

		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: 0054890

Facility Name: St Claras Rehab Senior Care

Address: 1450 Castle Manor Dr Lincoln 62656
Number City Zip Code

County: Logan

Telephone Number: 217-735-1507 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 2010

Type of Ownership:

xx VOLUNTARY, NON-PROFIT
xx Charitable Corp.
Trust
IRS Exemption Code 501c3

PROPRIETARY GOVERNMENTAL
Individual State
Partnership County
Corporation Other
"Sub-S" Corp.
Limited Liability Co.
Trust
Other

In the event there are further questions about this report, please contact:
Name: David M Underwood Telephone Number: (309)8237135
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) David M Underwood
(Title) EVP & CFO

Paid Preparer

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

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

Facility Name & ID Number St Claras Rehab Senior Care

0054890 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 _____

	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	106	Skilled (SNF)	106	38,796	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	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	20,661	8,580	3,003	32,244	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,661	8,580	3,003	32,244	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.11%

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 2/13/18

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 106 and days of care provided 3,003

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Claras Rehab Senior Care # 0054890 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	280,028	20,875	6,653	307,556		307,556		307,556			1
2	Food Purchase		235,258		235,258		235,258		235,258			2
3	Housekeeping	116,065	33,355		149,420		149,420		149,420			3
4	Laundry	103,108	17,076		120,184		120,184		120,184			4
5	Heat and Other Utilities			98,599	98,599		98,599		98,599			5
6	Maintenance	99,528	60,573	154,342	314,443		314,443		314,443			6
7	Other (specify):*											7
8	TOTAL General Services	598,729	367,137	259,594	1,225,460		1,225,460		1,225,460			8
	B. Health Care and Programs											
9	Medical Director			25,175	25,175		25,175		25,175			9
10	Nursing and Medical Records	2,654,557	209,269	149,073	3,012,899	(7,637)	3,005,262		3,005,262			10
10a	Therapy		240,963	40,122	281,085	(273,335)	7,750		7,750			10a
11	Activities	60,963	3,592		64,555		64,555		64,555			11
12	Social Services	59,125		3,172	62,297		62,297		62,297			12
13	CNA Training	2,979	2,828		5,807		5,807		5,807			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,777,624	456,652	217,542	3,451,818	(280,972)	3,170,846		3,170,846			16
	C. General Administration											
17	Administrative	110,710			110,710		110,710		110,710			17
18	Directors Fees											18
19	Professional Services			373,920	373,920		373,920	(14,318)	359,602			19
20	Dues, Fees, Subscriptions & Promotions			296,310	296,310	(242,103)	54,207	(43,424)	10,783			20
21	Clerical & General Office Expenses	266,404	16,008	19,763	302,175		302,175		302,175			21
22	Employee Benefits & Payroll Taxes			988,624	988,624		988,624		988,624			22
23	Inservice Training & Education			144	144		144		144			23
24	Travel and Seminar			3,761	3,761		3,761		3,761			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			107,802	107,802		107,802		107,802			26
27	Other (specify):* Lost resident items			(2,209)	(2,209)		(2,209)	(250)	(2,459)			27
28	TOTAL General Administration	377,114	16,008	1,788,115	2,181,237	(242,103)	1,939,134	(57,992)	1,881,142			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,753,467	839,797	2,265,251	6,858,515	(523,075)	6,335,440	(57,992)	6,277,448			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							635,728	635,728			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,887	4,887		4,887	445,287	450,174			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			680,730	680,730		680,730	(680,730)				34
35	Rent-Equipment & Vehicles			65,915	65,915		65,915		65,915			35
36	Other (specify):*											36
37	TOTAL Ownership			751,532	751,532		751,532	400,285	1,151,817			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			487,155	487,155	273,335	760,490		760,490			39
40	Barber and Beauty Shops			4,020	4,020		4,020		4,020			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					242,103	242,103		242,103			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			491,175	491,175	515,438	1,006,613		1,006,613			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,753,467	839,797	3,507,958	8,101,222	(7,637)	8,093,585	342,293	8,435,878			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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,335)			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	(4,642)			17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(250)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,318)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(38,782)			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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (61,327)		\$	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)	403,620		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 403,620		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 342,293		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		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11		(14,318)	19	11
12		0	19	12
13		(250)	27	13
14		(38,782)	20	14
15		(4,642)	20	15
16		(3,335)	32	16
17		0	24	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	(61,327)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Claras Rehab Senior Care# 0054890

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,318)	0	0	0	0	0	0	0	0	0	0	(14,318)	19
20	Fees, Subscriptions & Promotions	(43,424)	0	0	0	0	0	0	0	0	0	0	(43,424)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(250)	0	0	0	0	0	0	0	0	0	0	(250)	27
28	TOTAL General Administration	(57,992)	0	0	0	0	0	0	0	0	0	0	(57,992)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(57,992)	0	0	0	0	0	0	0	0	0	0	(57,992)	29

Summary B

12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

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
				St Clara's Senior Serv	Lincoln	Sponsor Org
Board of Directors List Attached				Castle Manor	Lincoln	Supportive Living
(Not for profit Board-No individual ownership)						

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	4	5	6	7	8	
Schedule V			Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Item		Name of Related Organization				
1	V			\$			\$		1
2	V	34	Rent	680,730	St Clara's Senior Services Inc.	0.00%		(680,730)	2
3	V								3
4	V	30	Depreciation		St Clara's Senior Services Inc.		635,728	635,728	4
5	V	32	Interest & Loan Fee Amort		St Clara's Senior Services Inc.		448,622	448,622	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 680,730			\$ 1,084,350	\$ * 403,620	14

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

Facility Name & ID Number St Claras Rehab Senior Care # 0054890 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	Board Members are not compensated for their services				0	0			\$ 0		1
2											2
3											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 St Claras Rehab Senior Care # 0054890 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	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
2										2
3										3
4										4
5										5
6										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	TOTALS					\$	\$		\$	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	Heartland Bank & Trust		xx	Mortgage			\$	13,119,945			\$ 448,622	1
2	Heartland Bank & Trust		xx	Payroll Protection Program				918,800				2
3												3
4												4
5												5
	Working Capital											
6	Heartland Bank & Trust		xx	Line of Credit							4,887	6
7												7
8												8
9	TOTAL Facility Related						\$	14,038,745			\$ 453,509	9
	B. Non-Facility Related*											
10	Interest Income										(3,335)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (3,335)	14
15	TOTALS (line 9+line14)						\$	14,038,745			\$ 450,174	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

[illegible]

NOTES:

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

FACILITY NAME St Claras Rehab Senior Care COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0054890

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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

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.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 75,442

B. General Construction Type: Exterior BrickFrame MetalNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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).

St. Clara's Senior Services - Owns real and personal property.

Castle Manor - Supportive living facility located adjacent to St. Clara's Manor. Separately owned with separate management but also sponsored by St. Clara's Senior Services

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:

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number St Claras Rehab Senior Care

0054890

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	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	106			2018	\$ 18,516,091	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10	No Improvements in 2018			2018						10
11										11
12	No Improvements in 2019			2019						12
13										13
14	Planted trees throughout the property			2020	17,570					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	Book Depreciation					463,488		463,488		35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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	\$ 1,691,077	\$ 167,565	\$ 167,565	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,691,077	\$ 167,565	\$ 167,565	\$		\$	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	Maintenance	2015 Grand Caravan	2015	\$ 32,723	\$ 4,675	\$ 4,675	\$		\$
77									
78									
79									
80	TOTALS			\$ 32,723	\$ 4,675	\$ 4,675	\$		\$

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)			\$	20,257,461
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	635,728
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	635,728
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	

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				
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:St. Clara's Senior Services
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:	2018	106		\$680,730			3
4	Additions							4
5								5
6								6
7	TOTAL		106		\$680,730			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

None
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:\$65,915Description:Copiers and televisions
- (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.

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		2,828		2,828
3	Classroom Wages (a)				
4	Clinical Wages (b)		2,979		2,979
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,807	\$	\$ 5,807
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,807			

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		hrs	\$		\$ 218,508	\$		\$ 218,508	1
2	Licensed Speech and Language Development Therapist		hrs			71,392			71,392	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			197,255	113		197,368	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				240,850		240,850	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					40,122			40,122	13
14	TOTAL			\$		\$ 527,277	\$ 240,963		\$ 768,240	14

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

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 477,129	\$	1
2	Cash-Patient Deposits	63,293		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	549,258		3
4	Supply Inventory (priced at FIFO)	72,811		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,674		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(695,903)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 486,262	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - 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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 486,262	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,947,718	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	63,293		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	261,205		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,767		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	14,137		36
37	Deferred Stimulus	384,351		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,672,471	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,672,471	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,186,209)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 486,262	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,653,434)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,653,434)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(532,775)	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)	\$ (532,775)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,186,209)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Claras Rehab Senior Care

0054890

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	\$ 6,951,798	1
2	Discounts and Allowances for all Levels	(1,606,847)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,344,951	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,344,310	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,344,310	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	464,954	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,780	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	396,365	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	577	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 866,676	23
	D. Non-Operating Revenue		
24	Contributions	9,175	24
25	Interest and Other Investment Income***	3,335	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,510	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,568,447	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,225,460	31
32	Health Care	3,451,818	32
33	General Administration	2,181,237	33
	B. Capital Expense		
34	Ownership	751,532	34
	C. Ancillary Expense		
35	Special Cost Centers	491,175	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,101,222	40
41	Income before Income Taxes (line 30 minus line 40)**	(532,775)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (532,775)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		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)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? 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	1,634	1,702	\$ 69,697	\$ 40.95	1
2	Assistant Director of Nursing	1,893	1,972	69,459	35.22	2
3	Registered Nurses	10,251	10,678	340,304	31.87	3
4	Licensed Practical Nurses	29,472	30,700	819,759	26.70	4
5	CNAs & Orderlies	73,919	76,999	1,306,724	16.97	5
6	CNA Trainees	282	282	2,979	10.56	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,365	1,422	48,614	34.19	8
9	Activity Director					9
10	Activity Assistants	4,753	4,951	60,963	12.31	10
11	Social Service Workers	3,149	3,280	59,125	18.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,857	23,809	280,028	11.76	15
16	Dishwashers					16
17	Maintenance Workers	5,510	5,740	99,528	17.34	17
18	Housekeepers	10,660	11,104	116,065	10.45	18
19	Laundry	8,278	8,623	103,108	11.96	19
20	Administrator	1,997	2,080	110,710	53.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,310	12,823	266,404	20.78	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)					33
34	TOTAL (lines 1 - 33)	188,330	196,165	\$ 3,753,467 *	\$ 19.13	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		\$ 6,653	L1 C3	35
36	Medical Director		25,175	L9 C3	36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,637	L10a C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,172	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 42,637		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 44,552	L10 C3	50
51	Licensed Practical Nurses		37,580	L10 C3	51
52	Certified Nurse Assistants/Aides		59,304	L10 C3	52
53	TOTAL (lines 50 - 52)		\$ 141,436		53

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?

Yes

If YES, give association name and amount. HCCI - \$6,362

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

Yes

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

Yes

(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?

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

Yes

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

7 Yrs

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

\$ 5,000

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.

(9) Are you presently operating under a sublease agreement?

YES

xx

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

xx

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.

\$ 242,103

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. \$ 405

(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?

NA

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.

\$ 0

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name: JM Abbott

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details. None Claimed

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

St. Clara's Manor
2020 Cost Report
Supplemental Schedules
Reclassification Entries

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 240,850
Purchased Hospital Services	10,188
Purchased Laboratory Services	22,441
Purchased Radiology Services	7,493
Amount Reclassified to Line 39	\$ <u>280,972</u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (58,194)
Provider Assesment Fee - \$6.07	(183,909)
	<u>(242,103)</u>
Provider Participation Fee	<u>242,103</u>

3. Schedule V - Line 10 to Line 10a - Reclassifications

<u>Line Item</u>	
Pharmacy Consultant - Other Nursing	(7,637)
Pharmacy Consultant - Therapy	7,637
	<u>0</u>