37	3
4	Licensed Practical Nurses	8,005	8,272	235,762	28.50	4
5	CNAs & Orderlies	31,276	32,242	515,712	16.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	110	129	1,205	9.34	8
9	Activity Director	150	190	3,043	16.02	9
10	Activity Assistants	710	710	10,133	14.27	10
11	Social Service Workers	2,080	2,080	48,938	23.53	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	40,270	19.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,437	12,176	161,742	13.28	15
16	Dishwashers					16
17	Maintenance Workers	2,082	2,097	39,566	18.87	17
18	Housekeepers	14,571	15,186	159,279	10.49	18
19	Laundry					19
20	Administrator	2,080	2,080	77,004	37.02	20
21	Assistant Administrator	679	727	15,846	21.80	21
22	Other Administrative					22
23	Office Manager	2,083	2,148	38,663	18.00	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,439	1,515	54,637	36.06	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	5,070	5,118	136,171	26.61	33
34	TOTAL (lines 1 - 33)	94,100	97,476	\$ 1,906,625 *	\$ 19.56	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	13,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,306	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	6	342	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)	6	\$ 19,848		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,473	\$ 132,741	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,473	\$ 132,741		53

South Elgin Rehabilitation & Health Care Center
0053140
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,080	2,080	78,750	37.86
Transportation	862	888	8,265	9.31
Marketing	2,128	2,150	49,156	22.86
TOTAL	5,070	5,118	136,171	

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
Steve Bennett	Administrator	0	\$ 77,004	Workers' Compensation Insurance	\$	121,793	IDPH License Fee	\$ 3,980
Michael Wickstrom	Asst. Admin.	0	15,846	Unemployment Compensation Insurance		11,005	Advertising: Employee Recruitment	
				FICA Taxes		137,751	Health Care Worker Background Check	
				Employee Health Insurance		3,588	(Indicate # of checks performed 6)	
				Employee Meals			Patient Background Checks 25	725
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits	1,269
				Employee Relations		1,479	Home Office Allocation	2,871
				Home Office Allocation		9,546		
				Employee Retirement		1,964		
				Administrator Benefits		15,396		
							Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 92,850					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$	302,522		\$ 8,845
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 226,900					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
			\$ 226,900	Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Ability Network	Computer Services		\$ 6,541					
Comcast Cable	Computer Services		1,300					
Cook County Circuit Clerk	Legal Filing Fees-1/7/20		62					
Kane County Circuit Clerk	Legal Filing Fees-1/7/20		367				In-State Travel	
Chicago Title Insurance	Lien Title Seach-1/17/20		1,150					
				N/A				
							Seminar Expense	
							Home Office Allocation	18
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
			\$ 9,420				TOTAL	\$ 18

* Attach copy of IMRF notifications

**See instructions.

South Elgin Rehabilitation & Health Care Center
0053140
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)		9,420
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	324
Duane Morris	Legal	453
Lexis Nexis	Legal	9
Livingston, Barger, Brant, Schroeder	Legal	17
Miller, Hall, Triggs	Legal	56
Miscellaneous	Legal	21
SB2	Legal	167
SmithAmundsen LLC	Legal	1,036
Sorling Northrup	Legal	296
Illinois Secretary of State	Legal	457
CliftonLarsonAllen	Accounting	1,288
Ginoli & Co.	Accounting	11,088
Ability Network	Computer Services	3,306
Allscripts	Computer Services	522
AOD Matrix Care	Computer Services	5,807
AT&T	Computer Services	6
ATS	Computer Services	317
CCH	Computer Services	18
Charter Communications	Computer Services	29
Citrix Systems	Computer Services	99
Comcast	Computer Services	34
ITSavvy	Computer Services	153
Kemper Technology	Computer Services	755
Miscellaneous	Computer Services	216
Pearl Technology	Computer Services	137
Stratus Networks	Computer Services	600
TR Professional	Computer Services	13
David Budde	Other Prof Fees	13
DJ Howard and Associates	Other Prof Fees	25
Getzler Henrich & Associates	Other Prof Fees	102
LRI Consulting Services	Other Prof Fees	99
McQuellon Consulting	Other Prof Fees	63
Miscellaneous	Other Prof Fees	49
Optimizer	Other Prof Fees	54
Registered Agent Solutions	Other Prof Fees	30
RSM McGladrey	Other Prof Fees	328
SB2	Other Prof Fees	419
Sedgwick CMS	Other Prof Fees	565
Tarver Program Consultants	Other Prof Fees	78
Total (agree to Schedule V, line 19, column 8)		<u><u>38,469</u></u>

South Elgin Rehabilitation & Health Care Center
0053140

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

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	720
Auto Repairs		299
Mileage-Travel		1,886
Home Office Allocation		4,018
		<u>6,923</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. \$ 28,882 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. \$ 159,514
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? No Indicate the amount. \$ _____

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